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Sexual and Reproductive Health and Health Sector Reform in Latin America and the Caribbean: Challenges and Opportunities

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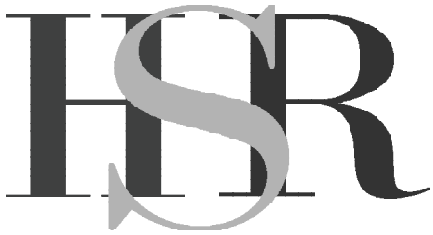

IN LATIN AMERICA AND THE CARIBBEAN

CHALLENGES AND OPPORTUNITIES

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List of abbreviations and acronyms

AGI	The Alan Guttmacher Institute
AID/USAID	United States Agency for International Development
AIDS	Acquired immunodeficiency syndrome
AP	Action Program
AVSC	Association for Voluntary Surgical Contraception
CBO	Community based organization
CC	Cervical cancer
CDC	Centers for Disease Control
Cedpa	Center for Development and Population Activities
Cepar	Center for Responsible Paternity Studies
CNDM	National Council on Women's Rights (Brazil)
DALY	Disability adjusted life years
DFID	Deparment for International Development
DV	Domestic violence
ECLAC	Economic Comission for Latin America and the Caribbean
ESCAP	Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
FAO	United Nations Food and Agriculture Organization
FONAP	National Population Fund
FP	Family planning
HIV	Human immunodeficiency virus
HPV	Human Papiloma virus
HSR	Health sector reform
IDB	Inter-American Development Bank
ICPD	International Conference on Population and Development
IDDS	Dominican Institute of Social Security
IEC	Information, education and communication
ILO	International Labor Organization
IPAS	International Projects Assistance Service
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
ISAPRES	Previsional Health Institutions
IUD	Intrauterine device
IWHC	International Women's Health Coalition
LAC	Latin America and the Caribbean
MM	Maternal mortality
NDHS	National Demography and Health Survey
NGO	Non-governmental organization
NIDI	Netherlands Inter-Disciplinary Demographic Institute
NRC	National Research Center
ODA	Overseas Development Agency
PA	Plan of Action
PAISM	Women's Integerated Health Care Program

PATH	Program for Appropriate Technology in Health, International
PNAIDS	National AIDS Program
PRB	Population Reference Bureau
RHP	Reproductive Health Program
RTI	Reproductive Tract Infections
SESPAS	State Ministry of Public Health and Social Assistance
SIDA	Sweedish International Development Agency
SISBEN	Beneficiary Identification System
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
SUS	Single Health System (Brazil)
TFR	Total fertility rate
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WB	World Bank
WEDO	Women's Environment and Development Organization
WHO	World Health Organization
YPLL	Years of potential life lost

Introduction

Most countries in Latin America and the Caribbean (LAC) are at varying stages of a reform process whose primary objective is to improve the response capacity of health systems by upgrading the effectiveness and sustainability of programs and services. Changes promoted by the reform focus especially on priority health needs and underprivileged society groups.

The spectrum of health needs in our region is broad, and setting priorities is not an easy task. However, some problems of patent importance, which affect broad sectors of the population and have serious consequences, can be tackled with cost-effective technologies. Such is the case of sexual and reproductive health (SRH), the significance of which has been recognized by most LAC governments and civil society.

Reform projects offer a unique opportunity to reconsider policies, programs and services aimed at facing the issues encompassed in the term SRH. Nonetheless, the formulation of a strategy and the identification of concrete measures in that regard represent a true challenge, as previous experiences that could sustain such efforts are few. Therefore, the convergence of endeavors of various actors is essential: health professionals, specialists in reform, and representatives of civil society as well as activists and members of the private sector.

This document describes one of the first projects carried out in LAC to explore strategies to promote the convergence of health sector reform processes and SRH improvement. Focusing on 12 countries in the region, this project was designed and executed under the auspices of the Inter-American Development Bank (IDB).

This report presents first a description of the fundamental concepts related to SRH and the general panorama of the situation in the region, as well as examples of key contributions of research, policies and programs. The second section describes the general aspects of the health sector reform (HSR) and presents some relevant cases as way of example. Particularly, it includes brief accounts of reform projects with specific activities focused on responding to SRH needs.

The document also includes the results of three sub-regional meetings held in June and July, 1999, sponsored by the IDB and organized by the Population Council (LAC Regional Office). Representatives of the host country, the Dominican Republic, El Salvador, and Nicaragua attended the first meeting, in Mexico City. The second meeting was held in Quito, with the participation of representatives of Bolivia, Colombia, Ecuador, and Peru. The last meeting took place in Brasilia, where colleagues from Argentina, Brazil, Chile and Paraguay participated. All these countries are a reflection of the regional gamut of SRH conditions (Annex 2) and the various degrees of progress in health sector reform (Annex 3).

Special care was given to the selection of participants, who could contribute a wide range of viewpoints. Participants included ministries, nongovernmental organizations (NGOs), academic institutions, private enterprises, and other institutions interested in topics of reform and SRH. In addition, IDB officials and researchers from

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Countries that participated in the three workshops on sexual and reproductive health and health sector reform, conducted in 1999

the Population Council's LAC Regional Office attended these meetings (for additional information on the attendees, see Annex 4).

Each meeting lasted three days. The meetings started by briefly presenting the advances of the reform and the SRH situation in the participating countries. Afterwards, a summarized version of the contents of the basic document prepared by those responsible for the project was presented;[1] each document had been previously distributed among the participants. Subsequently, the participants were divided into discussion groups that utilized a question guide prepared by the coordinators (Annex 5). The results of the groups were then presented in plenary sessions for general discussion. An edited version of the contributions that resulted from the consultations can be found in "Contributions of Regional Consultation Meetings" in this same document.

[1] Ana Langer, The Population Council, and Gustavo Nigenda, Instituto Nacional de Salud Pública, México.

Sexual and Reproductive Health

Fundamental concepts

In September 1994, the International Conference on Population and Development (ICPD) was held in Cairo, Egypt. This conference achieved impressive consensus on what to do regarding some of the most urgent world problems (Ashford, 1995:2). Representatives of 179 countries adopted an Action Program (AP), which includes the definitions of sexual and reproductive health that are currently used worldwide (United Nations, 1995; National Research Council, 1997).

Rather than as a mere absence of disease or ailments, SRH is defined by Cairo's AP as a general state of physical, mental and social well-being, in all aspects related to the reproductive system, its functions and processes. SRH comprises the capacity of enjoying a satisfactory sexual life, without the risk of procreation, and the freedom to decide on all aspects related to the exercise of sexuality. In like manner, the AP sets forth that men and women alike are entitled to receive information, choose and have access to safe, efficacious and acceptable methods for the regulation of fertility, as well as receive adequate health care services that guarantee safe pregnancy and delivery.

Another significant contribution of the ICPD is the legitimization of a discourse that emphasizes the relationships between social and economic development and SRH, while recognizing the existence of gender discrimination against women, which places them in a disadvantageous situation, characterized by lesser decision-making power and limited access to social, community and family resources.

These social variables add up to undeniable biological factors that account for the greater impact that reproduction and its deviations from normaly have on women. Not surprisingly then, most available epidemiological information on reproductive health focuses on women. Likewise, SRH programs and services are, in general, directed to women.

Cairo's AP recognizes the central role that relations between men and women plays in regards to women's health and rights, and declares that men must assume the responsibility for their sexual behavior, fertility, contagion of sexually transmitted diseases (STDs) and the well-being of their partners and the children they procreate.

In 1995, the International Conference on Women was held in Beijing, China. It was also convened by the United Nations. At that conference, the ICPD commitments were ratified. In 1999, five years after Cairo, the international community conducted the first evaluation of achievements and delays concerning priority issues, in order to advance towards improving sexual and reproductive health (*Cairo + 5*).

This meeting highlighted the serious problem represented by sexually transmitted diseases (especially the human immunodeficiency virus HIV/AIDS), the emphasis was on the importance of information and access to SRH services as strategies to decrease the growth of the epidemic. Safe motherhood was also extensively discussed, as well as the accessibility and quality of family planning (FP) services. Addi-

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tionally, attendees carefully evaluated the contributions made by multi and bilateral organizations, foundations, governments and social development banks towards the fulfillment of the commitments acquired in Cairo. In general, the amount of money invested so far has been much less than that promised five years ago.

Although this conference allowed ratifying the commitments acquired in Cairo, the 180 participating countries disagreed on the topics of induced abortion, family planning and sexual education at schools. The Vatican and some Latin American countries (Argentina, Guatemala and Nicaragua) advocated the most conservative positions. Brazil and Mexico, in contrast, were recognized among the countries that have contributed more resources towards the adoption of Cairo's AP.

The relationship between poverty and SRH is not linear but circular: poor socioeconomic conditions determine ill SRH, and ill SRH conditions a precarious socioeconomic situation.

Role of non-governmental organizations in the field of sexual and reproductive health

In the last decades, the feminist movement and other organized groups of the civil society gained great international presence. The movement participated decisively in the world conferences of the nineties, especially in the ICPD, where strategies to achieve reproductive health and rights were defined (Family Care International and Safe Motherhood Inter Agency Group, 1998).

In LAC, the organization of the civil society for activism and service provision has been escalating, in accordance with the growing importance that NGOs have attained worldwide. Therefore, it is reasonable to expect that these organizations will play an increasingly important role in the field of SRH and the struggle for respect for women's rights.

Improving SRH has positive consequences for the woman, her family and the community. Actually, when opportunities for women to carry out non-reproductive functions increase, general and familial socioeconomic development improves.

Sexual and reproductive health and poverty

The influence of poverty (whether at the personal, family, community or national level) on health in general has been widely documented. This association is particularly noticeable in the case of SRH. In any epidemiological study, poverty is expressed in high levels of fertility, and maternal and perinatal morbidity and mortality.

The influence of poverty on SRH is at times direct (as is the case of maternal deaths, which concentrate among women without the necessary resources to seek help at health services or that live in isolated communities) or indirect (when due to her limited decision power within the family, a woman does not react in a timely manner to a health problem of her own). In fact, the World Health Organization (WHO) maintains that the most sensitive indicator in the presence of socioeconomic differences is, undoubtedly, maternal mortality.

The relationship between poverty and SRH is not linear but circular: poor socioeconomic conditions determine ill SRH, and ill SRH conditions a precarious socioeconomic situation. The multiple effects of a maternal death serve as a dramatic example: the death of a young woman from causes that are generally preventable represents a loss of productivity for the national economy and the household. Additionally, a maternal death has an intergenerational effect that leads both to a reduced likelihood of the children's survival and receiving health care and education, and the daughters' increased risk of living in union at an early age.

Improving SRH, on the other hand, has positive consequences for the woman, her family and the community. Actually, when opportunities for women to carry out non-reproductive functions increase, general and familial socioeconomic development improves. In fact, studies have shown that women invest a larger proportion of their income in their children and households than their partners do, and that frequently, women who have jobs devote more "quality" time to their children than those that are solely dedicated to household chores.

Sexual and reproductive health in Latin America and the Caribbean

Examination of SRH indicators at the aggregated —regional or country— level suggests that LAC, in general, enjoys better conditions than other developing regions, such as Africa and Southeast Asia. However, the levels of these indicators are far below those of developed societies and even below those of other countries with similar macroeconomic conditions. Such is the case, for example, of Argentina, a country whose gross national product is relatively high and where, nonetheless, maternal mortality and other reproductive health indicators are similar to those of much poorer countries. Furthermore, regional averages conceal marked inequalities among socioeconomic strata, sub-regions, urban and rural populations, and ethnic groups, which are a reflection of unequal wealth distribution.

This section examines some sexual and reproductive health indicators that allow illustrating the sharp contrasts in the region, emphasizing the 12 countries that participated in the discussion exercise described in this document: Argentina, Bolivia, Brazil, Colombia, Chile, Dominican Republic, Ecuador, El Salvador, Mexico, Nicaragua, Paraguay, and Peru. Remarkably, available information does not present a detailed picture of the phenomena, nor does it capture the totality of the variations within these countries.

Fertility and contraception

LAC is the region in the developing world that has experienced the most noticeable fertility decrease in the past decades. Currently, the estimated total fertility rate (TFR) in the region is 3.0 (Population Reference Bureau, 1998a), with the highest values in Central America (3.4) and Bolivia and Paraguay (Table I).[2] Concurrently, in LAC, the number of children that women and men wish to have has decreased remarkably in the last decades: from 6 in 1960 to 3.3 in 1990-1995.

The reduction of fertility in the last 30 years is largely attributed to the increased use of modern contraceptive methods.

The reduction of fertility in the last 30 years is largely attributed to the increased use of modern contraceptive methods. Prevalence of use varies from country to country, as a reflection of population policies in each nation. For the region as a whole, estimates reveal that 67% of urban married women use a contraceptive method, 58% of which are modern methods (Table I).[3]

Table II presents data that correspond to ten of the 12 countries that participated in this exercise (Argentina and Chile do not have such information). This table shows that the method mix varies substantially. For example, use of contraceptive pills by women, married or in union, ranges from a low 3.8% in Bolivia to 20.7% in Brazil. Percentages of sterilized women vary from 6.8% in Paraguay to 40% in Brazil and Mexico. Vasectomy is consistently low in all countries, from 0% in Bolivia and El Salvador to 2.6% in Brazil. In contrast, use of traditional methods is particularly high in Peru (26.2%).[4] Variations in the use of contraceptive methods reflect differences in social conditions, urbanization, demographic structure, and cultural and religious characteristics. As previously mentioned, data on contraception in Argentina were not found. This country's demographic profile differs from that of most nations in the region, in that it lacks clear population policies and family planning services in public health systems.

Variations in the use of contraceptive methods reflect differences in social conditions, urbanization, demographic structure, and cultural and religious characteristics.

[2] TFR: Average number of children per woman throughout her reproductive life.

[3] "Modern methods" are those that have high efficacy and include hormonal oral contraceptives or injectables, the intrauterine device (IUD), tubal ligation, vasectomy, subdermal implants, condoms and diaphragms.

[4] "Traditional methods" are those that do not involve technology; they consist of special precautions to reduce the risk of pregnancy. Such "methods" include rhythm, coitus interruptus or withdrawal, the Billings method, among others, and are substantially less efficacious to prevent a pregnancy than "modern" methods.

Table I
Selected demographic data of 12 countries in Latin America and the Caribbean, 1998

Country or region	Population (in millions) 1998	Birth Rate	Child mortality[1]	Fertility [2]	Life expectancy at birth[3]			Urban population %	Use of contraceptives by women (Population)	
					Total	M	W		All (%)	Modern methods (%)
Argentina	36,1	19	22,2	2,5	72	69	76	89	-	-
Bolivia	8,0	36	75,0	4,8	60	57	63	58	45	18
Brazil	162,1	22	43,0	2,5	67	64	71	76	77	70
Colombia	38,6	27	28,0	3,0	69	65	73	71	72	59
Chile	14,8	19	11,1	2,4	75	72	78	85	-	-
Dominican Republic	0,1	19	16,2	2,0	-	-	-	-	50	48
Ecuador	12,2	28	40,0	3,6	69	66	71	61	57	46
El Salvador	5,8	29	41,0	3,9	69	65	72	50	53	48
Mexico	97,5	27	28,0	3,1	72	69	75	74	65	56
Nicaragua	4,8	38	46,0	4,6	66	63	68	63	49	45
Paraguay	5,2	32	27,0	4,4	69	66	71	52	51	41
Peru	26,1	28	43,0	3,5	69	67	71	71	64	41
Central America	132	29	32,0	3,4	71	68	74	66	60	52
Latin America and the Caribbean	500	25	36,0	3,0	69	66	72	72	67	58
South America	331	24	37,0	2,8	69	66	72	76	72	62
The Caribbean	37	22	40,0	2,8	68	66	71	60	55	51

[1] Child mortality rate: Child deaths per 1,000 live births.
[2] Average number of children per woman throughout her reproductive life.
[3] Life expectancy at birth: Average number of years a newborn is expected to live, provided the current mortality trends remain unchanged.

Source: PRB, 1998: *Table of World Population. Brochure*.

LAC is a region in which fertility has decreased in the past decades as a result of population policies and the use of modern contraceptives, and other factors that have fostered such reduction...

In LAC, between 19% and 34% of women of reproductive age have an unmet need for contraceptive methods (The Alan Guttmacher Institute, 1998).[5] In absolute numbers, this means that 8 million women in Brazil, 1.8 million in Colombia, 351,000 in the Dominican Republic, 6.7 million in Mexico, and 1.9 in Peru are not using an effective method to prevent pregnancy, in spite of not wanting to get pregnant.

Summarizing, LAC is a region in which fertility has decreased in the past decades as a result of population policies and the use of modern contraceptives, and other factors that have fostered such reduction, such as urbanization, incorporation of women into the work market, increased schooling and in general, changes in values and culture. However, there are important issues still to be addressed, including:

- Creation of services that respond to the reproductive needs and expectations of FP users.
- Identification of population strata with unmet need for contraception, and development of programs that include such strata.
- Involvement of men in FP programs.

[5] These are women that, although they do not want to have more children or wish to delay childbearing, are not using contraception or resort to traditional methods, which are regarded as not very efficacious.

Table II
Percentage of women aged 15-49, married or in union, who are using contraceptive methods, in ten LAC countries

Country	Any method	Any modern method	Pills	IUD	Injectables	Vaginal method	Condom	Female sterilization	Vasectomy	Norplant	Traditional method*
Bolivia [a]	48,3	25,2	3,8	11,1	1,1	0,0	2,6	6,5	-	-	22,3
Brazil [b]	76,7	70,3	20,7	1,1	1,2	0,1	4,4	40,1	2,6	-	6,1
Colombia [c]	72,2	59,3	12,9	11,1	2,5	1,4	4,3	25,7	0,7	0,7	11,1
Dominican Republic [j]	56,4	51,7	9,8	1,8	0,1	0,1	1,2	38,5	0,2	0,1	4,7
Ecuador [d]	56,8	45,5	10,2	11,8	0,5	0,6	2,6	19,8	-	-	11,3
El Salvador [e]	53,3	48,3	8,7	2,1	3,6	-	2,1	31,5	-	-	5,0
Mexico [f]	66,5	-	14,0	23,0	5,0	-	6,0	40,0	-	-	15,0
Nicaragua [g]	60,3	57,4	13,9	9,1	5,2	-	2,6	26,1	0,5	-	5,1
Paraguay [h]	50,7	41,3	13,5	7,6	6,2	0,7	6,5	6,8	-	-	7,2
Peru [i]	59,0	32,8	5,7	13,4	1,9	1,0	2,8	7,9	0,1	-	26,2

* Includes rhythm and withdrawal, among others.
Note: No data available for Chile and Argentina

Sources:
[a] Macro International, Inc., 1998
[b] Macro International, Inc., 1997
[c] Macro International, Inc. 1996
[d] CEPAR/CDC, 1995
[e] ADS y cols., 1994
[f] CONAPO, 1997
[g] Macro International, Inc., 1999
[h] CEPEP/CDC/USAID, 1997
[i] Encuesta Demográfica y de Salud Familiar, 1991-1992. Perú
[j] Macro International, Inc. ,1990

- Promotion of respect for the right of women and partners to decide on the number and spacing of their children.
- Substitution of demographic goals as success or impact indicators with goals that favor satisfaction of users' needs.
- Involvement of other sectors (education, the media, and civil society, among others), in efforts aimed at improving FP services.
- Assurance that vertical FP programs will not deteriorate or lack resources because of their incorporation into integrated SRH programs that include prenatal and STD care.

Maternal health

Maternal health encompasses all the phenomena that occur around pregnancy, delivery and puerperium. These processes imply important adjustments for the women at the biological, psychological and social levels, and are not exempt from risks. In matters of health, complications are common. Nonetheless, current technologies allow detecting and treating most of them. Regrettably, in developing countries, especially in the poorest sectors, these technologies are not always available to the individuals that need them most. In fact, broad sectors of the population do not receive yet medical care during pregnancy and childbirth, or have access to substandard services only.

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The term "maternal morbidity" includes complications related to pregnancy, childbirth and puerperium. Poor-quality hospital records and the fact that many women in our countries do not attend health services result in scarce, average-

quality information about morbidity. Nevertheless, during pregnancy, delivery and puerperium, as many as 15% of the women are known to suffer life-threatening complications that are mostly sudden and unpredictable. Furthermore, repeated morbidity may produce long-term side effects, such as prolapse and fistulas, which extensively affect the women's quality of life.

Maternal deaths concentrate in women that lack information, who have limited decision power, mobility, and access to material resources, and restricted influence to persuade others into respecting their rights as health service users.

Maternal deaths[6] constitute the end of the spectrum of disease. According to Mora and Yunes (1993), in LAC the probability of a maternal death from causes associated with pregnancy or childbirth is 1 out of 79. This probability is much higher in some countries in the region and for certain population sectors and ethnic groups. In fact, there is a variability that ranges from 1 per 410 women in Uruguay, to 1 per 26 in Bolivia (Table III). Maternal mortality[7] ranges from 36 maternal deaths per 100,000 live births in Uruguay, to 650 per 100,000 in Bolivia (PRB, 1998b).

Maternal deaths concentrate in women that lack information, who have limited decision power, mobility, and access to material resources, and restricted influence to persuade others into respecting their rights as health service users. In LAC rural communities, a high percentage of women are still assisted by traditional birth attendants, a family member or no one at all; the distribution and number of available physicians do not meet attention needs and the number of trained midwives is still very low.

Women who die from such complications are usually young mothers of small children, and these deaths are preventable in more than 90% of the cases. When a woman dies, her family is

[6] Maternal death: The death of a woman from any cause related to or aggravated by pregnancy, delivery or puerperium.

[7] Maternal mortality (ratio): Number of maternal deaths per 100,000 live births.

Table III
Maternal health in Latin America and the Caribbean

	Risk of maternal death during reproductive life (women aged 15-49) 1 in (x) women*	*Maternal mortality (per 100,000 live births)*	*Percentage of trained providers at childbirth***
Argentina	290	50	96
Bolivia	26	650	46
Brazil	130	220	81
Colombia	300	100	85
Chile	490	44	98
Dominican Republic	230	110	90
Ecuador	150	150	64
El Salvador	65	300	87
Mexico	220	110	69
Nicaragua	100	160	61
Paraguay	120	160	66
Peru	85	280	53

* Risk of maternal death caused by pregnancy or delivery throughout a woman's life (example: 1 in 3,000 means low risk; 1 in 100 is high risk).

** Providers (physicians, midwives, nurses) trained in obstetric care per 100 live births.

Sources: WHO/WB, 1997; PRB 1998b

at risk of disintegration, because the primary childcare giver is lost. The likelihood of her children growing healthily, experiencing well-being or even surviving is extremely low. The community loses a fundamental member and the economy suffers the loss of the woman's contribution to the labor force.

The complications that lead to a maternal death are distinctly homogenous in poor countries. In the developing world, according to data published by Family Care International and the Safe Motherhood Inter-Agency Group (1998), the distribution of causes of maternal mortality is as follows: hemorrhage (24%), sepsis (15%), unsafe abortion (13%), eclampsia (12%), obstructed delivery (8%) and other direct causes (such as ectopic pregnancies, embolism and anesthesia-related complications) (PATH, 1999). "Indirect" causes (not associated with pregnancy, delivery or puerperium) account only for 20% of maternal deaths.

The proportion of induced abortion-related maternal deaths that has been officially recorded is far below the actual figures. In fact, many deaths brought on by the interruption of pregnancy are classified under hemorrhage or infection. Adequate recording of maternal deaths could double this proportion. Moreover, correcting the figures produced by the under-recording of maternal deaths in general, and of those that are associated with an abortion results in 10,000 deaths from abortion per year in the region. Induced abortion complications are important and require hospital attention. Furthermore, care provision for post-abortion complications consumes a significant amount of institutional resources. When the frequency of contraceptive use increases and the quality of services for complications improves, the number of deaths caused by abortion decreases (hence, the percentage of unwanted pregnancies).

Prevention of maternal deaths is a question of human rights and social justice. The actions needed to decrease maternal mortality are undoubtedly multi-sectorial in nature. In 1997 and 1998, the advances achieved during the decade that followed the launching of the Safe Motherhood Initiative were analyzed. Actions identified as key to abating MM include:

- Political commitment of governments, international agencies, social organizations and donors to direct resources towards cost-effective interventions for the promotion of maternal health; invest in maternal care services in settings where they are still unavailable; strengthen health institutions' capacity to assist obstetric emergencies, through equipment and training provision; involve private providers and insurance companies; and support voluntary social organizations to carry out community work.
- Public policies that improve women's access to good-quality information on SRH; provide women with education and economic opportunities and control over personal, family and community resources; and sensitize men to their role regarding the woman's condition, the couple's SRH and family life.
- Multi-sectorial programs and services oriented towards providing all pregnant women with access to quality health care, and adequate transportation means and routes to seek medical care.
- A health system that ensures labor care provision by trained professionals.

Sexually transmitted diseases

Sexually transmitted diseases (STDs)[8] have always been part of human history, but have be-

When a woman dies, her family is at risk of disintegration, because the primary childcare giver is lost.

Care provision for post-abortion complications consumes a significant amount of institutional resources.

Prevention of maternal deaths is a question of human rights and social justice. The actions needed to decrease maternal mortality are undoubtedly multi-sectorial in nature.

[8] The most frequent STDs are syphilis, gonorrhea, trichomoniasis, chlamydiasis, genital herpes and HIV/AIDS. Other common infections, such as candidiasis and bacterial vaginosis, can be transmitted sexually, but are not necessarily originated by sexual contact, as they are the result of vaginal flora imbalance.

STDs affect millions of women worldwide and have significant negative effects on their health…

come more prevalent in the last decades. This increase in prevalence, the appearance of the acquired immunodeficiency syndrome (AIDS) pandemic and evidence of greater vulnerability of women to these infections have made STDs the focus of international concern.

STDs represent a greater risk for women because of the female genital anatomy, which makes them especially susceptible to infections. Furthermore, many STDs are asymptomatic in women, thus remaining unnoticed and hence, undetected and untreated. Social and cultural inequality contributes to exposing women to greater risk. Women frequently lack control over the circumstances that surround their sexual lives, are not aware of their partners' sexual practices or are unable to negotiate the use of condoms, which is the only current measure available to prevent STDs.

STDs represent the second most important cause of the burden of disease (second only to causes related to maternal health) among young adult women in developing countries.

STDs affect millions of women worldwide and have significant negative effects on their health (pelvic inflammatory disease and infertility, ectopic pregnancy and vulvo-vaginitis), their quality of life (painful intercourse, ailments such as pruritus and discharge) and their children's health (contagion of infection, low birthweight and fetal death), among others. From a social perspective, the obvious association of STDs with sexuality has given rise to an unspoken taboo against these diseases among women. On the one hand, women dare not seek medical help when they suffer from a sexually transmitted disease; on the other hand, health professionals do not ask them about such ailments. Furthermore, STD management has not been integrated into the SRH service package, especially into FP services.

The probability of man-to-woman HIV contagion is eight times greater than woman-to-man transmission. Additionally, the ratio of man-to-woman transmission of HIV/AIDS infection in the region is closing. In mid 1996, estimates showed that such ratio was 4 to 1 for Latin America and 5 to 1 for the Caribbean.

According to the Report on World Development (World Bank, 1993), STDs represent the second most important cause of the burden of disease (second only to causes related to maternal health) among young adult women in developing countries (Fathalla, 1994; Van Dam, 1995). In spite of the lack of reliable information about STD prevalence and incidence, some calculations for LAC have been carried out. For example, for the region as a whole, the number of individuals affected by curable STDs (gonorrhea, chlamydiasis, syphilis and trichomoniasis) among adults (aged 19-45) was 24 million in mid 1995, nearly 10% of the total global estimate (250 million) (ODA, 1996). In like manner, the total annual estimate of new cases of curable STDs among adults was 34 million for LAC and 333 million worldwide, in 1995 (ODA, 1996). Also in 1995, the annual estimate of new cases of gonorrhea among adults in LAC was 7.1 million (62 million worldwide), 1.3 million cases of syphilis (12 million globally), 10 million cases of chlamydia (89 million worldwide) and 18 million cases of trichomoniasis (170 million globally) (ODA, 1996). These appalling figures are much smaller than those observed in other regions of the world, particularly in SoutheastAsia and Africa.

AIDS is, undoubtedly, the STD of more devastating consequences. Actually, it is the most important cause of death among men aged 25 to 44 in the region (Izazola and Huerdo, 1998). Transmission patterns have moved from an initial prevalence of man-to-man transmission to heterosexual transmission (Izazola and Huerdo, 1998). The probability of man-to-woman HIV contagion is eight times greater than woman-to-man transmission (Padian *et al.*, 1997). Additionally, the ratio of man-to-woman transmission of HIV/AIDS infection in the region is closing. In mid 1996, estimates showed that such ratio was 4 to 1 for Latin America, and 5 to 1 for the Caribbean (ODA, 1996); other estimates for that year were 3.6:1 for Latin America and 1.9:1 for the Caribbean (Cuchi, 1997).

Throughout 1990, the male population in LAC lost three times more DALYs[9] (341,000) than the female population (102,000) due to HIV

[9] DALYs: Years of healthy life lost. A measurement of years lost due to both premature death and disability resulting from morbidity.

(ODA, 1996; World Bank, 1993). The presence of other sexually transmitted infections increases the risk of HIV contagion. Such association has been shown for those STDs, such as syphilis, that cause ulcerative lesions.

Vertical transmission of the virus to newborns also represents a significant problem, especially in developing countries, whose resources are usually too limited to implement prophylactic treatments for mothers infected with HIV. In 1996, the accumulated number of vertically infected children was 67,000 in Latin America and 21,000 in the Caribbean (ODA, 1996). The number of new cases of child infection was 9,000 in Latin America and 5,000 in the Caribbean, in 1996.

The AIDS epidemic is evidently a regional public health priority (Izazola and Huerdo, 1998). However, attention paid to AIDS varies. The obvious association of AIDS with sexuality has resulted, more often than not, in the promotion of confusing and not very explicit information regarding the use of the condom and sexual practices. Such information has brought forth disastrous consequences, as prevention is the only strategy available so far to control the epidemic. Brazil and Mexico are the two countries in Latin America with the most developed AIDS-control strategies, which include the participation of public health programs and especially NGOs. Women and youth require special attention in the fight against AIDS. Actually, it is among them that the epidemic spreads faster. Clear and explicit information and services, and negotiation power are some tools with which both women and young individuals can be equipped to fight against this infection.

The actions needed to face this problem are manifold and involve several sectors. Among such actions, the most important are:

- To create awareness among governments and societies regarding the importance of disseminating information and reinforcing preventing behaviors.
- To disseminate information and establish preventive programs targeted on the youth, at schools and through the media.
- To promote, especially among women and young women, negotiations with men about condom use. To investigate the factors associated with the successful use of a condom.
- To integrate STD screening and treatment with other reproductive health services.
- To avoid any violation to human rights, as well as discrimination against individuals who live with HIV/AIDS.
- To make information, medication and techniques that decrease the risk of vertical transmission available to all pregnant and HIV/AIDS-infected women.
- To ensure collaboration between civil society groups, especially activists, and public programs and services.
- To obtain the necessary funds to stop the escalation of the HIV/AIDS epidemic.

Cervical cancer

In past years, the relationship between cervical cancer (CC) and the Human Papilloma Virus (HPV), a sexually transmitted infection, has been fully established. This discovery explains the connection between CC, the age at first intercourse and the number of partners. From this perspective, CC is an STD, hence an item on Cairo's reproductive health agenda.

Cancers of the reproductive system are the main cause of death from cancer among adult women in Latin America and the Caribbean, being cervical cancer the most frequent. Available data suggest that each year between 20,000 and 30,000 women in the region die from it (Restrepo, 1993), in spite of the fact that this cancer is preventable (as it is a sexually transmitted infection), detectable (through Papanicolaou smear), of slow evolution and curable if discovered at early stages.

Unfortunately, in the past 20 years, mortality caused by CC has increased in most countries of

The obvious association of AIDS with sexuality has resulted, more often than not, in the promotion of confusing and not very explicit information regarding the use of the condom and sexual practices.

Cancers of the reproductive system are the main cause of death from cancer among adult women in Latin America and the Caribbean, being cervical cancer the most frequent.

the region. Only in some are slight decreases observed: between 1975 and 1985, mortality rates in Chile, Ecuador, Paraguay, Peru, Puerto Rico, Trinidad and Tobago, Uruguay and Venezuela have decreased from –0.7 to –1.7% (Restrepo, 1993). This decrease has little significance from the perspective of public health, especially in view of the fact that CC is a reproductive health problem that can be confronted with preventive strategies of proven cost-effectiveness.

In LAC, most women who die from CC are underprivileged and have limited access to adequate gynecological care and preventive education, including data on risk factors and identification and early treatment of cervical lesions. Additionally, early CC screening programs are deficient regarding coverage and quality. In general, these programs focus on women of higher socioeconomic levels of low and medium-risk ages.

In LAC, most women who die from CC are underprivileged and have limited access to adequate gynecological care and preventive education.

An effective response to CC includes the following challenges to health systems:

- To provide women with information about the relationship between cervical cancer and HPV infection, underscoring the importance of early screening and treatment.
- To establish early screening programs for CC and HPV infection. Such programs should be characterized by first-rate quality, broad coverage and follow-up systems.
- To integrate CC screening, diagnosis and treatment with other reproductive health services.
- To establish referral systems and ensure treatment for women with advanced CC.

Domestic violence against women

Violence derived from gender inequalities has different expressions, including rape, sexual abuse of children and domestic violence (DV). The latter has been globally recognized as a priority problem in SRH (Heise, 1994; Heise *et al.*, 1994).

According to the US National Research Council, 30% of the women in two Caribbean islands, 20% in Colombia and 60% in an area in Santiago de Chile reported having been battered by their husbands.

In Latin America and the Caribbean, data on DV prevalence are very limited. However, several studies suggest that this problem affects many women in the region. According to the US National Research Council (Buvinic *et al.*, 1999), 30% of the women in two Caribbean islands, 20% in Colombia and 60% in an area in Santiago de Chile, reported having been battered by their husbands. Data collected by another report (Buvinic *et al.*, 1999) also highlight how important DV is to women in the region. For Colombia, Costa Rica, Chile, Mexico and Nicaragua, that report presents figures that suggest that physical violence, particularly within the marital or daily life context is surprisingly common. A study sponsored by the Inter-American Development Bank gathers figures on domestic violence (physical, sexual and psychological) and its perpetrators (Buvinic *et al.*, 1999). Prevalences are astoundingly high (Table IV).

The implications DV has on a woman's physical and mental health are considerable, in both the short and the mid-terms, and include direct physical lesions, pelvic inflammation, unwanted pregnancy and abortion, as well as various psychological traumas: depression, anxiety, and sexual dysfunction (NRC, 1997:31). In addition, DV has many indirect effects on a woman's reproductive health, as it limits her control over her sexual life, which in turn puts her at risk of STDs, unwanted pregnancies and unsafe abortion.

The roots of violence against women lie on social conditions. Gender inequality, social acceptance (implicit or explicit) of men's power over their partners, women's limited access to information and family resources, alcoholism, a lack of legislation to protect women and scarcity of public institutions where they can seek help, as well as the incipient organization of civil groups, are some of the factors that underlie the high frequency of this phenomenon in LAC.

The effort needed to overcome the problem of DV requires the participation of several sectors of society. Thus, the following is necessary:

Table IV
Prevalence of violence against women in the Americas

Country	*Type of violence*
Canada (1993) +	25% physical
Colombia (1990) +	34% psychological 20% physical 10% sexual
Colombia (1995) #	19% physical
Costa Rica (1994) +	75% psychological 10% physical
Chile (1993) *	34% psychological 11% physical (severe) 16% physical (moderate)
Guatemala (1990) +	49% abuse 74% by an intimate partner
Haiti (1996) +	70% abuse 36% by an intimate partner
Mexico (1995) +	45% abuse 18% psychological and sexual 16% physical and psychological
Mexico (1996) #	16% physical
Mexico (1997) *	13% physical
Nicaragua (1995) #	40% physical
Paraguay (1996) #	9 % physical 31% psychological
United States (1986)	28% physical

\# Throughout her life
* In the last year
\+ Non-specified period

Source: Buvinic et al., 1999.

- Policies that protect women, typify domestic violence as a crime, and implement the corresponding punishment.
- Programs and services whereby health providers learn about the prevalence, manifestations and ways of detecting signs of violence in their patients.
- Special agencies and services with personnel trained in providing legal counseling and orientation to victims, regarding the institutions where they can seek help.
- Specialized government and civil society agencies that attend to women and that work with men, the usual perpetrators of violence. Both governments and NGOs play an essential role in offering efficient options. Colombia, Mexico, and other countries in the region are making headway in that regard.
- Cultural and social changes that foster improvement in a woman's condition and give her greater power in public and private spheres.

Sexual and reproductive health of adolescents and young adults

The social position of adolescents, which is characterized by dependency and physical and emotional immaturity, makes the youth vulnerable, especially in matters of SRH.

International organisms, governments and the civil society have recognized that adolescents and young adults are a priority group. The social position of adolescents, which is characterized by dependency and physical and emotional immaturity, makes the youth vulnerable, especially in matters of SRH.

In 1996, estimates showed that there were nearly 148 million individuals, aged 10 to 24, in LAC. This figure represents approximately 30% of the total population in that year. In the region, a high proportion of adolescents are sexually active before marriage. Additionally, the age of union has somewhat decreased in the last decades and continues to lower among women (Table V). The early beginning of procreation is associated with an equally early age at first union, low schooling levels and certain cultural norms that foster the wife/mother role as the most legitimate for women. A factor that contributes to early fertility is that contraceptives are less frequently used to delay the first birth than to delay subsequent births.

The early beginning of procreation is associated with an equally early age at first union, low schooling levels and certain cultural norms that foster the wife/mother role as the most legitimate for women.

A union at an early age is associated with premature dropping out and high fertility. Young women under 16 years and without schooling

start living in union five times more frequently than their counterparts who have completed primary school. Individuals aged 15 to 19 are attributed approximately 30% of the regional fertility rate; Bolivia and Peru are the countries with the lowest percentage of adolescent pregnancies in the region (9%), whereas Nicaragua has the highest (17%) (Table V).

The pressure family and society exercise on the youth to start childbearing and living in union at an early age should be reduced.

Among young adolescents (under 17), physical immaturity increases the risk associated with pregnancy and childbirth. Actually, women who are under 15 are four times more likely to die from causes related to pregnancy than women aged 20 or older are. Furthermore, the children of adolescents have 30% more probabilities of dying during the first year than those of adult women (AGI, 1998).

In many countries in LAC, the percentage of births among women aged 15 to 17 is relatively high (AGI, 1998). In fact, 33% of the births in the region occur before a woman turns 20 (in Nicaragua, this figure reaches 48% and in El Salvador, it is 46%). In Peru, in turn, the frequency is slightly lower than the regional mean (27%). Data for Argentina, Paraguay and the Caribbean sub-region are not available.

A delay of the age of union, beginning of sexual life and birth of the first child can be accomplished only through a complex change in social and cultural expectations, together with better schooling and employment opportunities for the youth. Firstly, the pressure family and society exercise on the youth to start childbearing and living in union at an early age should be reduced. Such pressure is the result of the low social value assigned to women, which in turn translates into scarce opportunities to have the necessary training to perform a role other than that of a wife/mother. The lack of schooling condemns a woman to low social status, a state of ignorance of her rights, restricted access to the labor market, and low self-esteem. Additionally, a woman's low schooling becomes a factor in the late detection and inadequate management

Table V
Young population in Latin America and the Caribbean, 1996

	Population aged 10-24 (in millions)	*Population aged 10-24 (% of the total)*	*Average age at first marriage (all women)*	*Global fertility rate (GFR) (Total population)*	*Percentage of GFR that corresponds to population aged 15-19 (1996)*
Argentina	9,5	27	22,9	2,8	11
Bolivia	2,4	32	22,8	4,8	9
Brazil	48,6	30	22,6	2,9	13
Colombia	10,8	30	22,6	2,7	13
Chile	3,8	26	23,4	2,5	11
Dominican Republic	2,4	31	-	3,3	15
Ecuador	3,8	32	21,1	3,5	13
El Salvador	2,0	35	-	3,8	16
Mexico	30,5	32	20,6	3,1	12
Nicaragua	1,6	34	-	4,6	17
Paraguay	1,5	30	21,8	4,3	11
Peru	7,7	32	22,8	3,5	9
Central America	42,0	32	21,0	3,4	13
Latin America	148,0	30	22,0	3,1	13
South America	96,0	30	23,0	3,0	13
The Caribbean	10,0	28	21,0	2,8	14

GFR: Global fertility rate (Average number of children per woman throughout her reproductive life).

Source: PRB, 1996.

of her health problems and her children's, as shown by the consistent association between low schooling and extremely high maternal and child mortality (Langer and Lozano, 1999).

Within this general context, the specific areas in which progress should be made include:

- Development programs that increase education and employment opportunities for young individuals, as well as incentives to reduce dropout rates.
- Changes in the labor legislation to protect young women; opportunities for micro companies administered by women and support for female adolescents that work on productive projects.
- Sexual education and access to services and information in order to reduce the number of unions and pregnancies during adolescence, especially in rural areas.
- Access to specially designed, adolescent-oriented FP services.
- Services for adolescent mothers, where special emphasis on child upbringing and the importance of pregnancy spacing is placed.

Countries like Colombia and Mexico are leaders in LAC and the developing world in the ambit of program development for adolescent education and attention, in both the public and non-governmental sectors.

Reproductive rights

Currently, reproductive rights are part of the human rights already recognized by national laws, international treaties and other agreements. Reproductive rights refer to both men and women, and include acknowledgement that all couples and individuals are entitled to the following basic rights:

- To decide freely and responsibly on the number and spacing of children.
- To have access to adequate health services that enable women to experience safe pregnancy and delivery.
- To receive information and have access to the family planning methods of their choice, which should be safe, effective, affordable and acceptable.

Promotion of the responsible exercise of these rights should be the basis of policies and programs on reproductive health, including family planning. Guaranteeing reproductive rights is an effort in which governments and the civil society alike should participate. In many countries of the region, important measures have been taken to adapt laws and practices to guarantee reproductive rights. However, much remains to be done.

Currently, reproductive rights are part of the human rights already recognized by national laws, international treaties and other agreements.

Although Cairo's Action Plan establishes that abandoning demographic goals that consider the decrease of populational growth and fertility as primary success indicators of population programs is essential, many LAC countries still use such indicators as their objectives. These policies do not focus on the users' reproductive needs. Rather, they stimulate the use of definitive methods, such as tubal ligation, or long-term methods, such as the intrauterine device, that facilitate reaching such demographic goals. This promotion can be implicit or explicit, as is the case of programs that include clear incentives for providers for the IUDs they insert or the sterilizations they carry out. However, sterilizations that are not performed in compliance with fundamental ethical principles have very serious consequences. Denunciations regarding this practice have been issued in Bolivia, Mexico and Peru, and other countries in the region. Besides having personal and family consequences, violations to reproductive rights tarnish the reputation of programs and governments, promote distrust among the population and, on occasion, limit international assistance.

Besides having personal and family consequences, violations to reproductive rights tarnish the reputation of programs and governments, promote distrust among the population and, on occasion, limit international assistance.

Finally, there is another type of violation to reproductive rights, which is subtler but serious nonetheless: hindrance or refusal to provide individuals (or some groups, such as adolescents) with access to SRH services, especially contraception.

Sexual and reproductive health of relegated groups or populations with special needs

Most reproductive health programs and services, particularly FP services, have been designed to meet the needs of urban or semi-urban women. This emphasis leaves large population sectors unattended. Traditionally, men, indigenous and isolated rural populations, and adolescents have been recognized as groups with special needs, which are not covered by current services.

Deploying a significant, multidisciplinary research effort is necessary to determine men's needs and their role in the reproductive decision making…

The term SRH includes both men and women. However, as partners of women, men have been historically considered a problem that needs solving rather than a target population (Greene and Biddlecom, 1997; CEPAR/CDC, 1995). After the Cairo conference, men's biological and social reproductive needs have been explicitly recognized. Due to the traditional emphasis placed on women, deploying a significant, multidisciplinary research effort is necessary to determine men's needs and their role in the reproductive decision making, as well as to develop contraceptive technologies that allow men to share in the responsibility for contraception. Furthermore, services have to foster and facilitate men's participation by adopting special schedules, training personnel and in general, promoting a change in attitude among health providers.

Sexual and reproductive health reflects the socioeconomic level of a country, community and family, including a woman's condition. Additionally, it is a reflection of the utilization of services and their quality.

See the section on workshop contributions for information about problems of indigenous groups, and "Sexual and reproductive health of adolescents and young adults" for details on the situation of the youth.

In general, actions needed include:

- To set equity among social and ethnic groups as an objective of all development programs.
- To guarantee that all marginalized groups in our societies have access to education, employment and health, that is, to a dignified life.
- To learn about special reproductive health needs of marginalized groups and present alternatives to satisfying such needs.
- To consider the cultural, linguistic, and geographic peculiarities of marginalized groups to offer innovative, effective solutions.

Sexual and reproductive health and social inequality

International and financial organisms generally regard LAC as a region with less pressing needs than those of other areas in the developing world. In fact, health indicators such as child mortality, fertility and prevalence of some infections, such as AIDS and other sexually transmitted infections, are more favorable than those observed in Africa and countries in Southeast Asia, for instance. However, such global indicators hide profound inequalities among sub-regions, countries, social and ethnic groups, and genders. Indeed, Latin America is in many ways a mosaic, and reproductive health is no exception.

Sexual and reproductive health reflects the socioeconomic level of a country, community and family, including a woman's condition. Additionally, it is a reflection of the utilization of services and their quality. The influence socioeconomic factors have is clearly revealed in almost any reproductive health indicator: fertility and age at first pregnancy, contraception, maternal health, induced abortion, and cervical cancer.

Thus, for example, the results of the National Survey on Epidemiology and Family Health in Honduras (1996) show that the national average for hospital labor care is 54%. However, 68% of rural women, 71% of women classified as be-

longing to a "low socioeconomic level", and 74% of those classified under "no formal schooling" give birth at home. In Nicaragua, the global fertility rate for 1987-1992 was 3.19 in Managua, the capital city, whereas in rural areas it was 6.40. Similarly, drastic differences are found among women without schooling (GFR 6.93) and those who completed secondary school or higher (GFR 2.38) (Survey on Family Health, 1993.)

Response to sexual and reproductive health needs

Legislation, policies, programs and services

In LAC, legislation, policies and programs aimed at meeting regional reproductive health needs have often been established in recent years as a response to agreements signed by governments at the last two most important world conferences: ICPD (1994) and the World Conference on Women (1995). Following are examples of such efforts:

- Chile and Mexico explicitly guarantee reproductive rights. Chile created a new Program on Woman's Health, which includes sexual and reproductive health problems, and Mexico established the Reproductive Health General Directorate and a National Program on Women.
- In Bolivia, Dominican Republic, Guatemala, Haiti and Paraguay, the reduction of maternal mortality is one of the most important objectives of all reproductive health initiatives. The National Mother-Child Insurance in Bolivia provides women with free access to prenatal, labor and post-natal care.
- In El Salvador, the National Family Secretariat works with adolescents for the prevention of pregnancy and sexually transmitted diseases, such as AIDS, through information and counseling services.
- Efforts to improve family planning services in several countries in the region are underway. Budgetary allocations in Brazil consider the provision of a broad gamut of contraceptive methods that increases the likelihood of selection by users.
- Brazil is the first country in Latin America to create a National Commission on Population and Development.

The objectives of the most advanced programs are the provision of reproductive health services for women throughout their lives.

The objectives of the most advanced programs are the provision of reproductive health services for women throughout their lives, reduction of unwanted pregnancies and unsafe abortions, screening and treatment of cervical and breast cancer, improved and broader prenatal and post-natal care, increased medical care during childbirth, reduction of reproductive risk among women adolescents, and prevention of HIV/AIDS and other sexually transmitted diseases.[10]

The most recent trend of policies and programs in LAC has pointed towards the integration of reproductive health services, including family planning programs.[11] For example, the government of Bolivia has declared that family planning is only a component of SRH. However, in practice, only a handful of national programs offer a complete gamut of services. Thus, patient referral due to complications during labor is difficult, as primary care services are not integrated into secondary and tertiary attention. Similarly, HIV and STD prevention in general is carried out separately from maternal care, family planning and education. Moreover, nutritional supplementation is frequently omitted during pregnancy, especially among adolescents, and rarely do providers include screening and early treatment of cervical cancer, for instance, at the primary care level, in spite of existing measures of proven cost-effectiveness for that purpose.

[10] Although the Argentinian government has established that its citizens have the right to receive family planning services and that the State has to offer information about this subject, this is the only country in Latin America and the Caribbean that lacks a national family planning program.

[11] With the exception of Jamaica.

Frequently, service coverage and quality are deficient. This is a reflection of generalized deficiencies of the health system, squandering of resources, inefficient use and lack of systematic attention to many important health problems of underprivileged populations. In the same way, the priority given to SRH in terms of invested public resources is still low: estimates show that extra-budgetary expenses and external assistance finance up to 80% of all reproductive health services in the region.

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Another problem is that laws and policies related to SRH are not usually integrated into general policies that focus on women. Normally, the approach is not multi-sectorial nor does it include the gender perspective. In Colombia, Mexico and Peru, an explicit objective of SRH programs is to increase a woman's power. Nonetheless, the coordination of those programs that should participate in this effort is poor and its quality variable.

Another limitation of reproductive health programs and services is that they do not respond to the needs of rural and indigenous populations. Although such groups present much higher reproductive morbidity and mortality, few national policies include alternative care models for these communities. Colombia and El Salvador, as well as reproductive health programs in Mexico and Peru, constitute an important exception.

In LAC, providers' practice and pharmacies in the private sector are scarcely regulated.

Throughout the region, legal and programmatic provisions for reproductive health education and services among female adolescents vary. A small number of countries have specific policies and laws, in spite of the fact that through general reproductive health programs six of them have found that female adolescents are at high risk. Availability of information and statistics on adolescents is heterogeneous, which hinders the assessment of the situation. However, motherhood among young women is a problem that all countries recognize.

For a decision-making process to be carried out rationally, timely and quality information is essential.

In LAC, the practice of providers and pharmacies in the private sector is scarcely regulated. However, regional studies show that high proportions of men and women attend private services and purchase products at drugstores. In general, information and counseling offered at pharmacies are of poor quality, and sometimes dangerous (for instance, unnecessary, inefficacious medication to treat STDs). Private medical services lack quality controls and regulation. Therefore, quality of service is highly variable.

Another prevailing problem is that available statistical information is insufficient, outdated and of poor quality. Although health statistics systems in general have improved throughout the region, a complete and reliable recording of diseases, births and deaths remains an unattained goal. Furthermore, we do not have sex disaggregated statistical data, which could provide a much more precise perspective on women's health problems and differences by gender. Survey data on demographic behavior and health are available only for 13 countries in Latin America and the Caribbean. AIDS and STD epidemiological surveillance is limited to specific locations or populations and it is usually carried out only through sentinel studies.

Decision making on interventions aimed at improving sexual and reproductive health

Good SRH depends largely on available technologies and knowledge for the identification, early diagnosis and treatment of problems. These measures, in addition to being effective, should be affordable, and health interventions should include a reasonable balance between cost and effectiveness.

Making decisions will always be difficult, since the first reaction of all those interested in the well-being of the population is to assume that health should improve, whatever the cost. However, we know that such position is not realistic, as the necessary resources will not always be available, especially in developing countries.

For a decision-making process to be carried out rationally, timely and quality information is essential. This represents a challenge for LAC,

where in spite of recent advances in statistical information systems in some countries, the situation is far from ideal. In the field of reproductive health, available data come mainly from demographic and health surveys. Although such information is of good quality, it often lacks the required periodicity and representativity. For instance, many surveys are valid only at the regional level and do not allow for inferences at the municipal and community levels. Additionally, they usually recruit only women living in union, leaving out young and single women, and men. Furthermore, their approach is still centered on contraceptive practices, in spite of the efforts made to incorporate other issues, such as maternal mortality or sexually transmitted diseases. Lastly, we would like to add that these surveys have not been performed in all the countries in the region.

Vital statistics suffer from heavy under-recording, erroneous classification and a lack of sex disaggregation. Nonetheless, the worst deficiencies are found in morbidity records, due to low health service coverage and deficiencies of recording systems at health institutions. These factors seriously hamper rational decision making, as well as progress and priority assessment for programs and services.

In addition to epidemiological information, costing data of interventions and technologies are essential. For the evaluation of options, establishing a relationship between cost and effectiveness is critical. Regrettably, unit cost data of health services are difficult to obtain, because in general, only direct costs are considered, and fixed and indirect costs are omitted.

To check for balance between health needs and public policies, a set of indicators oriented to measure the *loss of healthy years of life* (Murray and Lopez, 1998), as a much more informative option for policy decision making than classic data on morbimortality, has been recently developed. Following is a description of some of the most important indicators that are being utilized in the region.

Reproductive health-related morbidity and mortality constitute the main cause of *disability adjusted life years*[12] (DALYs) (Bobadilla *et al.*, 1993) in the region. According to the World Bank, a health intervention in LAC can be deemed cost-effective if it allows "giving" an individual a DALY for less than US $160. In general, interventions aimed at improving SRH are highly cost-effective. For instance, prenatal care costs between 35 and 72 dollars per DALY, less than other medical interventions; prevention and treatment of sexual diseases save between 55 and 134 dollars per DALY; family planning saves between 112 and 464 dollars, and HIV/AIDS prevention and detection between 165 and 258 dollars. In countries with high CC prevalence, prevention and treatment are cost effective (in Peru, 160 dollars per DALY saved) (Table VI)

Another measurement used to analyze the effectiveness of health interventions is the *years of potential life lost* or YPLLs.[13] The impact of each specific intervention on mortality and morbidity varies according to local conditions. In the studies carried out, such variation becomes evident with the incorporation of factors such as coverage, efficacy and effectiveness of local programs. Effectiveness is the result of the disease's behavior, quality of services and characteristics of users, in the country in question.

Cost-effectiveness studies carried out in Latin America and the Caribbean, have repeatedly shown that prenatal and postpartum health care, breastfeeding promotion, contraceptive services, AIDS prevention, STD detection, and preventive techniques for early CC screening save many lives through relatively low-cost interventions (Table VI). Consequently, investment of

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[12] *Disability adjusted life years* refers to the healthy years lost due to premature death or disability.

[13] This indicator refers to the loss of potential life of a population due to a specific cause or general mortality, in relation to such population's life expectancy.

Table VI
Cost-effectiveness of reproductive health interventions in selected LAC countries (US$)

Country	*Intervention*	*Measurement**	*Result‡*
***Bolivia*[1]**	Vitamin A supplementation	US$/YPLLs gained	8
	Family Planning	US$/YPLLs gained	112
	Prenatal and labor care	US$/YPLLs gained	72
Mexico[2]	Prenatal care for high-risk pregnancies	US$/DALYs saved	43
	STD treatment (exception made of HIV) in high-risk groups	US$/DALYs saved	55
	IUD insertion	US$/DALYs saved	75
	Non-surgical family planning	US$/DALYs saved	96
	Non-specified subsidy for condoms	US$/DALYs saved	258
	Tetanus immunization	US$/DALYs saved	294
	Prenatal and labor care for low-risk childbirth	US$/DALYs saved	305
	Breastfeeding promotion	US$/DALYs saved	306
	Iron supplementation	US$/DALYs saved	313
	Vasectomy	US$/DALYs saved	376
	Cervical cancer screening	US$/DALYs saved	381
	Tubal ligation	US$/DALYs saved	464
	Treatment for abortion complications	US$/DALYs saved	817
***Dominican Republic*[3§]**	Prenatal and labor care	US$/DALYs saved	35
	STD prevention and treatment	US$/DALYs saved	134
	Family planning	US$/DALYs saved	402
	Cervical cancer prevention and treatment	US$/DALYs saved	5
	HIV/AIDS prevention and detection	US$/DALYs saved	165

* DALYs: Disability-adjusted life years are measurements of non-death health results, based on the time an individual suffers from disability.Through these measurements, the load of diseases and lesions on a human population is estimated based on the years of life lost due to disability or death

YPLLs: Years of potential life lost in a population due to a specific cause or general mortality in relation to such population's life expectancy.

‡ All cost-related efficiency coefficients are in constant 1994 US dollars

§ The Dominican Republic study only examined cost-effectiveness for the poor, who are defined as individuals that live in family units with unattended basic needs.

[1] Source: Ministerio de Desarrollo Humano, 1995.

[2] Source: FUNSALUD, 1994.

[3] Source: Oficina de Coordinación Técnica, 1997.

available health resources in these actions is more efficient than almost any other health service intervention. The associated benefits are significant: inter-generational transference of poor health and socioeconomic disadvantages are brought to an end; women and young women are provided mechanisms for making well-founded, healthy decisions on their lives, and transmission of AIDS and other high-cost associated diseases, such as tuberculosis, is reduced to a minimum.

Based on these indicators, the concept *burden of disease* can be constructed. This term is used not only to analyze health hazards in depth, but also to orient public policies and health expenditure. In that regard, the assessment of health policies requires four basic inputs: a) a comprehensive analysis of the epidemiological situation in terms of the burden of the disease; b) an inventory of available health resources; c) an evaluation of the political and institutional environment, and d) cost-effectiveness data on available technologies and strategies to improve health (Jamison *et al*., 1993). Estimates indicate that reproductive morbidity and mortality constitute 14% of the total burden of disease in Latin America and the Caribbean.

One of the most important applications of the *burden of disease* indicator is the design of intervention packages oriented towards gaining years of healthy life for the population. In that regard, since the last decade, health policies that, within a context of budgetary limitations offer effective solutions, have been tested (Bobadilla *et al*., 1993). Such interventions have received public and private resources and incorporated research results, in Brazil, Honduras and Mexico. Breastfeeding promotion is one of the most cost-effective interventions to prevent diarrhea and deaths from such disease, and gain healthy years of life. The benefits of this intervention are substantially higher than those of many other programs. For example, programs that eliminate breast milk substitutes are more likely to make a considerable impact per net incremental cost unit. The cost-effectiveness relationship is lower (but attractive nonetheless compared to other interventions) if the hospital has the capacity of establishing in-patient mother-baby nursing and avoiding bottle-feeding. The cost effectiveness relationship increases as programs consolidate. With an annual cost of US$ 0.30 or US$ 0.40 per birth, programs that start by feeding the babies with formula at day-care and nursing facilities can reduce the prevalence of diarrhea for US $0.65 - $1.10 per case, and prevent deaths from diarrhea for US$ 2 to US$ 4.

Countries like Mexico, with a mixed structure for health service provision, have carried out cost-effectiveness studies for their programs. Since resources for mother-child care programs were assigned empirically, in the eighties, the Mexican Social Security Institute developed a program to make expenditure more efficient, by considering the information collected by two instruments (a prospective study and a retrospective). A comprehensive average-cost analysis produced significant savings in the amounts allocated to these services: up to US$ 9 per dollar invested.

Notably, many factors that condition program effectiveness are related to the populational dynamics of each country. In the case of the Dominican Republic, governmental support for population programs that emphasized mother-child care and family planning reduced the birth rate from 50/1000 in 1960 to 34/1000 in 1980, and the mortality rate from 16.6/1000 to 8/1000 in the same period. This effect achieved a significant change in the demographic growth rate: from 3.3% in 1960 to 2.6% in 1980. However, an important social lag that translates into marked migration from rural to urban zones persists. Such migration changed the total population concentration in cities, from 30% in 1960 to 52% in 1980 (*Oficina de Coordinación Técnica/Comisión Nacional de Salud*, 1997). Given the economic limitations of this country, a Basic Health Service Plan for underprivileged individuals was created through the National Popula-

tion Fund (FONAP), the organization in charge of carrying out the SESPAS/IDSS/IADB project. This intervention focuses on priority issues, including prenatal and obstetrical care. Studies on fixed and variable costs were carried out and grouped under three headings: materials or inputs, personnel, and indirect costs. Simultaneously, the potentially beneficiary population was defined as 40% or more of the households with "largely unmet, basic needs". Coverage expansion in this country is estimated to have an incremental cost of US $15,872,770 annually, or US $18.41 per capita for the beneficiary population. Estimates show that investment in prenatal and obstetrical assistance is US $9,600,190; in FP, US $12,238,377; and in early cervical cancer screening US $76,837,193.

Estimates by the ICPD show that programs for SRH attention will require 17 billion dollars in the year 2000, an amount that will have to increase to 21.7 billion in 2017.

This brief synthesis of a bibliography that has increased enormously in the past decade allows appreciating the efforts made towards the rationalization of the decision-making in health and investment of resources.

Regrettably, the evaluation performed five years after Cairo shows that both contributions are far below the pledged amounts.

Funding for sexual and reproductive health care

Estimates by the ICPD show that programs for SRH attention will require 17 billion dollars in the year 2000, an amount that will have to increase to 21.7 billion in 2017. One of the main objectives of the conference for the progress evaluation of Cairo's Action Plan (*Cairo + 5*) was to reaffirm these commitments. Developing countries were expected to cover two thirds of these amounts and industrialized countries the remaining third.

Among development banks (the World Bank [WB] and regional banks), the WB has been the most important contributor to population and SRH.

Regrettably, the evaluation performed five years after Cairo shows that both contributions are far below the pledged amounts. In other words, industrialized countries that in 1994 promised to contribute 5.7 billion dollars yearly have only given 1.9 billion yearly, on average. Developing nations that in theory were going to pay 11.3 billion yearly have hitherto contributed 7.8 billion, on average, being Brazil, China, India, Indonesia and Mexico the main contributors. Bilateral and multilateral donors, as well as private foundations, lag further behind their respective commitments: rather than the 5.7 billion a year they had promised, they are contributing 1.9 billion annually, on average.

Estimating annual contributions from development banks is more difficult than estimating those from other donors, such as foundations.

Among development banks (the World Bank [WB] and regional banks), the WB has been the most important contributor to population and SRH. In fact, this bank is among the multilateral organisms that have provided the largest funds in this field, especially for services, development of population policies, HIV/AIDS prevention, and fertility surveys and census. Estimating annual contributions from development banks is more difficult than estimating those from other donors, such as foundations, particularly because development banks grant, in general, loans rather than donations, and because the funds thus contributed are expended throughout many years.

In 1996, the WB granted 509 million dollars for population activities, which was an unprecedented amount. Additionally, development banks granted 8 million dollars to "intermediary" donors for special projects in SRH, 7.3 million of which were donated by the WB and the remaining by the IADB and the African Development Bank.

In Latin America and the Caribbean, NGOs channeled 50% of international assistance (in 1987 and 1988). This percentage declined in the following years reaching 36% between 1989 and 1991, only to increase again to 51% in 1992 and 1993, and to decrease once more to 48% in 1994. From the donors' perspective, bilateral contributions amounted to 36% of the funds in 1987, which increased to 40% in 1990, decreased to 25% in 1994 and increased substantially to 45% in 1995, a year when multilateral organizations contributed only 18%. In 1996 (latest available data), LAC NGOs received 50% of the funds for SRH; bilateral organisms (especially AID) granted a third of the total assistance

for population, and multilateral organizations donated 16%. These figures and their fluctuations show the significance of increasing resources for SRH care, particularly in view of the enormous unmet need.

For more information on international funding for SRH, especially about contributions by private foundations to SRH in LAC, see Annex 6, where sources of the information included in both this section and the aforementioned Annex are also presented.

Health Sector Reform

After more than 40 years of predominance of the public sector in most health systems of the countries in the region, the search has begun for options to overcome the limitations of these models and for public institutions that guarantee adequate provision of health services (García and Tobar, 1997). The most important problems are inequality and lack of universal access to public services; insufficient resources and scarce supply; technical inefficiency; lack of technical-administrative standards; low productivity, inadequate distribution of human resources and inorganic growth of units; saturation of hospital care capacity, deficient infrastructure, lack of equipment and maintenance; unmet demand; poor service quality; excessive concentration of physicians in urban areas and insufficient providers in rural zones; and inadequate professional training. Organizational in nature, these problems compound other issues that are found in broader dimensions of the social and political ambit. These dimensions include population demands for better health care and the democratization process of many societies in the region.

The reform of LAC health systems has introduced modifications to overcome these problems by broadening coverage (especially for rural populations that have no access to services), improving expenditure efficiency, developing financial innovations, reorganizing services, and enhancing response capacity and quality of care. This process seeks to increase effectiveness of health services, guarantee their sustainability, and improve the quality of care at the primary and preventive level, where most reproductive health services are provided (Merrick, 1999).

The mechanisms to attain these objectives vary throughout the region, depending on the specific history of each health system. All these mechanisms attempt to break away from a configuration characterized by the separation of the social security sector (with multiparty funding), the public sector (with government funding) and the private sector (Table VII). In general, a consequence of this scheme is segmented access to services, according to each social group's financial capacity, and a scarcely regulated private sector that operates according to a payment-per-service arrangement. Social security is organized in different modalities, but in all instances it covers populations that are integrated into the productive sector of the economy. Moreover, services by health ministries focus mainly, although not exclusively, on the non-insured population, seeking a redistribution effect of public expenditure (Musgrove, 1991). In practice, the overlap between the populations covered by one or the other sector is important and it reflects still another aspect that the reform is trying to correct.

In this context, changes to the prevailing State model in LAC have focused on adopting a scheme that allows diversifying the sources of funds for health services and broadening coverage. This trend has favored expenditure policies oriented toward the production of personal services, frequently undermining the importance of public health programs. According

The reform of LAC health systems has introduced a series of modifications that seek to overcome these problems by broadening coverage (especially for populations that have no access to services in rural areas), improving expenditure efficiency, developing financial innovations, reorganizing services, and enhancing response capacity and quality of care.

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Table VII
Characteristics of health systems and reform in 12 countries in Latin America and the Caribbean

Country	*Health system coverage*	*Sectors*	*Care levels*	*Sources of funds*	*Reform legislation*	*Programs for women*	*Reform strategy*
Argentina	Social work 48% Public sector 47,5% Private sector 4,2%	-Social work -Public services -Private services	Three levels in both the public and private sectors	-Public (national, provincial, municipal) -Social work (employers, employees, public) -Private (insurance, payment per service)	Constellation of laws and decrees		-Health services decentralization (self-management hospital programs) -Social work deregulation
Bolivia	53% public sector; the remaining is covered by several sectors	National Health System -Departmental health divisions -Local private health divisions and others	Three levels	-National General Treasury, municipalities, companies, households, international cooperation and NGOs	Administrative Decentralization Law	National Mother-Child Insurance	Creation of the Administrative Decentralization Law
Brazil	55% public 45% private	-Public services (SUS) -Private services	Three levels in both the public and private sectors	-Public (federal, state and municipal) -Private (insurance companies, direct payment by user)	1988 Federal Constitution	Comprehensive Woman, Child and Adolescent Care Program	-Function separation -Creation of SUS -Ministry of Health with coordination and regulation functions
Colombia	83% total	General Health Insurance System -Health promotion companies	Four levels	Contributions fund Solidarity and guarantee fund	-*Ley 10* (Health Municipalization Law) -VII Commission of the Senate and the House of Representatives -*Ley 100* (1993)		-Universal social security -Contributions scheme -Subsidy scheme
Chile	91,5% total	-Public (National Health Care System, Ministry of Health) -Private	Three levels in both the public and private sectors	-Public (National Health Fund) -Private (ISAPRES)			-Public sector decentralization -Strengthening of the private service market
Dominican Republic	97% public sector; the remaining is covered by several sectors	-Public (SESPAS) -Social Security Institute -Private	First and second levels	-Government -Users -Donations -International assistance	-Executive Commission for the Health Reform -Technical Secretariat to the Presidency, and Ministry of Health		Creation of an organism that depends on the Presidency for the execution of the project
Ecuador	70% total	-Ministry of Public Health -Social security -Private Well-Being Committee	Three levels	-World Bank -Taxes -Oil -Direct payment	Project to strengthen and broaden basic health services		-915 Executive Decree -Decentralization of public and social security services -Regulation of private participation -Search for new sources of financing

Country	*Health system coverage*	*Sectors*	*Care levels*	*Sources of funds*	*Reform legislation*	*Programs for women*	*Reform strategy*
El Salvador	55,5% public 5% private	-Public (National Health System, Social Security) -Private	First and second levels	-World Bank -Government -International assistance	General health policy		-MSPAS leads the process -Function separation -Decentralization of public services -Private sector participation
Mexico	93,2% Total	-Public (SSA) -Social security (IMSS, ISSSTE) -Private (insurance companies, payment per service)	Three levels in both the public and private sectors	-Public -Private -Mixed	-General Health Law -Social Security Law	National Program on Cervical Cancer Prevention	-Definition of the National Development Plan -Promotion of the Program on Health Service Decentralization -Coverage Expansion Program
Nicaragua	85% Total	-Public (MINSA, INSS) -Private	First and second levels	-International assistance -Companies -Taxes -Credit -Households -NGOs	Law that creates the Single National Health System	Integrated Woman-Child Care Program	-Consolidation of the National Development Plan -Decentralization -Reactivation of Social Security
Paraguay	Less than 70% of the population	-Public services (MSPBS) -Private services	Three levels in both the public and private sectors	-National Budget -Contributions by employers and employees -Fees, payment per service	1996 National Health Law	Maternal Care Program sponsored by the IADB; Reproductive Health Council	Decentralization of the Ministry of Public Health and Social Well-Being
Peru	67,2% total	-Public (Ministry of Health, Peruvian Social Security Institute) -Private	Three levels	-Public -Private -International assistance	Law for the Modernization of Social Security	Program for the Year 2000	-National Program on Health for All -Decentralization -Creation of local health administration committees

SUS: Single Health System
ISAPRES: Previsional Health Institutions
MSPAS: Ministry of Public Health and Social Assistance
SSA: Ministry of Health
IMSS: Mexican Social Security Institute
ISSSTE: Institute of Social Security and Services for Government Workers
MINSA: Ministry of Health
INSS: Nicaraguan Social Security Institute
MSPBS: Ministry of Public Health and Social Well-Being
SESPAS: State Ministry of Public Health and Social Assistance

Sources: Database of the Collection, Analysis and Dissemination Center for Health Reform Initiatives (NAADIIR), 1999; PAHO, 1998.

When the market logic operates in the field of health, it requires mechanisms to ensure the equity of resource distribution, while guaranteeing an efficient resource allocation; this does not necessarily imply conflict.

to this assumption, the definition of priorities for public expenditure in the short term becomes fundamental, because the existing trend has pointed towards the abandonment of redistribution models.

In fact, with the reform, the emergence of market powers for the distribution of health resources and provision of services has made it necessary to create regulation mechanisms that, according to various analysts, the State alone has the capacity to design and execute. Several fora have emphasized that when the market logic operates in the field of health, it requires mechanisms to ensure the equity of resource distribution, while guaranteeing an efficient resource allocation; this does not necessarily imply conflict. Reform proposals consider the State the main social actor that has to assume responsibility for regulating the system, although not necessarily in an exclusive manner. Actually, the participation of other actors (such as professionals) could also be important. However, in most countries, since the reform, the State has shown a significant weakness when it comes to the development and application of such mechanisms.

Gershberg (1996) showed evidence of the complexity of the regulatory process in a study carried out by the IDB on the decentralization processes in education and health, in Mexico and Nicaragua. In both instances, the regulatory capacity of the central level was partially transferred to the local level. However, after some time, some of the powers were retransferred to the central level. Remarkably, in Nicaragua some decentralized units increased their capacity to regulate private attention units. This represents a challenge to the reform, as it is necessary to define the regulatory capacity that corresponds to the central and the local levels.

Several areas are in great need for regulatory mechanisms. Such areas include supply of private insurance, access to services, accreditation for health personnel, and physical resources, as well as quality and price of medication.

Several areas are in great need for regulatory mechanisms. Such areas include supply of private insurance, access to services, accreditation for health personnel, and physical resources, as well as quality and price of medication. The behavior of health providers, particularly medical personnel, is one of the areas that require more regulation. Predominant public systems found in the salary an adequate way of controlling care costs, but this also generated a negative effect on the health providers' behavior. In practically all the countries in the region, modifying provider payment systems is deemed necessary to counterbalance the disadvantages of the salary scheme. However, applying such modifications requires a detailed situational analysis in each country, before proposing a well-articulated policy.

Objectives and axis of the reform

The national health policies that lead the reform in Latin America and the Caribbean have promoted the following basic principles: equity, efficiency, quality, and sustainability. Nevertheless, some reform processes have stated other principles, such as universality, subsidiarity of the public sector, and intersectoriality.

At the operational level, the components of reform programs include the definition of a policy and an organic and functional administrative model; service improvement and management simplification; integrated financial administration; institutional rationalization and creation of civil service careers; service decentralization; transference of public enterprises; sectorial strengthening; technological update, and other actions to modernize management, coordination and dissemination of the reform program.

Decentralization: Initial axis of public sector reform

Decentralization is a strategy that has been adopted in practically all the countries committed to the reform process. However, the methods and the length of implementation vary. Through decentralization, preparation of budgets and administration of funds for service provision will be transferred from the central to the local or municipal levels, so that fund administration

operates autonomously. This implies that the decision-making will take place at the local level, especially on how and where resources should be applied for program development and service provision.

Decentralizing efforts have produced different results in the countries that have started this process. Most of these countries have faced difficulties, especially the problem derived from the fact that responsibility transference is not supported by a financial transference, which is essential for the efficacious execution of these new tasks. Decentralization processes have also encountered logistical obstacles: functions are delegated from the central level to units that lack the necessary trained personnel to carry them out; this in turn has resulted in a partial transference and the recentralization of the structure at the intermediate levels, between the central level and municipalities (Green, 1992).

Decentralization constitutes a special challenge to reproductive health programs, whose organization has traditionally been vertical (for instance, mother-child health and family planning programs). Actually, responsibilities are usually transferred to the local level, but the organizational structure remains vertical, thus hindering the definition of priorities, program cost estimation and assurance of financial sustainability, and a correct operation in terms of technical quality and efficiency, at the local level.

Recently, questioning the achievements of the decentralization process has led to new proposals for service management, including the model of self-management service unit, the public-private mix for service provision, competition among providers and payment mechanisms linked to productivity.

The challenge of broadening coverage

Broadening coverage is one of the most important challenges to health reform programs in LAC. In fact, a basic principle of the reform is to make primary and preventive health services accessible to most individuals, especially to vulnerable and less frequently served groups. The degree of success varies from country to country. In Colombia, an immediate effect of the reform was broadening coverage to reach 81% of the population of the country. This achievement is mainly the result of the implementation of basic packages of health services, which combine curative and preventive interventions. The definitions of the basic package differ from country to country, but all of them include interventions of higher cost-effectiveness. For example, the basic package in Colombia involves a great number of interventions, whereas in Mexico it includes slightly more than 10.

Decentralizing efforts have produced different results in the countries that have started this process. Most of these countries have faced difficulties.

The priority of reproductive health interventions of basic packages should not be defined *a priori*, but as a response to the specific needs of each locality (according to the principle of decentralization). This definition should allow the efficient use of subsidies that the States channel for the provision of such packages. The relationship between the definition of health needs and the correct allocation of resources has not been satisfactorily solved. Another important challenge is the organizational modification that would have to be carried out for the implementation of reproductive health programs at the local level.

Decentralization constitutes a special challenge to reproductive health programs, whose organization has traditionally been vertical (for instance, mother-child health and family planning programs).

An aspect that is closely related to broadening coverage is charging fees to the users of services, even in populations that live in poverty and extreme deprivation. Several countries have found that charging fees to these groups seriously limits their access to services. Health ministries can only deem these fees adequate when they help to control demand, which in turn makes the operation of health systems more efficient. Such is the case of progressively higher fees, based on the individual's income and whether interventions are essential or optional (for example, higher fees for cosmetic surgery than for prenatal care). If a policy's objective is to influence utilization patterns, the alternative of not

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charging a fee should be considered (Creese, 1991).

Fee collection constitutes a contribution that is potentially capable of improving the health sector's financial basis, but it can also deny access to individuals whose health needs are the most urgent (Stuart, 1999). Selective fee collection should be carefully designed to ensure that only those that can afford them pay fees, and that the resulting income improves health care quality and access. Several developing countries are already designing and implementing differentiated-fee systems that prioritize socioeconomic criteria. In LAC, Colombia has been working, with promising results, with the Beneficiary Identification System (Sisben) to determine basic unmet needs. Nonetheless, this system still requires adjusting to determine unmistakably what populations have the greatest needs.

Selective fee collection should be carefully designed to ensure that only those that can afford them pay fees, and that the resulting income improves health care quality and access.

A fair system should include the identification of users whose access to health services is in danger, as well as the redistribution of funds for primary care. The best strategy is to charge fees to users of secondary and tertiary care services, although the political and administrative reality of many developing countries does not allow implementing these mechanisms. Therefore, probing alternative options is urgent.

...health ministries should have a statutory and regulatory function, social security should play the role of fee collector and fund administrator, and the private sector jointly with the public sector should provide services.

Role of social security in reform processes

Before the reform of the sector, regional health systems witnessed significant growth of social security. In countries such as Argentina, Colombia, Mexico or Peru, social security covers important sectors of the population. Concerning reproductive health, social security plays a relevant role, because it is the provider of a large number of maternal health and family planning services. Mexico is one of the most prominent countries in that regard. Concurrently, social security systems became autonomous structures, with little functional dependence on health ministries. The reform seeks to achieve integrated health systems to improve their efficiency, a process that has faced many problems due to changes in public and social security structures that pursue objectives that are not necessarily compatible. This in turn results in very lax relationships between the two sub-sectors, exception made of the processes in Brazil and Colombia.

A rational differentiation of functions among health ministries, social security and the private sector has been proposed as the fundamental axis of the reform (Frenk, Londoño and Lozano, 1999). Those who advocate this position submit that health ministries should have a statutory and regulatory function, social security should play the role of fee collector and fund administrator, and the private sector jointly with the public sector should provide services. Some LAC countries have made progress in that regard, although in many the separation of functions has not entirely occurred: health ministries continue to offer services, private funding keeps growing, whereas social security continues to carry out functions in all areas. Brazil, Colombia and Chile may be the countries where functional separation has been better defined.

Since reproductive health is a priority in many countries, noting how the various reformed systems reflect such priority will be interesting. Thus, whether the regulatory role of the public sector manages to preserve reproductive health programs as a priority and private insurance companies include reproductive health services (and at what cost) in their service packages remains to be seen.

Participation of the private sector in reform processes

Reform processes of health systems in LAC have sought to keep an open space for private participation, but they have always highlighted the need for developing regulatory mechanisms. Chile presents a health system that formalizes the participation of the private sector, even though in practice its integration has been

partial and has generated enormous inequities and inefficiencies. In this country, the reformed health system has the obligation to pay for health care, while allowing individuals to seek care at state facilities or Previsional Health Institutions (Isapres), which are private. The Isapres are authorized to receive and administrate the fees, and provide health services directly or via a third party.

As yet, most countries in the region that have reformed systems have not defined the role of the private sector, particularly that of companies or providers that operate for profit. In contrast, LAC has been recognized for the participation of non-profit, non-governmental organizations that promote women's health care. Since Cairo's conference, these organizations have grown significantly and their capacity to mobilize national and foreign resources and to provide services has been remarkable. In general, NGOs operate autonomously or in collaboration with the public health service structure. Regarding reproductive health services within the context of the reform, the role of NGOs is essential due to their capacity for responding to population needs and the quality of the services they provide. Integrating NGOs into the process of reform will depend on the actors' willingness to cooperate and the improvement in resource administration mechanisms and response capacity of civil organizations.

A modality of integrating private services into a health system is contracting out such services with public funds. According to advocates of this mechanism, public funds can be distanced from providers and directed to resource allocation (distribution). Consequently, a contract is also said to be a tool for modifying the providers' behavior.

There are three arguments that justify the introduction of contract-based models: the value of competition and service structures associated with private organizations, the importance of public guidelines for resource allocation, and the belief that contracting-out itself is enough to foster performance improvement. In some countries, the reform process has resulted in a generalized adoption of contracting models within a public financing framework (for example, in Colombia). Many other countries are already planning to increase contractual arrangements in the public sector and between the public and private sectors. However, the partial use of contracts to respond to specific problems has been much more frequent than extensive contracting-out (McPake and Mills, 2000).

Within the African context, the lack of capacity and experience of governments constitutes a significant restriction, because ministries of health are not used to establishing the type of relations that contracting-out entails. However, the Zimbabwe experience shows that such restriction can be overcome by actions aimed at increasing abilities and providing relevant experience. Abilities can also be developed through "on-the-job" training. The most important restrictions for successful contracting-out are usually external to a ministry of health and include: centralized bureaucratic —still unreformed— systems that are not flexible enough to formulate and handle contracts or that delegate too much responsibility or authority to managers; an inability to deal with the labor implications of contracting-out, and a lack of political support to make decisions that are unpopular among the workers of the sector.

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However, a buyer's context and capacity explain only partially the heterogeneous advance of contracting models. The development of the private sector, particularly the extent to which market relationships prevail, has been equally important. Market relations, like those that emphasize competition, imply a varied typology of interactions: competitive offers require restrained communication between competitors; the practice of giving out gifts as part of the government-provider interaction should not exist; and contract monitoring should have legal support. Changing the nature of the buyer-provider relationship will entail a lengthy process.

Managed care as an organization model for service production in the reform

In most countries in LAC, the private sector continues to be regulated by the free supply-demand scheme, which has characterized it throughout the century. Nevertheless, new organization modalities of reform processes have emerged: managed competition and managed care. The former refers to the establishment of free market conditions to generate an adequate health service supply financed by the demand. The latter can be defined as a strategy that seeks to rationalize the resources for service provision by making costs suitable and establishing quality criteria (Medici *et al.*, 1997). Managed care is a service provision modality that has gained popularity since the reform, as it is a care system that places special emphasis on cost control and utilization levels through detailed monitoring, in order to offer cost-effective, high-quality interventions. Although in LAC there are antecedents of autochthonous managed care models, the regional market of health services has recently witnessed the growth of imported, mainly American, models.

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Through this process of importation, multinational corporations have just begun to find a potentially attractive market in LAC's middle classes. Under this model, corporations apply strategies that have proven successful in the US market and that consist of: a) sharing financial risk with care providers; b) emphasizing the reduction of hospital stay days; c) regulating physicians' fees; d) fostering self-health care; and e) restricting access to specialized medicine, unless the patient pays part of the costs.

Several managed care modalities have been implemented in Argentina, Brazil, Colombia, Chile and Mexico. However, only few are operational within the framework of a managed competition model like that of Colombia.

A concrete example of the expansion of managed care in Latin America is CIGNA International, who announced the formalization of an association with Integrated Health Plans, a managed care organization based in Guadalajara, Mexico, known as "Mediplan". This organization is currently operational in at least 14 states of Mexico, and has 14,000 members. CIGNA's vice president gave three reasons to justify their decision of integrating into the Mexican market: the volume of the Mexican population (95 million), trade deregulation in the region (North American Free Trade Agreement), and the health service reform that will provide health maintenance organizations with access to social security funds in the country. The limited development of managed health care in Mexico (less than 2% of private care expenditure) also represents an element on which CIGNA bases its expansion project, south of the border. Remarkably, CIGNA is among the largest American organizations involved in the provision of health services and other benefits for workers (disability and retirement services). In Brazil, CIGNA manages health plans for 2.5 million individuals, in a joint business venture with a local bank, as well as a prepay health plan. CIGNA Salud Isapres in Chile provides managed care services to nearly 100,000 inhabitants. In Guatemala, through its managed care network, it serves 40,000 individuals. Not surprisingly, CIGNA declared profits for 15 billion dollars in that country, in the first nine months of 1998.

Several managed care modalities have been implemented in Argentina, Brazil, Colombia, Chile and Mexico. However, only few are operational within the framework of a managed competition model like that of Colombia. The most attractive element for large corporations seems to be the transference of social security funds for the acquisition of private services. Such transference has also been promoted in other countries.

The advantages and disadvantages of the application of managed care for profit are strongly debated in many countries. Although achievements in terms of efficiency and cost control seem promising, an erroneous selection of population groups that cannot afford the payments constitutes a great risk and signifies an extra burden for public services. Reproductive health is of potential interest for managed care models,

because the target population, women of reproductive age, is very large, particularly in those countries where social security does not cover the relatives of the insured. Additionally, most reproductive health interventions are low cost and highly cost-effective, grave complications are not very frequent, effective preventive interventions are available and their costs, in general, can be reliably estimated. Finally, regulation of the care process can be easily protocolized.

Health sector reform criticisms

A current trend critical of reform programs needs careful consideration. This position is largely supported by civil society groups that have been key actors in the efforts aimed at improving sexual and reproductive health since Cairo's conference, and who are also committed to compliance with the Action Plan that 179 countries signed at the end of the Conference.

According to the advocates of this position, reform programs represent the introduction of principles of market economy into a fundamental social sector —health—, but such introduction is in practice incompatible with Cairo's vision of social justice and human rights. In fact, this viewpoint perceives the reform as an integral aspect of structural adjustment policies.

However, theoretically at least, the reform is granted some benefits. Thus, the principle of decentralization is acknowledged when it means transferring responsibility and the decision-making capacity from the central to the local and community levels. Nonetheless, transference of responsibilities is not usually accompanied by adequate resource distribution that would allow local officers to guarantee broadly accessible, quality services. This worsens because of the smaller economic power of most provincial and rural populations, whom the reform asks to pay fees for services (WEDO, 1999).

Another important criticism is the restricted vision that reform programs have when they regard health as a "commodity", without taking into consideration the influence that the economy, the environment and the culture have on the complex phenomenon of health. Additionally, this position underscores the fact that reform programs are based on unproven assumptions: that the poorer groups of the population have certain capacity to pay for health services and that governments have the technical, managerial and administrative resources to carry out the required actions, and support decentralized agencies. Regarding this last issue, reform critics maintain that in countries where the government's technical, managerial and regulatory capacity is limited, reform programs, although well designed in theory, generate poor results.

Among the most important issues under debate are the establishment of fees or payment for services and budgetary transference from governments to private service providers. Regarding the former, critics state that the reform has restricted access to broad sectors of the population, especially women, with serious consequences for their reproductive health.[14] Medication, consultations and diagnostic analysis, formerly free, are no longer affordable for many women, forcing them to delay the help seeking process and face a greater risk of disease and death. A survey carried out in 70 countries showed that the interviewees regarded the fees as the most important obstacle to the achievement of goals of reproductive health programs (WEDO, 1999).

Concerning the payment for services, what providers in some countries earn through the re-

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[14] This appreciation, however, is not fully accurate, based on the information presented in former sections. In many countries, the first achievement of the reform has been increased service coverage, particularly for population sectors that live below the poverty line, and who are the priority recipients of public subsidies. Actually, fee collection for services tends to affect more the population groups that do not live in extreme poverty and that have to contribute part of the cost of such services.

formed system has been said to constitute a true incentive for unnecessary and even ethically questionable clinical or surgical interventions. Such is the case of Cesarean section, a method of terminating pregnancy that has reached epidemic proportions in most LAC countries. An alternative to reverting this situation is designing service packages whose cost can be determined prospectively (for C-section, since the beginning of the pregnancy) to ensure integrated services and establish quality care as the sole incentive for the professional.

Contributions of Regional Consultation Meetings

Proposals to improve sexual and reproductive health care in the context of health sector reform

During the consultation meetings, comments on the problems and opportunities created by reform programs were used to strengthen initiatives aimed at improving sexual and reproductive health in the participating countries. The following is a summary of the most important points.

New funding approaches

The reforms of health systems construct schemes of incentives for service providers. The strongest incentives derive from financing mechanisms, which in many countries in the region are based on historical (retrospective) assumptions or supply subsidies. Such an approach does not stimulate health promotion and prevention, only expenditure. In other words, it rewards disease. This way of approaching incentives has negative repercussions, especially for sexual and reproductive health care that depends heavily on promotion and prevention activities (see "Quality of sexual and reproductive health services").

In Colombia, the reform restructured funding mechanisms through demand subsidies (*Ley 100*, 1993). This has created incentives to promote essential aspects of reproductive health programs (for example, family planning as a preventive measure, and attention to processes that are usually normal, such as pregnancy and delivery).

Health sector reform increases the population with access to services; thus, it promotes competition among providers and becomes an incentive for those that offer more and better services (as has been the case of Profamilia, an organization based in Colombia that competes against other public and private providers).

Supply subsidies through public assistance will have to continue in many countries and serve some specific population groups whose access is limited, or who do not commonly seek preventive services. Regarding such services, prospective budgeting should be implemented together with performance incentives (for example, productivity of SRH services) and a managerial evaluation system.

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Quality of sexual and reproductive health services

It is essential that managers of health reform programs understand that efficient use of resources is closely linked to service quality: only quality programs will manage to prevent or treat SRH problems. Therefore, only such programs will be efficient.

The execution of HSR programs implies important changes that affect administrators, managers and providers. The necessary training to perform these new roles should include special subjects and courses that ensure technical competence for SRH care.

Quality care implies availability of resources at care provision units. In countries like Bolivia, the challenge is to make the necessary

Recognizing and respecting the rights of women is vital for quality care. This is one of the weakest aspects of care provision in the countries in the region, whose strengthening has been sought through sensitizing health providers.

resources accessible to the population, particularly indigenous groups in remote geographical settings.

Recognizing and respecting the rights of women is vital for quality care. This is one of the weakest aspects of care provision in the countries in the region, whose strengthening has been sought through sensitizing health providers. As part of the reform process, training for providers should include these aspects, with special emphasis upon informed consent and confidentiality of SRH service provision. In countries like Bolivia, Colombia and Ecuador, services rendered by many NGOs comply technically and ethically with the highest quality standards. Therefore, reform formulations should consider NGOs.

In sexual and reproductive health, responding to needs perceived by service users is a matter of the utmost concern. Such response should include understanding and respecting the culture, customs and traditions of the users, without detriment to technical quality. In that regard, decentralization offers a very good opportunity.

SRH programs and services should respond to the characteristics and needs of the community they serve.This objective can be accomplished through the reform, especially decentralization.

Organization of sexual and reproductive health programs

The health sector reform represents an opportunity to establish new ways of organizing programs and services and, regarding sexual and reproductive health, overcome the vertical approach of traditional programs (family planning, mother-child health, AIDS). Additionally, HSR constitutes an open space to set up comprehensive services.

The reproductive health paradigm that has been promoted since Cairo's ICPD stresses that the incorporation of men is fundamental to the success of the programs. The reform is an opportunity to develop strategies that include the partners of women who receive services.

SRH programs and services should respond to the characteristics and needs of the community they serve. This objective can be accomplished through the reform, especially decentralization. A very important strategy is to promote community participation in the design and development of programs. In Paraguay, this participation is construed as a requirement to attain sustainability of health programs at the local level. The community can also play a continuous supervisory role of the services it receives; in Nicaragua, this has been achieved through the promotion of "social audits" as elements of local integrated health systems. The mechanisms to strengthen the relationship between the governments and the civil society are manifold. Therefore, Brazil has developed state and municipal commissions to that end.

Awareness of the importance of sexual and reproductive health

For the reform to be instrumental in reinforcing SRH programs and services, it is essential that those who participate in the process understand its importance for the population. It is also necessary to prove, for example, that:

- Maternal morbidity and mortality have serious consequences for the family and the community. Hospitalization or death of a young woman due to preventable, treatable causes (as is the case of more than 90% of obstetrical complications), when her social and labor productivity are at their peak, has an enormous cost for the individual, the family, the nation, and society as a whole.
- Reproductive health is fundamental to the development of community and country, and human resources.
- Good reproductive health produces huge social and economic benefits, elements that are central to the reforms of the sector.

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importance of this health issue. Consequently, it is essential to strengthen the link between the public sector and the NGOs and improve the direct participation of women in decision making.

Decentralization of sexual and reproductive health services

Decentralization means potential challenges and advantages to SRH programs and services, because redistribution of power, responsibilities and budget between the central and local levels is no easy task.

In Brazil, transferring the agenda from the central to the decentralized level was a very complex process, as "attitudes had to change". In that country, compliance with norms at the local level is one of the greatest challenges. Actually, there is a Family Planning Law but norms for 5,000 municipalities have not been created yet.

In Mexico, as in other countries that have a long centralizing tradition, ensuring that each decentralized unit has adequate installed capacity to perform its functions is an enormous task.

Decentralization of reproductive health programs becomes more difficult due to a lack of adequate human resources. In Mexico, at the local level, individuals operate the programs correctly, but do not have the necessary training or experience to perform the new functions; "a service planner cannot be created overnight."

At the central level, there is often a lack of awareness of limitations. Decision makers at that level have to know that programs, particularly in the field of reproductive health, will always do with available resources.

Establishing clear, efficient communication channels or bridges between the central and the local levels is essential to facilitate definition and compliance with the objectives of reproductive health programs.

Experience shows the enormous value of defining priorities at the local level and of attaining negotiating capacity with the central level. Both tasks demand promotion of community participation.

The role that NGOs have played in the field of reproductive health has to be acknowledged, not only as service providers, but also as developers of the population's decision-making capacity at the local level.

In Brazil, decentralization has brought women's groups and local managers closer together, a process that in turn has allowed a better definition of priorities, favored inter-sectorial management, and facilitated program follow-up.

Legislation on sexual and reproductive health

Creating, modifying, and extending the legal framework in the field of SRH is necessary to ensure that changes the health system reform generates do not stray from their original goal or delay the achievements accomplished by international commitments and the long struggle of different groups in society.

Subjects like unsafe abortion require an urgent revision of legislation. Apart from the social sensitivity this issue generates, illegal abortion produces a significant burden of disease and death in the region, especially for women with less resources or information who have no access to a safe pregnancy termination. Those responsible for legislation on the matter cannot ignore this reality.

Mechanisms for the thorough compliance with legislation have to be defined. It is important that the health sector reform allows strengthening the State's new functions, particularly those related to the system's regulation. This way, all agents involved may be able to fulfill their tasks adequately and according to defined rules.

Through legislative reforms, strengthening and developing institutions like the Ministry for Women in the Dominican Republic can be at-

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tained. This Ministry fosters the development of health programs for women from a gender perspective.

Sensitizing, training and "supervising" those who administer justice is of the utmost importance, because the fate of women involved in delicate SRH situations depends on their decisions.

Sensitizing other social actors (the media, senators and representatives, and others) regarding the need for legislating on this matter is important, so that they can support the projects knowingly.

Training, sensitizing, and "supervising" those who administer justice is of the utmost importance, because the fate of women involved in delicate SRH situations depends on their decisions.

Surveillance of compliance with Cairo's and Beijing's international agreements is fundamental, as well as seeking changes in local legislations derived from such agreements. Peru has organizations that are responsible for overseeing compliance with the Action Plans signed by this country at these international conferences.

In matters of human and reproductive rights, it is important to promote, implement and evaluate the efficacy of new advocacy mechanisms, such as public and government attorneys and constitutional guarantees for the protection of civil rights.

National legislations need to undergo modifications to improve women's opportunities and empowerment.

Sexual and reproductive health care for indigenous populations and individuals living below the poverty line

These groups are discriminated against and the object of all sorts of abuse. They also face social isolation owing to the remote location of their communities, which hinders access to health and social services, as well as education and employment.

Compared to the average LAC population, indigenous and rural groups are especially vulnerable, due to their health needs and unfavorable rights situation. These groups are discriminated against and the object of all sorts of abuse. They also face social isolation owing to the remote location of their communities, which hinders access to health and social services, as well as education and employment. This context determines a particularly poor SRH profile. Asurvey carried out in Guatemala showed that compared to mestizo mothers, indigenous women have, on average, two more children and five more child deaths per 1,000 life births. Additionally, only 11.7% receive professional labor care compared to 52% of mestizo women. In Bolivia, underprivileged women marry during adolescence and their fertility rate is very high until they turn 30; but they do not interrupt childbearing throughout their reproductive life (Vidal-Zeballos, 1994). These conditions have serious implications for the design of policies and programs.

Regardless of the ethnic group, poverty implies differences in fertility, reproductive risk and use of services, which affect the distribution of human resources. Recent studies have shown that such distribution affects global economic growth rates. Additionally, current distribution modalities, which are not very equitable in Latin America and the Caribbean, have a negative, disproportionate impact on the income of the poor (Birdsall and Londoño, 1997).

In Bolivia, since the creation of the mother-child insurance, access to services and quality of care improved remarkably. However, many communities, especially indigenous groups, have yet to receive reproductive health services.

In other countries, the decentralization process has allowed extending coverage to include marginalized areas. Nevertheless, whether such coverage extension has benefited indigenous populations is still under evaluation, because as previously mentioned, the geographical location of many of these groups is so isolated that transportation to health centers is very difficult and time-consuming.

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Countries like Colombia, where a significant percentage of the population is covered by insurance companies, need a selection procedure that allows identifying the target populational groups of reproductive health programs, that is, women of reproductive age, adolescents in rural zones and indigenous population.

In Peru, the Manuela Ramos Movement is testing an original strategy that seeks to provide

indigenous women with access to reproductive health services. The ReproSalud project combines the efforts of two local non-governmental organizations and USAID's, aiming at increasing SRH service demand and utilization by urban and rural women, especially indigenous users. ReproSalud's approach is based on women's participation in community projects and on the protection of women's rights as individuals and members of society. Thus far, regarding the design of educational programs, ReproSalud has enabled the participation of thousands of women, who have voiced their interests and needs, to foster the correct utilization of services (Annex 1).

A very important problem in the region is the lack of qualified personnel. To solve this problem, adequate schemes of economic and professional incentives that guarantee appropriate work and living conditions for service providers have to be generated. Recent experiences have shown some significant problems. For example, having residents for two years in rural zones is no guarantee that the newly graduate will stay in the region. A good countermeasure would be to train the community's personnel and particularly reinforce their abilities to attend to local problems. Most reproductive health problems can be solved without a physician.

Finally, governments should ratify their commitment to the most vulnerable groups, mainly indigenous populations. These commitments should crystallize into facts; they should transcend rhetoric and translate into budgets, organization of services that accommodate the needs of these sectors, communication that truly allows reaching them, and careful consideration of the culture of these groups so that culture does not become a barrier to messages and services.

Role of the IDB in Sexual and Reproductive Health Promotion

The consultation meetings identified several routes the IDB could use to promote sexual and reproductive health in Latin America and the Caribbean. In general, the IDB's position is more advantageous than that of other international funding organizations because of its regional character and sensitivity to the cultural and social peculiarities of the region. Additionally, the governments regard the IDB as a reliable interlocutor that will not try to impose priorities and values that are not shared by potential beneficiaries. The IDB has recently carried out important activities for the mobilization of financial resources and technical assistance in reproductive health. However, the expectations this effort generates in the middle and long terms will be demarcated by limitations imposed by scarce resources, competition against other areas, and prioritization defined by recipients. Following are some suggestions in regards to the role the IDB can play in the region:

The IDB has recently carried out important activities for the mobilization of financial resources and technical assistance in reproductive health.

In spite of the limited budget it has, the IDB could support governments and non-governmental organizations by providing non-reimbursable resources for SRH projects.

- **To influence LAC governments so that they consider sexual and reproductive health a priority in loan applications.** IDB's advisers/experts could encourage those that are responsible for outlining governmental projects (ministries of finance and health) to consider SRH a priority, incorporate specific SRH content, establish mechanisms of collaboration with NGOs, seek to approach the community, take into account the gender dimension, and promote greater participation of women in various social areas. With this strategy, resources for programs and sexual and reproductive health services could increase.
- **To influence governments and non-governmental organizations so that they request support from the IDB for SRH projects.** In spite of the limited budget it has, the IDB could support governments and non-governmental organizations by providing non-reimbursable resources for SRH projects. Based on the experience of obtaining donations to promote women's leadership, other areas of national or regional interest that could benefit from this sort of support could be identified. Such donations could be given to NGOs to reinforce their negotiations with the public sector, as these organizations would be perceived as legitimate partners in this field.
- **To support the identification of strategic areas for the advancement of SRH and obtainment of special ("small") loans for its development.** The IDB and the governments could identify and support strategic activities through a mechanism known as "small loans". Examples of these activities include development and maintenance of information systems, training for providers in specific aspects, support for sectors other than health so that they can develop activities aimed at improving women's condition (education, work), etcetera. Although this

mechanism does not constitute significant expenditure, investment in crucial, strategic activities could have a great, positive impact.

- **To support pilot projects.** Through different financing schemes, the IDB could promote innovative models for the provision of reproductive health services to verify their effectiveness and sustainability in the middle and long terms.
- **To support training.** The IDB could have a positive impact in the short term by stimulating the creation of training programs for specialists in the operation of reproductive health programs, mainly in managerial areas, where there is a great void.
- **To identify countries with special needs and help them obtain funding from the IDB itself and other financing agencies**. International assistance is unequally distributed among Latin American countries, that is, not always according to their needs. The IDB could help concentrate the greatest efforts in countries with the most urgent needs and little international support, such as Ecuador, El Salvador and Paraguay.
- **To promote greater support for reproductive health with other social development banks and donors in general.** The IDB could play a leading role in the financial community of international assistance (especially the World Bank, who has hitherto been a leader among development banks). Because the IDB is one of the members of the international community that subscribed to Cairo's Action Plan, it can legitimately promote among its partners compliance with acquired financial commitments.
- **To foster international assistance for a broad range of sexual and reproductive health problems.** In the field of SRH, international assistance continues to focus largely on family planning. The IDB could help direct funds to other equally important areas that lack sufficient financial aid.
- **To design innovative models to support non-governmental organizations.** There should be a stronger link between governments, women's organizations, reproductive health services and universities, in regards to reproductive health. The IDB could strengthen that link.
- **To invest in sectors other than health, which have a direct impact on SRH.** This would stimulate the inter-sectorial relationship, whose development is strategic, because education, employment or micro-company development policies have proven highly beneficial to SRH improvement.

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Conclusions

Is it feasible and advisable to reinforce reproductive health activities in reform programs? What are the opportunities, challenges and obstacles?

Most countries in Latin America and the Caribbean are immersed in two simultaneous processes: the reform of their health systems and compliance with the commitments made at the International Conference on Population and Development in 1994, and ratified at subsequent international meetings.

On the one hand, reform programs aim at improve the health of the population by ensuring efficient usage of resources through cost-effective programs, improving the quality of care, guaranteeing adequate services for the poor and marginalized, and avoiding the investment of most health resources in tertiary care at urban hospitals.

On the other hand, Cairo's Action Plan demands fundamental changes in the type of care that has been traditionally provided. Specifically it discards the demographic objectives of family planning programs, emphasizing instead compliance with the reproductive expectations and well-being of women users; integrating services and programs, which have heretofore been vertical, whether at the same location or through efficient referral systems; including sexuality and gender as essential dimensions in all matters related to sexual and reproductive health; providing trained personnel, adequate infrastructure, and efficient managerial, administrative and supply systems to support the new responsibilities of programs and services; and establishing mechanisms for inter-sectorial collaboration and dialogue between governments and the civil society.

Is it possible and desirable to make both agendas compatible? In other words, is it feasible and advisable to reinforce reproductive health activities in reform programs? What are the opportunities, challenges and obstacles? To answer these important questions, we need to reflect on the reasons that would justify such effort, and on what needs to be integrated and how to do it.

We hope this document has contributed convincing arguments regarding why it is necessary to undertake this task. In fact, the reproductive health section presented data that clearly show the effect that problems with reproductive health have on public health in our region. We also stressed that there are cost-effective technologies to prevent, detect and treat most reproductive health problems, generally at the first or second care level. In like manner, we pointed the unequal distribution of the burden of problems, which is concentrated in under-resourced populational groups. That is to say, we clearly presented the enormous influence that social and economic strata have on reproductive health. Finally, we described the multi-sectorial nature of the activities required and the need for close collaboration between civil society and the governments.

The chapter about the reform explained the main principles that rule these programs: emphasis on priority problems and implementation of cost-effective interventions; coverage expansion to include marginalized groups; and collaboration among sectors, governments and the civil

society. Evidently, there are many important points of contact between the two processes.

The questions about what and how to achieve greater integration of the processes of reform of the health sector and reinforcement of sexual and reproductive health cannot be answered with a single formula, because only solutions set forth in the context of each country can be successful.

The consultation meetings provided relevant information and opinions of the active group of actors in both ambits of interest: the reform of the sector and reproductive health. These viewpoints were generally based on personal experience of decision makers, academics, NGO managers and diligent observers.

Without denying the value of the interesting contributions made by these participants, we would like to stress that these efforts were only the first step towards achieving a goal that still lies further ahead. A limitation of this project was a lack of representativity, as the sample did not reflect the standpoints of all the actors involved in the development of reform and reproductive health programs. Indeed, the absence of higher-level decision makers, who in spite of having been invited could not participate for various reasons, was patent. Therefore, a future task will be to have in-depth consultations with protagonists to be able to propose realistic scenarios to reinforce sexual and reproductive health within reform processes in Latin America and the Caribbean. Additionally, it is essential to carry out pilot projects that allow, under real conditions, designing and evaluating concrete mechanisms to intercommunicate the actors of both processes and integrate fully all those individuals that can and should contribute to the betterment of the population's health and well-being.

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Annexes

ANNEX 1

Special sexual and reproductive health programs within the context of the health sector reform

Many countries in Latin America and the Caribbean have made women's health care, especially reproductive health, a priority. Most of these initiatives derive from the agreements reached at the international conferences in Cairo and Beijing. Nonetheless, only few countries in the region have explicitly incorporated programs devoted to women's reproductive needs into the reform of their health systems. Following is a brief description of some important examples.

Bolivia: National mother-child insurance and basic health insurance

The National mother-child health insurance, created by the Supreme Decree No. 24303, of May 24, 1996, grants all women the right to receive prenatal, labor and complicated-labor care, as well as consultation during puerperium and medical services for small children, at the facilities of any public health institution and health insurance company. In fact, this program subsidizes service supply, by offering incentives to obstetrical care providers.

Regarding financial support, this program receives a percentage of municipal budgets. With these resources, the program pays the insurance that finances the benefits related to recurring costs incurred by maternal care and medical services for the pathologies that are the main causes of child mortality in the country.

The National mother-child health insurance is being replaced by the Basic Health Insurance, a package that is not only for mothers and children, but also for groups that live below the poverty line, that is, for individuals that make up approximately 11% of the Bolivian population. Yet, it is not clear what filters are to be used to decide who is entitled to these services and who is not. Activists are fighting to make this insurance available to a much broader population sector. The new package includes various maternal and reproductive health activities, such as prenatal, labor and complicated-labor care, and obstetrical emergencies. Apparently, the package will not include contraceptive provision due to the scarcity of inputs in the country.

Remarkably, Bolivia has just legalized surgical contraception (tubal ligation) and injectable contraceptives. There is much concern about the quality of these services, as providers have not received adequate training in pertinent technical and ethical aspects. The inclusion of sterilizations in the FP program has opened the door to violations of reproductive rights, which is a serious problem in any country, but mainly in Bolivia, where 30 years ago cases of female sterilizations performed without consent (and frequently without the women's knowledge) were repeatedly denounced. This incident caused generalized distrust of all family planning and reproductive health programs, a feeling that prevails even today.

It is important to note that, in compliance with Cairo's commitments, the Bolivian government has recently created the National Sexual and Reproductive Health Forum, a group of governmental and civil organizations, donors and other participants. The forum meets periodically to analyze aspects related to the national policy in matters of reproductive health. The leaders of this effort are the Ministry of Health and the Coordination Program of Comprehensive Health

(Procosi), an IPPF affiliate that groups all non-governmental organizations financed by the U.S. Agency for International Development.

Brazil: Reform programs and the sexual and reproductive health agenda promoted by civil society activists[1]

The opposition of the Catholic Church and the military prevented the population policy, in effect as from 1970, from including contraception programs in the public sector. This policy, however, did not hinder the endeavors of non-governmental groups, operational since 1960, in matters of family planning.

In the late seventies, a complicated democratization process accompanied by an economic crisis and rampant inflation began. During this time, the responsibility for public health services fragmented to become a model that emphasized hospital care, focused more on the cure than on prevention, and depended on contracted private service providers.

Between 1970 and 1980, the military regime implemented policies that seemed to have contributed to a 25% reduction in the fertility rate: the network of services and consumer credit expanded, messages regarding the benefits of a small family and contraception were disseminated through the media (especially television), and coverage by the National Health System and social security was enhanced. These policies, together with rapid urbanization, resulted in growing acceptance of modern contraceptive practices by the population.

The 1980s were primarily a period of increased democratization and greater political participation by the people, which had a significant effect on health policies and national initiatives in reproductive health. A strong demand for reform of the health system led to the passage of the constitutional provisions that established the Universal Health System (SUS), which is a universal (total coverage), integrated and decentralized system that includes social control mechanisms in the form of health councils at the national, state, and local levels. In this period, women's rights groups demanded the distribution of contraceptives by the government and the legalization of abortion. This discourse contributed to the recognition of reproductive freedom of choice as a fundamental right.

In 1984, the Ministry of Health developed the Women's Integrated Health Care Program (PAISM), which included obstetrical care, cancer prevention, sexually transmitted disease care, adolescent and menopausal care, and contraception. About the same time, the National Council on Women's Rights (CNDM) and state councils were created, as well as the Committee on Reproductive Rights, all of which supported the PAISM and played a critical role during the drafting of the new Constitution that guaranteed freedom of choice and access to family planning.

Between 1984 and 1988, PAISM introduced standards for programs and services, distributed materials, and provided training and improved awareness among service professionals. However, subsequent economic and political turmoil delayed the passage of enabling legislation under the Constitution, and PAISM languished. In 1993, while integrating Brazil's delegations for the International Conference on Population and Development, the PAISM principles were revived through debates and seminars involving government, academic and civil society organizations.

Although during PAISM's first ten years of existence significant efforts in some states of the country were carried out, these activities were insufficient, because integrated services, as described in Cairo's Plan, were not implemented. Additionally, no consistent coordination existed with the HIV/AIDS program (PNAIDS), and

[1] This section is based on Correa, S., Piola, S. and Arilha, M. (1996). *Reproductive health in policy and practice*. Washington, D.C.: Population Reference Bureau.

fragmentation and overlapping of responsibilities persisted at the state and municipal levels.

After the International Conference on Women (Beijing 1995), the reproductive health and rights agenda recaptured visibility. After 1996, the health sector reform regained strength that crystallized into important changes within the SUS. Thus, a vast network of public and private services was created. Moreover, primary care became the service axis and, just as important, local managers were granted autonomy to define priorities and allocate resources. The latter constitutes a crucial element to ensure access to reproductive health services and quality of care. Simultaneously, sources of income for the SUS were created to guarantee its economic sustainability.

The present structure of the SUS resulted from several experiments, among which PAISM was a very important antecedent. However, this program's organization, like that of other initiatives, was vertical, as was the case of the special program on adolescents, the HIV/AIDS program, and gynecological cancer care. This fragmentation is contrary to service integration, which is an essential item on Cairo's agenda. Additionally, it contradicts the policy of decentralization and definition of local priorities promoted by the SUS, which requires that local managers are convinced of the relevance of reproductive health.

In 1995, the government created the National Commission on Population and Development, whose mandate is to follow up compliance with Cairo's commitments. One of the priorities of this commission's agenda is sexual and reproductive health. In addition, in 1995, a position for a women's rights advocate was created at the National Health Council, as well as several advisory boards to foster Cairo's recommendations. In 1997, a new coordinator was appointed to PAISM, who was closely acquainted with the ICPD agenda. Because of the above, the Ministry of Health made reproductive health activities a national priority in 1998.

Thanks to the influential role the women's movement played not only at the federal but also at the decentralized levels, reproductive health efforts became a priority. In fact, from 1995 to 1998, the number of interactions between government and the civil society increased and reproductive health themes gained more visibility, which resulted in the creation of the aforementioned boards and accountability mechanisms for SUS's commitments. Advocacy organizations had a strong influence on public debate in that regard.

During that period, numerous meetings with managers, physicians and women's groups took place. In some states and municipalities, programs designed to involve professionals in a more significant fashion were reactivated. In Brazil, as well as in other countries, the background, attitude and ideology of health professionals have always been a significant obstacle to reproductive health programs.

The Brazilian experience is an example of the challenges and dilemmas that result from trying to match the Cairo agenda to the health system reform. For five years, implementation of PAISM was held up by the problems encountered in consolidating the SUS, as well as by important funding problems of this system. Fortunately, these reforms encouraged local initiatives that gave priority to reproductive health actions.

Another important challenge was to overcome the vertical approach of the programs mentioned in paragraph 7.3 of ICPD's Action Plan to establish comprehensive services. Such integration requires acknowledging reproductive health as a "system priority" to ensure good care provision for the individual user and guarantee quality public health interventions.

Finally, another challenge is to recognize that reproductive health services and supplies cannot be provided exclusively through the public health system. Although SUS is universal, many people use the private sector for contraceptive services and methods. Therefore, the system must

also take into account private sector supply and demand.

Throughout this long and complex process, women's organizations have been essential in exerting pressure on the health system (persuading decision makers, and sensitizing and training health professionals) and indispensable for informing the civil society, that is, creating coalitions and alliances, stimulating public debate and systematically monitoring the new policies.

The government of Brazil opened the door to the participation of the civil society, especially women's groups. Therefore, compared to other countries, Brazil's experience has facilitated more decisively the participation of activists in reform programs. Maintaining or increasing this level of participation in future projects with federal governments that are less committed, or with state and municipal officers that are less open to dialogue and collaboration, has to be ensured. The IDB could promote the continuity of this process by showing the governments with whom it negotiates that participation of the civil society in an organized fashion is essential, as it increases the appeal of projects that seek financing.

Colombia: Health sector reform and reproductive health program development by NGOs[2]

Reforms of health systems influence directly and significantly the development of reproductive health programs. Moreover, sectorial reforms generate opportunities by creating mechanisms of funding and incentives that further improve reproductive health program coverage and growth. However, the health sector reform can also have a negative effect and hamper the sector's response to reproductive health needs.

The recently started Colombian process presents elements that are thought provoking. Following is a brief analysis of the characteristics and main effects of the interaction between the health sector reform and reproductive health programs in this country.

In the last four decades, Colombia has experienced relevant and internationally recognized achievements in reproductive health. This progress is largely due to the decisive, continuous effort of a private, non-profit organization known as Profamilia, which is a pioneer of reproductive health programs. This entity filled the void that the almost non-existent intervention of the State and scarce interest of private providers had created.

In December 1993, Colombia begins a profound transformation of its health system through the passage of a new law, the *Ley 100*. Such transformation seeks to establish a regulated competition model that gradually provides all inhabitants with universal, obligatory coverage through a package of basic benefits. The new system is fundamentally universal and mandatory, and offers integrated services, promotes (State-regulated) competition among insurance companies and between public and private providers, guarantees users' freedom of choice, increases community participation, and demands solidarity from the rich and healthy with the poorest, more vulnerable sectors of the population.

Thus, the new health model in Colombia has substantially changed critical variables of the sector by ensuring greater availability of financial resources, modifying the global payment mechanism (from subsidizing supply to subsidizing demand), favoring health promotion and prevention activities, and generating interest in the efficiency of resource utilization. Through these changes, Colombia seeks to increase progressively the percentage of the population with the ability to demand services and trans-

[2] This section was written by Juan Pablo Uribe, technical coordinator with the Fundación Corona, professor at the Faculty of Medicine of the Pontificia Universidad Javeriana, and former Vice Minister of Health of Colombia.

form drastically the behavior of institutions dedicated to service provision.

Of special importance in reproductive health are two plans of benefits that were created within the new system:

1. The *Mandatory Health Plan* (a basic package of benefits for individual coverage), which considers specific sexual and reproductive health interventions for all its affiliates, including sexual and reproductive health information, counseling and education; self-esteem and self-care promotion; contraceptive method provision and integrated obstetrical care.
2. The State's *Basic Care Plan* includes general interest or public health activities, which consist of educational programs on sexual and reproductive health topics, among others.

The new model of health service insurance, financing and provision in Colombia offers interesting opportunities to develop reproductive health programs, including:

- A substantially increased number of individuals with the ability to effectively demand sexual and reproductive health services. This would include the poorest, most vulnerable population groups that currently have individual, subsidized insurance. Such insurance has contributed to overcoming the primary access barrier to assistance: the inability to pay for services.
- More stable sources of financing for reproductive health services, which reduce the traditional dependency of these programs on international donors. Nowadays, organizations like Profamilia have more entities that purchase their services, thus enabling them to cover broader groups of the Colombian population.
- The possibility of crossed service subsidies. Changes in financing modalities should allow offering subsidies to benefit the most vulnerable, high-risk groups within the coverage of both the system as a whole and NGOs that provide reproductive health services.
- Increased financial resources and demand by population groups with payment capacity generate a larger service offer. Currently, in Colombia, more public and private institutions provide reproductive health services to users who have freedom of choice, thus competing with Profamilia and other providers. This dynamics has exerted positive pressure on all institutional service providers to make them improve their internal management capacity, institutional efficiency and quality of services.
- Health promotion and disease prevention activities, which are fundamental to sexual and reproductive health programs, are stimulated with a demand subsidy in the form of payment per training.

In Colombia, while HSR creates the aforementioned opportunities, the new mechanisms of service insurance, financing and provision are likely to produce inconvenient and unexpected results that could pose a threat to present achievements in reproductive health and hinder an adequate response to populational needs. Among these risks are the following:

- Fragmentation of reproductive health programs into isolated localized activities, inserted into the benefit plans that are offered by many insurance companies and providers. This situation is contrary to the Cairo Action Plan's recommendations that stress that reproductive health service integration is an essential element of the new paradigm. Additionally, this fragmentation reduces quality of care and increases the number of missed opportunities for providing care, while decreasing the effectiveness and efficiency of interventions. This has created the need for considering innovative institutional schemes, for both service insurance and provision, aimed at achieving this much-desired integra-

tion. Furthermore, to counterbalance the risk of fragmentation, adequate system regulations are critical.

- With the new financing scheme for individual insurance (via demand subsidies), insurance companies may prefer healthier populations to those that are exposed to a higher risk of disease (risk selection). This phenomenon has particularly relevant implications in reproductive health, because very vulnerable groups and those that suffer from complications coincide. Therefore, on the one hand, an adequate risk adjustment in the payment per training scheme (to include variables such as gender, age and geographical area) is required; on the other hand, close monitoring of the performance of insurance companies by regulating entities is crucial.
- Imposing inadequate fees for some services may have negative effects. Excessive prices could lead to a moral risk in the service offer (for example, it could mistakenly encourage production of a given service, including provision of some contraceptive methods). Conversely, extremely low prices could produce barriers to the service offer in that service providers could avoid "underpaid" interventions and perform instead better-remunerated procedures. Note that, however, fees could also contribute to overcoming previously identified inequities among population groups.
- High rotation of affiliates among insurance institutions (worse still, their "free" entry and exit of the insurance system) annuls the insurers' original purpose, which is to intensify promotion and prevention. This in turn makes them reconsider the actual scope of freedom of choice and State's responsibility when facing interventions of public interest.
- The existence of marginalized sectors that lack individual insurance under the regulated competition model demands that the State offer coverage to certain regions and populations through service supply subsidies and prospective budgets linked to managerial performance plans. Thus, the State would preserve its regulatory function and capacity of timely intervening to correct inequities.

In conclusion, the Colombian experience, although incipient, is a source of knowledge for those interested in linking reproductive health programs with sectorial reforms. Such reforms represent one of the best options to broaden program coverage, as they increase demand for financed services with duly focalized subsidies. Likewise, the new incentives will strengthen institutional service provision, by improving efficiency and fostering greater quality and innovation in programs.

Within this context, the indispensable regulatory role of the State regarding incentives and opportune correction of possible inequities that affect vulnerable groups helps preserve the social function of reproductive health services. Colombia offers lessons that countries of similar characteristics could apply to reproductive health services and programs. The IDB could play a fundamental role by supporting communication, learning, and collaboration among countries in Latin America and the Caribbean, so that the more advanced nations support those that lag further behind.

Nicaragua: Program of Integrated Care for Woman and Child

In 1995, Nicaragua's Ministry of Health created the General Directorate of Integrated Care for Woman and Child, whose objective is to guarantee the implementation of the eponymous program at primary health care units by training health providers.

Two innovative proposals are noticeable: a) to transform the traditional mother-child vision into health care for women, children and adolescents, from a gender perspective, which includes promotion of self-esteem and self-care, and sexual education, and b) to incorporate the

theme of intra-familial violence as a public health problem.

A substantive axis of the proposal is integrated care, which contemplates all the factors that have an effect on health, defines those susceptible of a direct intervention, and determines what social and state sectors should approach such factors, promoting effective inter-programmatic and inter-sectorial coordination (Ministerio de Salud de Nicaragua, 1995).

Peru: Project 2000

In the early nineties, in a setting dominated by a complex and problematic social situation, the Peruvian State initiated a process to reform health services to achieve universal, solidary and equitable coverage. This process includes an important reproductive health component to broaden reproductive health coverage and access, with special emphasis on family planning and obstetrical care.

Thus, the Reproductive Health and Family Planning Program (Project 2000) was created. Evaluating the achievements of this program, whose ambitious objectives are to be reached through a participatory and plural strategy, would be premature.

Peru: ReproSalud project[3]

This project illustrates the sort of challenge implied in offering an effective response to the sexual and reproductive health needs of marginalized urban and rural indigenous populations in our countries, and in transforming women in these groups into protagonists of their own health care. This endeavor should be carefully, slowly and responsibly carried out, taking into account cultural and religious idiosyncrasies and seeking innovative ways of overcoming geographical, linguistic and cultural barriers, as well as the distrust originated by years of abuse these sectors of the population have endured. This case underscores the importance of incorporating NGOs into HSR projects that seek to reach communities of this kind.

The ReproSalud project is a cooperation agreement between the Manuela Ramos Movement,[4] Alternativa and AID, which came into effect in October 1995. The Manuela Ramos Movement is in charge of the project's execution and direction. ReproSalud's purpose is to improve the reproductive health of peri-urban and rural women, so that they increase demand and utilization of services, while developing their capabilities to carry out reproductive health interventions.

The project is based on the following principles:

- *A gender perspective* that empowers women to increase their self-confidence and promote the exercise of their decision-making capacity.
- *Community participation*, so that women develop individual and organizational abilities, by reaffirming their capacity to voice individual needs and negotiate with institutions and authorities.
- *Support for the initiatives of community-based organizations* that show potential to improve women's reproductive health and situation through income-generating activities.
- *To strengthen women's capabilities* to enable them to defend their sexual and reproductive rights at the local, national and regional levels.
- *Sustainability*, so that interventions by women's organizations endure, originate from within such organizations and are sustained through the development of their own internal potentialities.

[3] Section written by Ella Carrasco, a representative of ReproSalud and the Manuela Ramos Movement.

[4] Feminist NGO founded in May 1978.

- *Flexibility* to adapt gradually to specific needs and progress of the women themselves and of the regions.

The strategy of the project consists in recognizing women's capacity to identify their own problems and overcome them by carrying out small projects.

Based on this strategy, community-based organizations (CBOs) were invited to participate in a call for proposals to become ReproSalud's counterparts. So far, the project has selected 175 women's CBOs, located in the Ancash, Ayacucho, Huancavelica, La Libertad, Lima, Puno, San Martín and Ucayali departments.

With the collaboration of the selected CBOs, studies on *self-diagnosis in reproductive health* are underway. One hundred and fifty eight such studies have been hitherto carried out with the participation of 3,596 women. The reflection process included in these studies allows women to share their knowledge and voice their concerns in regards to the problems they deem the most frequent and serious.

The problems that women regarded as priorities included "suffering during labor", "many children" and "white discharge menses", which to some extent coincided with those collected by the latest National Demography and Health Survey (NDHS). In fact, in places where maternal mortality is higher, women reported pregnancy and labor-related problems as the most serious. Another example is adolescent pregnancies, for which there were also matches with NDHS data. A problem that women from all regions mentioned was "white discharge" (vaginal discharge caused by reproductive tract infections), which jeopardizes female sexuality and creates much fear because of its association with cervical cancer (CC). Multiparity is another problem common to all regions. Less frequently, other women's organizations have mentioned unsafe abortion, prolapse, "ailments of the critical age", and CC, among others. Domestic (and non-domestic) violence is inextricably intertwined with the aforementioned problems, as it may trigger or worsen them.

During the last self-diagnosis session, women identify the resources they can use to overcome priority problems; based on this, they design a project. Most projects are educational in nature and consist in the formation of community promoters that will be in charge of replicating informative activities with CBO men and women. So far, 156 ongoing projects are being led by 122 CBOs that work with 731 partner women's organizations.

This work modality has reached 28,286 women, 7,221 men and 4,980 adolescents. It boasts a dimension that transcends health objectives and allows women to develop and strengthen their decision-making skills, exercise their rights and become interlocutors that interact with public and private institutions, voicing their concerns and demands and creating solidarity ties with other women's organizations, State institutions[5] and the civil society to achieve their objectives.

The second axis of the project is to support income-generating activities that reduce women's poverty, based on the assumption that if a woman has more resources and further develops her abilities to take care of her health, she will invest such resources in improving it.

The third axis of the project is promotion and advocacy of women's rights. Hence, agreements with public health officers in each region have been subscribed in order to create bridges between women and services, incorporating women's vision of their problems, as well as their expectations concerning care. Additionally, seminars to examine specific problems and workshops for health providers, on quality of care, violence and gender, have been carried out.

[5] Preferably, the Ministry of Health.

ANNEX 2

Classification of countries that participated in the consultation meetings according to their sexual and reproductive health situation

Three essential reproductive health indicators were taken into account for this exercise: global fertility rate, use of contraceptives, and maternal mortality (Tables I, II and III). By setting limits for those indicators, the 12 participating countries were classified as "good", "average" and "bad" (Table A). At the second stage, based also on these three indicators, the participating countries were grouped as follows: countries with greater, average and limited advances (Table B). To this "quantitative" classification, notes regarding the political position and/or specific problems of some of the countries under consideration were added (these notes are not the result of research or any systematic data search; they are only appreciations by the authors).

Table A
Classification of countries according to their reproductive health situation

Indicators	*Good*	*Average*	*Bad*
Fertility	(2-2,5)	(2.6-3,5)	(3.6 and higher)
(GFR: Average number of children per woman at the end of her reproductive life)	Argentina Brazil Chile Dominican Republic	Colombia Mexico Peru	Bolivia Ecuador El Salvador Nicaragua Paraguay
Contraceptive use	(77-65)	(64-50)	(49 and under)
(Percentage of women of reproductive age that use contraceptives)*	Brazil Colombia Mexico	Dominican Republic Ecuador El Salvador Nicaragua Paraguay Peru	Bolivia
Maternal mortality	(44-50)	(51-250)	((251 and higher)
(Maternal deaths/100,000 live births)	Argentina Chile	Brazil Colombia Dominican Republic Ecuador Mexico Nicaragua Paraguay	Bolivia El Salvador Peru

* No data available for Chile and Argentina.

Table B
Classification of countries according to advances in sexual and reproductive health

Countries with GREATER advances (two "good" level indicators, or two "good" and one "average" level indicators)

- Argentina
- Brazil
- Chile

Countries with AVERAGE advances (one "good" level indicator, two "average" level indicators)

- Colombia
- Mexico
- Dominican Republic

Countries with LIMITED advances (only "average" and "bad" level indicators)

- Bolivia
- Ecuador
- El Salvador
- Nicaragua
- Paraguay
- Peru

Notes

Argentina. With only few exceptions, this country does not offer public reproductive health services. However, the fertility rate has been very low throughout the last decades. The government has maintained very conservative positions at international conferences. It has not carried out demography and health surveys. Consequently, data on contraceptive use are unreliable and lack representativity. Because of its macro economic and development indicators (which are in general, better than those of the rest of the region), Argentina is not on the list of priority countries of organisms that provide international assistance.

Bolivia. After Haiti, this is the second poorest country in the region. Bolivia has a very high proportion of indigenous population. Although much remains to be done in regards to coverage and quality, the government has recently made SRH a priority, as well as serious attempts to improve services. SRH indicators are very poor, especially maternal mortality. USAID, the United Kingdom Department for International Development (DFID), and most multilateral and bilateral agencies and private foundations have contributed funds for SRH activities.

Brazil. Advances in SRH have been the result of public programs and the pressure and contributions of civil society groups, mainly feminist organizations (see the Brazilian experience). Brazil is a priority country within the World Bank's broad program on HIV/AIDS treatment. USAID closed its population program because of the high prevalence of contraceptive use observed in the country. Brazil has committed and highly trained human resources.

Colombia. This is a country with significant advances in SRH, which are largely the result of programs and services that until very recently had only been developed by private organisms such as Profamilia, a local IPPF affiliate. The government's intervention contributed little but did not hinder the activities of other entities. Currently, the public sector plays a much more important role and collaborates with private organizations in this field (see Annex 1, for the Colombian experience). Colombia has not received help from AID in regards to population and SRH for many years.

Ecuador. This is a poor country, with a high percentage of indigenous population and a very unstable political situation. SRH programs and services have traditionally been operated by NGOs (especially Cemoplaf, an IPPF affiliate). Ecuador has good research and data generation groups in SRH.

El Salvador. The political situation of this very poor country has become more stable in the last few years. Together with the other Central American countries, El Salvador is on the list of priority countries of many assistance agencies. At international conferences, its government has traditionally held a very conservative position, aligned with that of the Vatican, although lately it has become more liberal.

Chile. This country has made important advances in sexual and reproductive health thanks to

very active programs that have been implemented by the public sector in the last decades. Chile's position at the *Cairo + 5* Conference was much more progressive than at former conferences. SRH is an essential element of reform programs of health systems.

Dominican Republic. For many years, this Caribbean country has actively carried out SRH programs and achieved good indicators for a developing country. HIV/AIDS is a serious problem in the Dominican Republic because of the industry of sexual tourism that is particularly prevalent in the north of the country (Puerto Plata).

Mexico. This country is a leader in population programs and regarding the government's commitment to family planning. Mexico has maintained a very liberal, protagonistic position at UN conferences. However, inequality in wealth distribution and poverty still prevail in the country; therefore, health indicators are not among the best in the region. In March 1999, USAID stopped supporting population programs (using the same "graduation" criterion it applied to Brazil and Colombia), but Mexico is among the priority countries of most private foundations and bilateral and multilateral agencies.

Nicaragua. A very poor country, Nicaragua has a long history of community participation and organization of the civil society, as well as highly active non-governmental organizations, particularly feminist groups. SRH indicators are very unfavorable, especially maternal mortality.

Paraguay. Dictatorships and instability characterize the political situation of this is poor country. However, with the creation of the Ministry of Women and the Reproductive Health Council that has representatives in various sectors, an institutional modernization phase has apparently begun. The national fertility rate is high.

Peru. This country's government subscribed to an active population policy in the first years of the Fujimori administration. Currently, contraception is intensely promoted and cases of abuse in matters of human rights have been denounced. Peru has a high percentage of indigenous population that lives in areas that are difficult of access. Thanks to AID's support, an innovative SRH program for rural areas is being developed. This program is managed by an NGO that is dynamically involved in SRH (see Annex 1, for more information on ReproSalud). Peru has a high maternal and child mortality rate and it is a priority country for AID, DFID, the European Union and many foundations. The country has trained human resources.

ANNEX 3

Progress of health sector reform

The nineties witnessed relevant advances in the health reform process in Latin America and the Caribbean. The participation of international agencies has been key to this progress. The reforms pursue common objectives, as all of them seek to broaden coverage, improve quality of care, make efficient use of resources, and reduce inequalities in the distribution of health resources. Nonetheless, even when these objectives and the mechanisms utilized to achieve them are shared, each country has set forth reform programs that vary according to the structural aspects of their health systems and the resources on which they count for their execution.

The following table presents an evaluation of the progress of reform programs in 12 countries in Latin America and the Caribbean, according to their goals. The general criteria to characterize reforms are changes in the financing and budgetary scheme, service structure and care model, and participation of the private sector.

Table C
Progress of health sector reform in 12 countries in Latin America, 1999

Country	*Reform goals*	*Progress*
El Salvador	Two-phased reform process. Restructuring of MSPAS (public sector) and the rest of the system. Decentralization of the MSPAS service structure. Cost recovery mechanisms.	**Incipient**. Decentralization with transference of functions and responsibilities at the local level has started.
Mexico	Decentralization of the public assistance sub-sector. Broadening of coverage through service packages for the underprivileged population. Mechanisms for the distribution of financial resources to reduce inequality. Decentralization of the social security structure, change in the scheme of budgetary allocation for care units and in the care model.	**Intermediate**. Public assistance decentralization is at a very advanced stage. Security has modified its budgetary allocation scheme, but it has not achieved changes in the care model to promote competition among providers.
Nicaragua	Decentralization of the Ministry of Health services. Reactivation of social security as a source of health care financing for the working population, with a scheme of structured competition among providers.	**Intermediate**. Decentralization of the Ministry of Health has already begun. Reactivation of social security has started and public and private providers are competing for funds.
Dominican Republic	Setting an integrated model where SESPAS (public sector) plays managing and regulatory roles and IDSS (social security) finances and provides services. Decentralization through administrative entities and creation of provincial funds. Provision of public-private services.	**Incipient**. Decentralization of SESPAS. Advances in the structuring of juridical framework and in the definition of inter-institutional analysis groups.
Bolivia	Decentralization of public service structure at the municipal level. Changes in budgetary structure. Creation of care provision programs for specific groups to broaden coverage.	**Intermediate**. The decentralization of the public system has been completed and is undergoing a process of adjustment. However, the integration of social security and other sub-sectors into the system has not been completed.
Colombia	Decentralization of the public service structure. Definition of an integrated care model with separation of functions among agencies, and competition between public and private care providers.	**Advanced**. Decentralization has been achieved. The care model was redefined; it has broadened coverage and allowed the involvement of new financing and managerial entities, and made competition possible between public and private providers. At present, the system is undergoing adjustments at all levels.
Ecuador	Proposal for a mixed public/private model with separation of functions, decentralization at the local level, and competition among providers. The social security reform has not been defined.	**Incipient**. Decentralization has made very little progress. This is also true for changes in financing and implementation of a new care model.
Peru	Health sector modernization without integrating MINSA (public sector) and IPSS (social security). Restructuring of funding, provision and supervision functions. Separation of functions in the system and decentralization of the service structure have been foreseen.	**Incipient**. There has been little progress in changing the structure of the system. There have been advances in coverage broadening and operation of specific programs.
Argentina	Decentralization of public services. Deregulation of social work to promote competition among providers. Implementation of the self-management service unit model.	**Advanced**. Decentralization is at a very advanced stage. Deregulation of social work is also at an advanced stage and undergoing adjustments. The self-management service unit model is already operational.

Country	*Reform goals*	*Progress*
Brazil	Creation of a unified model to universalize access to services. Decentralization of service structure. Introduction of PAB to improve equity. Competition between public and private providers.	**Advanced**. Care unit decentralization with ample participation by the community and local governments. Structured competition is operational. Problems with cost inflation.
Chile	Creation of two funds: a public (Fonasa) and a private (Isapres) fund. Decentralization of the public service structure by adjusting fund distribution at the municipal level to reduce inequality. Competition between Fonasa's and Isapres's providers.	**Advanced**. Clear definition of both sub-sectors with adverse selection of population groups by the private sector. Service municipalization. Competition for funds by both sub-sectors.
Paraguay	Proposal for the creation of a National Health System. The proposed system includes separation of financing, insurance and service provision functions. Decentralization of the public sector.	**Incipient**. Decentralization at the municipal level has progressed. However, the existence of the National Health Fund that would be in charge of financing the system has not been regulated.

MSPAS: Ministry of Public Health and Social Assistance
SESPAS: State Ministry of Public Health and Social Assistance
IDSS: Dominican Social Security Institute
MINSA: Ministry of Health
IPSS: Peruvian Social Security Institute
PAB: Basic Assistance Service Package
Fonasa: National Health Fund
Isapres: Previsional Health Institutions

Sources: Database of the Collection, Analysis and Dissemination Center for Health Reform Initiatives (NAADIIR), Mexican Health Foundation / National Public Health Institute; Data and Analysis System for the Health Sector Reform, PAHO.

ANNEX 4

List of participants in regional consultation meetings

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ANNEX 5

Discussion guide for regional consultation meetings

Below is a list of thematically organized questions that was used during the discussion sessions of the consultation meetings held in the countries presented in Annex 4. For the three meetings, the authors prepared the first version of the questions, which were subsequently adapted according to Merrick's text (1998). The final version of the list, which was used as a discussion guide, is presented hereinbelow sorted out by themes.

Resource allocation and priority definition within the context of decentralization

- What could ensure adequate attention and financing for sexual and reproductive health programs in a decentralized system?
- When limited resources and installed capacity demand the gradual introduction of a basic service package and a definition of priorities, what criteria should be used to define priorities?
- If the methodology of burden of disease guides the distribution of resources, how should sexual and reproductive health conditions (such as pregnancy and family planning), not diseases, be included?
- How could we ensure the success of programs aimed at specific population groups within the context of comprehensive sexual and reproductive health services? For example, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) prevention programs for men and commercial sex workers, who are non-traditional users of sexual and reproductive health programs.

Service financing and provision

- How could we assess the impact of changes promoted by the reform (devolution to private organisms, insurance schemes, cost recovery) on sexual and reproductive health programs?
- Would non-governmental organizations (NGOs) that are service providers have to broaden their field of action to include contracting-out?
- Should insurance schemes cover family planning and other sexual and reproductive health services?
- Does service access for women that belong to the poorest groups hinder cost recovery?
- How can we persuade governments and international organizations to increase financing for activities that promote the improvement of sexual and reproductive health?
- When various integrated sexual and reproductive health care options are assessed, how should costs for specific components be determined and how could their effectiveness be evaluated?
- What are the lessons we can learn from the experiences of other countries?

Redefinition of functions at the central level

- Within the decentralization process, what could be done to preserve the functions of the central level (quality control, definition of norms, technical support)?
- What has been the experience of countries whose reforms have progressed?
- How important is the central level's regulation regarding adequate sexual and reproductive health service provision, in each country?

Strategies for service provision

- Is it feasible to use new strategies and apply new methodologies to determine sexual and reproductive health needs and assess health service demand within the context of decentralization?
- At the decentralized level, how could the service provision capacity be evaluated and what steps would be necessary to increase the capacity to respond to community needs?
- What is needed to ensure that a health system does not lose what it has gained and does not face problems such as lack of resources, particularly contraceptives?
- How feasible is an integrated reproductive health service provision?

Quality of care

- How could the quality of sexual and reproductive health programs be assured within decentralized structures?
- What could be done to update knowledge of health personnel and help them show a positive attitude as service providers?

Reproductive health legislation

- Is it necessary to broaden and/or modify the legal framework in matters of reproductive health?
- Regarding reproductive health service provision, how could compliance with legal provisions be guaranteed within reformed systems?

Strategic questions for the middle term

- How can governments and international organizations be persuaded about the importance of improved reproductive health for national and regional development?
- How could broadening the agenda (adopting the reproductive health paradigm) be achieved so that investment or advances in areas such as family planning, that have been traditionally financed by international funding organizations and governments, do not decrease?
- How will the involvement of sectors —other than health— in programs aimed at improving sexual and reproductive health, reducing gender-based differences and, in general, improving women's condition be promoted?
- How will the interest of international financing organisms be drawn to Latin America and the Caribbean? How can investment in areas (such as health, education, nutrition, women's micro companies, etc.) that directly affect sexual and reproductive health be maintained and increased in spite of the fact that some regions in the world have needs that are still more pressing?
- How could international financing organizations (World Bank, Inter-American Development Bank) be persuaded to increase support for non-governmental organizations?
- How could more funds be acquired to research into the links between reproductive health and development, and health systems and services, particularly cost-effectiveness of sexual and reproductive health interventions? How could support for the formation of professionals in sexual and reproductive health in the region be increased?

- How could bilateral and multilateral donors and private foundations be influenced to adopt a common agenda to optimize and achieve synergy among the various support programs?
- How could the development of concerted sexual and reproductive health agendas be promoted among governments, civil society and donors in the region?

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ANNEX 6

International funding for sexual and reproductive health

Following are the resources that various agencies have contributed towards sexual and reproductive health development in LAC in recent years.

Private foundations in the United States

The Ford Foundation. In 1996, total funds granted to the region for all activities, including sexual and reproductive health, amounted to USD $33,061,602 (Foundation Center, 1999). The Ford Foundation funds are conferred upon a wide variety of international agencies that support efforts in sexual and reproductive health. Among such agencies are the Inter-American Development Bank and IPPF/WHR.

In the national ambit, in 1997, the Ford Foundation sponsored sexual and reproductive health activities of national/local organizations for periods of two and three years (Annual Report, 1998). Funds were granted as follows:

Brazil: USD $2,423,500 for research and training in reproductive health (gender, policy and participation, among others), public education, creation of networks and reproductive rights.
Chile: USD $189,600 for reproductive rights and sexual violence prevention.
Colombia: USD $331,000 for reproductive rights, institutional development and research on masculinity.
Mexico: USD $3,078,800 for research and training in reproductive health, community participation, promotion, dissemination, and reproductive rights.
Peru: USD $409,800 for reproductive health data dissemination, reproductive health promotion and community development.

The MacArthur Foundation.* In 1996, total funds granted to LAC for all activities amounted to USD $13,429,672 (Foundation Center, 1999).

At the national level, in 1997 and 1998, The MacArthur Foundation granted funds for two and three-year periods, including:

Brazil: USD $2,149,400 for research and training in sexual and reproductive health among adolescents, reproductive rights, and prevention of gender-based violence.
Mexico: USD $2,592,900 for research and training in sexual and reproductive health among adolescents, prevention of sexually transmitted diseases/human immunodeficiency virus/acquired immunodeficiency syndrome, gender, and reproductive rights.

The Hewlett Foundation. In 1996, total funds transferred to LAC for all activities amounted to USD $3,290,000 (Foundation Center, 1999). Most of Hewlett's reproductive health funding was granted as "general support". The foundation has selected a number of technical assistance agencies in the United States and Europe (AVSC, IPPF, Ipas, IWHC, Care, CEDPA, Pathfinder, Marie Stopes), which use a percentage of the funds to support reproductive health activities in LAC.

* Source: (www.macfdn.org).

In the national ambit, in 1997, the Hewlett Foundation sponsored national/local organizations for periods of two and three years (Annual Report, 1998):

Brazil: USD $625,000 for research on behavior in health, and demography.
Costa Rica: USD $135,000 for population programs in Latin America.
Mexico: USD $1,765,000 for local groups that work on aspects related to reproductive health, service provision, adolescent health, and research.

The Packard Foundation. In 1996, total funds transferred to LAC for all activities amounted to USD $2,034,994 (Foundation Center, 1999). Packard supports US and international agencies that provide technical assistance in LAC, such as IPPF/WHR and AVSC.

At the national level, in 1996, the Packard Foundation funded sexual and reproductive health activities for periods of two and three years (Annual Report, 1997), including:

Brazil: USD $47,710 to support legal abortion services.
Mexico: USD $753,975 for infrastructure, promotion, research, training and service provision. The themes covered included sexual and reproductive health among adolescents, reproductive rights, and midwife participation and support.

The Bill and Melinda Gates Foundation.*
Current global fund: USD $4.2 billion. Funding priorities in health include improvement of voluntary access to family planning, safe motherhood and cervical cancer prevention.

* Source: (www.gatesfoundation.org).

Bilateral assistance in reproductive health in LAC

Sweden (Swedish International Development Agency, SIDA)

Total amount for population assistance in 1996 (defined as family planning and assistance related to public education and development policies, obtainment of demographic data, AIDS prevention and maternal care): USD $57.9 million, of which approximately 1.5 million was granted through bilateral agreements, 20 million through multilateral agreements and 22.9 million to various NGOs.
Geographic priorities: Central and SouthAfrica receive most of the Swedish bilateral assistance in sexual and reproductive health. Sweden also finances small initiatives in Nicaragua and other general activities in Central America.
Priority programs: Human rights, gender equity, maternal health and newborn care, fertility regulation, abortion services and unsafe abortion management, HIV/AIDS, health among adolescents, and violence and abuse prevention.

United Kingdom (Department for International Development, DFID)

Total amount for population assistance in 1996: USD $106.4 million, of which approximately 23 million was granted through bilateral agreements, 30 million through multilateral agreements and 53.4 million to several NGOs.
Geographic priorities: The DFID has traditionally prioritized those developing countries that have historical ties with Great Britain. In 1996, only 3% of total funds were transferred to LAC (Bolivia and Peru).
Priority programs: Sexual and reproductive health among adolescents, STD/HIV prevention, prevention of maternal morbidity and mortality,

unmet needs in family planning, promotion of gender equity and reproductive rights, and sexual violence management.

United States (Agency for International Development, USAID)

Total amount for population assistance in 1996: USD $637.7 million, of which approximately 230 million was granted through bilateral agreements, 30 million through multilateral agreements and 377.7 million to several NGOs.
Geographic priorities: Fifteen countries receive most of the funds this agency grants. Bangladesh, the Philippines, Kenya and India were the most important recipients of funds between 1993 and 1997. For the time being, no country in LAC is among AID's priorities.
Priority programs: Family planning continues to be USAID's platform for reproductive health efforts. Other activities include technical assistance and training in service provision, acquisition of goods, and social marketing. USAID also supports a variety of research activities related to reproductive health, including biomedical studies, development of new contraceptive technologies, and demographic surveys.

Interpretation of the "Donor Expenses for Latin America" matrix. Definitions

Population assistance. According to the ICPD Action Plan for 1994, "population assistance" is divided into four categories.

Family planning: Contraceptive supplies and service provision, growth capacity for information, education and communication (IEC) regarding FP and development aspects, national growth capacity through training support, infrastructure development and facilities improvement, development policy and evaluation programs, basic service statistics and focalized efforts to ensure quality of care.

Reproductive health: Routine information and services for prenatal care and safe, normal childbirth, and postnatal care; abortion; IEC on RH, including STD, human sexuality, planned parenthood, harmful practices, adequate counseling, STD and RTI diagnosis and treatment according to available resources; infertility prevention and adequate treatment according to available resources; and STD referral, education and counseling services, including HIV/AIDS, and pregnancy and labor complications.
HIV/AIDS: Education through school-based programs and the media, promotion of voluntary abstinence, responsible sexual behavior and ample distribution of condoms.
Basic research: National development capacity by means of data analysis and programmed collection; research, training and policy development.

Support channeling. According to the 1996 Global Population Support Report (UNFPA/NIDI, 1996), support channels are divided into three categories:

Bilateral: Twenty-one governments of industrialized countries, the European Union, all members of the Organization for Economic Cooperation and Development (OECD).
Multilateral: A variety of UN organizations, including ECLAC, ESCAP, ESCWA, UNDP, UNICEF, FAO, ILO, UNESCO, WHO, and the World Bank and other regional development banks.
NGOs: Foundations, universities, non-profit, non-governmental organizations. A substantial percentage of USAID's funds are channeled through these "cooperation agencies," which are mostly international NGOs.

The fourth channel in the matrix is completely separated from the first three. Under "Foundations" are the four leading private foundations that contribute to the development of reproductive health initiatives in Latin America: the Ford

Foundation, the Hewlett Foundation, the MacArthur Foundation, and the Packard Foundation.

These foundations have promoted a number of relevant activities that include research, service provision, training/skill development, institutional development, and promotion. In most cases, identifying a separate list of expenses was not possible.

Final expenses: The term "final expenses" in this Annex refers to funds granted by a primary or intermediary donor to a final recipient, in a given year, for population programs and projects. Final recipients can be governments of developing countries, NGOs and offices of donor agencies in developing countries. The programs that use the funds do not necessarily have to be located in developing countries, but include activities such as research that benefit more than one developing country or region.

Notes of interest

- In 1996, primary funds for international population assistance reached USD $1.5 billion. If bank loans are also considered, then primary funds are slightly higher than USD $2 billion.
- Total primary funds, including those granted by development banks, increased 54%, reckoned from the period before the Cairo conference to 1996. That is to say, funds increased from USD $1.3 billion in 1993 to slightly over USD $2 billion in 1996. This figure is roughly 35% of the USD $5.7 billion agreed upon at Cairo's conference; such amount represents the international financial contribution to ICPD Action Programs for the year 2000.
- To reach ICDP's target resources for the year 2000, primary funds for population assistance should total USD $2.3 billion in 1995 and USD $3.0 billion in 1996, provided the funding increment (USD $0.7 billion yearly, in the 1995-2000 period) remains constant.

In 1996, primary funds from 21 developed countries and the European Union totaled nearly USD $1.4 billion of which:

- 55% came from two countries: The United States (USD $638 million) and the Netherlands (USD $112 million).
- 94% was contributed by ten countries: Australia, Canada, Denmark, Germany, Japan, the Netherlands, Norway, Sweden, United Kingdom and the United States.

Officially, population assistance from all donor countries was 2.46% of the funds for development support in 1996, which is higher than the 2.32% granted in 1995.

In 1996, final expenses amounted to USD $422 million (28%) in Central and South Africa; 367 million (24%) in Asia Pacific; 197 million (13%) in Latin America and the Caribbean; 104 million (7%) in Western Asia and North Africa, and 25 million (2%) in Europe. The remaining 26% was transferred to inter-regional populational assistance.

- In 1996, 37% of final expenses for population assistance were destined to family planning services, 33% to basic reproductive health services, 16% to sexually transmitted diseases and HIV/AIDS, and 14% to basic research, data and analysis of development and population policy.

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