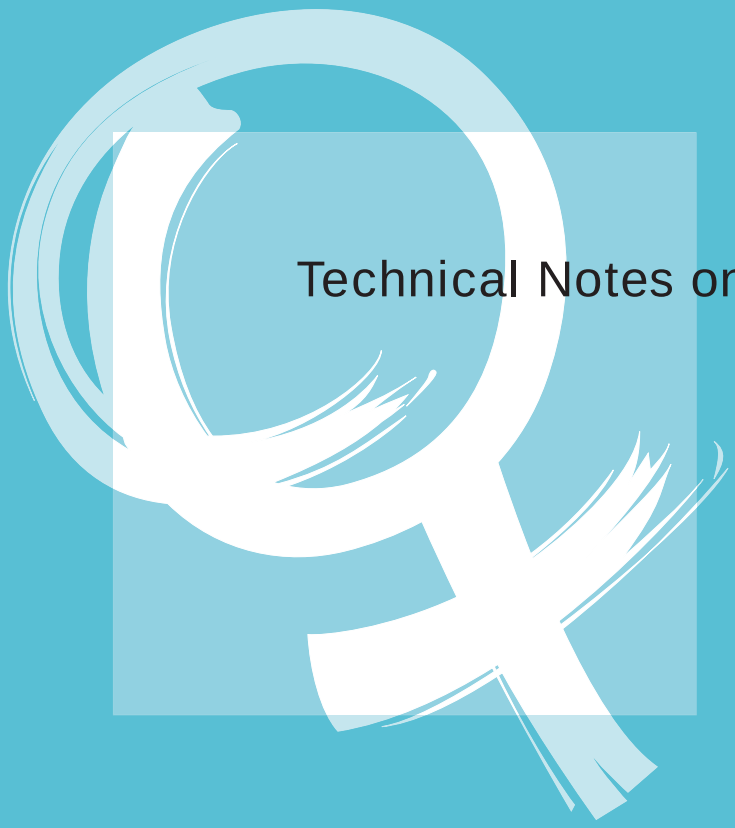

Technical Notes on Reproductive Health

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These Technical Notes on Reproductive Health *were produced with partial support from the Ford Foundation and the Government of Norway*.

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Technical Notes on Reproductive Health

January 2000

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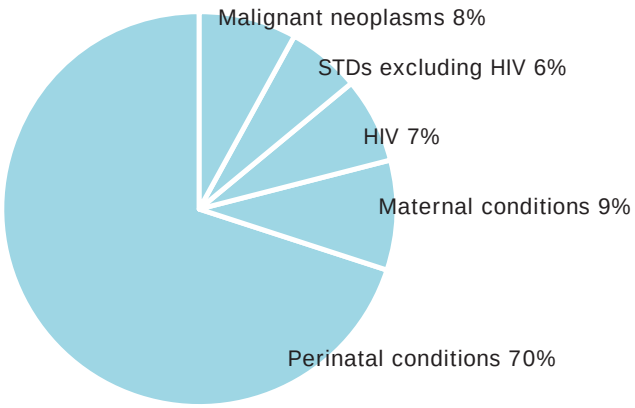
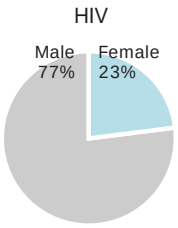
The Burden of Reproductive Ill Health in Latin America and the Caribbean

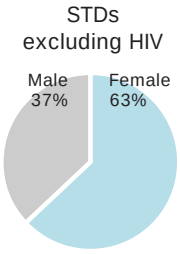
- How significant is the problem? Reproductive health related morbidities and mortalities account for 14 percent of the total burden of disease in Latin America and the Caribbean, making these causes the single largest producer of disability-adjusted life years[1] (DALYs) lost in the region.

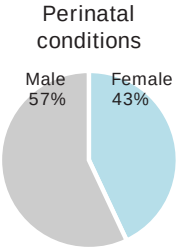
DALYs Lost to Reproductive Morbidities and Mortalities in Latin America and the Caribbean, 1990

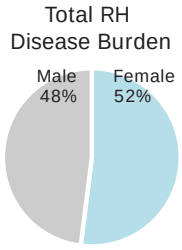


- What are reproductive morbidities and mortalities? Reproductive health morbidities and mortalities include: sexually-transmitted disease (syphilis, chlamydia, gonorrhea); human immunodeficiency virus (HIV); maternal conditions (hemorrhage and associated anemia, sepsis, hypertensive disorders of pregnancy, obstructed labor, abortion and associated infertility); perinatal conditions[2] (low birth weight, birth asphyxia and birth trauma); and reproductive malignant neoplasms (breast, uterine and ovarian cancers). The source for the data is Murray and Lopez 1996. This estimate is conservative since other reproductive health conditions, such as reproductive tract infections, should be included, but have not been reliably measured.
- Who suffers? These conditions primarily affect women and men of reproductive age and their children, and are closely linked with poverty (see Technical Note 2). The graphs show the distribution of STDs, HIV and perinatal conditions among females and males and the proportions of total reproductive health disease burden attributable to women and men. Malignant neoplasms and maternal conditions are attributable only to women, and therefore are not presented in graphic format.
- What can we do? Reproductive health not only implies freedom from reproductive morbidities and mortalities, but also an ability to conceive and bear healthy children in the numbers and at the intervals that a woman and









1. Disability-adjusted life years are time-based measures of health outcome that incorporate non-fatal health outcomes (i.e., disability). The measure allows a quantification of the burden of disease and injury on human populations, in terms of life years lost to disability and death.
2. Perinatal conditions represent 70 percent of total reproductive ill-health burden because they are a direct result of a mother's poor health and nutritional status prior to and during pregnancy, the management of labor and delivery, and the same complications that can cause women's deaths. More than one-third of perinatal deaths are attributable to a mother's health and nutritional status. Women with poor nutritional status, for instance, RTIs or other infections during pregnancy are more likely to have low birth-weight infants. The perinatal mortality rate of a low birth-weight baby is 20 to 30 times higher than that of a fetus or infant of normal weight. Many low birth-weight infants who do not die may suffer serious neurological problems, hearing and visual defects.

her partner desire. Disease burden data shows that safe pregnancy and delivery, healthy spacing of births, and infection prevention and control continue to be public health priorities. Comprehensive, integrated reproductive health programs are in place in every country in Latin America and the Caribbean (see Technical Note 8 for examples). However, these programs have not yet reached the most vulnerable populations: impoverished women, indigenous women, adolescent girls and high-risk men.

- Is it cost-effective to prevent and treat these conditions? Cost-effectiveness studies conducted in Latin America and the Caribbean repeatedly show that prenatal and post- partum health care, breastfeeding promotion, contraceptive services, AIDS prevention, STD screening, and simple preventive techniques to detect cancer early, can save more lives and thus spend scarce health dollars most effectively within the health sector than almost any other health service intervention. Positive externalities associated with each service are significant. Some include arresting the intergenerational transfer of ill-health and socioeconomic disadvantage; providing women and girls the means to make informed and healthy choices about their lives; and minimizing the spread of AIDS and associated transmission of costly secondary diseases, such as tuberculosis.

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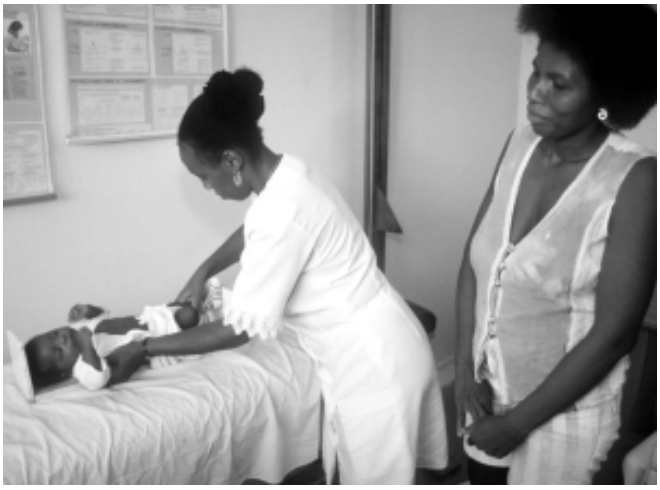
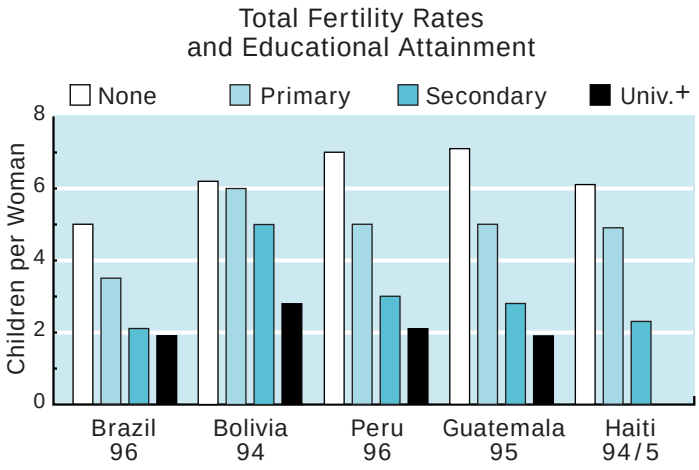
Making the Connection between Reproductive Ill Health and Poverty in Latin America and the Caribbean

- The connections between poverty and reproductive ill health, as expressed through high fertility and perinatal mortality, are multidimensional. Conceptually, poverty is both a determinant and a consequence of reproductive ill health, either directly or through a series of proximate determinants. The links between poverty, low educational attainment, high fertility, and poor child and maternal health are well documented. Fertility decreases monotonically as education increases. Across Latin America and the Caribbean, women who live in urban areas and women who work for cash have fewer children than do other women. A mother's death during childbirth means not only the loss of her productivity to both the national economy and the household, but also has an inter-generational effect through her child's reduced chances of survival and health. Studies show that surviving children are three times more likely to die within two years than children who live with both parents; and many motherless children, particularly girls, get less health care and education as they grow up. Thus a mother's sickness and death affects her household's socioeconomic status, and this status in turn affects the proximate determinants of health.
- Socioeconomic inequalities in the distribution of high-risk fertility and mortality and in the use of services affect the distribution of human capital. This is particularly disturbing since recent studies show that the distribution of human capital (see Technical Note 3) affects overall rates of economic growth, and the current highly inequitable distribution patterns in Latin America and the Caribbean affect the income growth of the poor disproportionately (Birdsall and Londoño 1997).
- Social status, a distal determinant of fertility, acts on fertility levels through "proximate determinants," such as age at marriage, use of contraception, and duration of breastfeeding.[1] Proximate determinants of fertility do not simply act on fertility, they act on a woman's entire life, thereby recreating poverty conditions for women and their children. In Bolivia, poor women marry in their teens and have very high fertility up to the age of 30, while the poorest women marry even younger and continue to have children throughout their entire reproductive lives (Vidal-Zeballos 1994). These reproductive patterns have profoundly negative implications for women's life choices in schooling, employment and child care.



WILLIE HEINZ

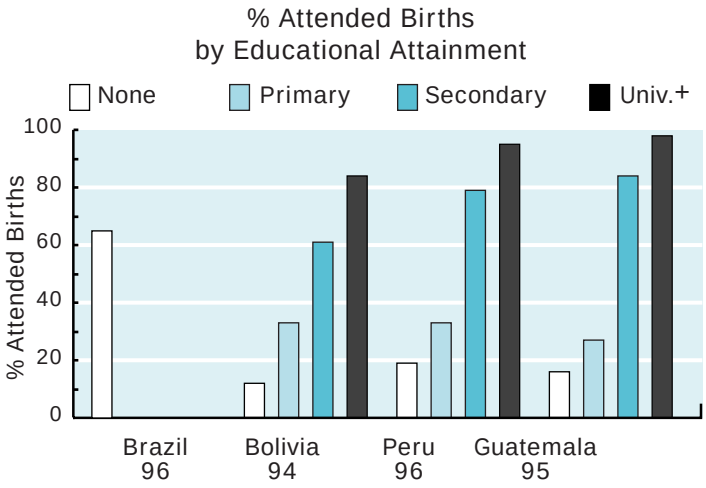
1 Studies have found that between 94 and 97 percent of variations in fertility levels can be explained by these three proximate determinants (Bongaarts 1978, 1982; Bongaarts and Kirmeyer 1982; Vidal-Zeballos 1994; and others).



- Using educational attainment[2] and place of residence[3] as a proxy for socioeconomic status[4], indicators of fertility and perinatal (neonatal) mortality coincide with socioeconomic disparities in the region. Fertility is higher among rural than urban women and women with primary or no education compared to women with secondary education and above. Perinatal mortality among these women is highest, as is maternal mortality. Attended births predominate among urban, relatively well educated women.

There are striking differentials in the number of children a woman will have over her lifetime according to place of residence and the level of a woman's educational attainment. Urban-rural differentials in fertility have narrowed in most countries over the past two decades, but widened in Peru and Mexico (Muhuri et al 1994). Other studies show that while total fertility has declined over time, the sharp differences in Latin America and the Caribbean between poor countries and rich countries and, within countries, between the poor and the rich has been maintained over time (CELADE 1997). Women who work for cash for a non-family enterprise have lower fertility than non-working women. The difference in TFRs is more than 2 children in Bolivia and Guatemala and approximately 1.5 children in Brazil, Ecuador and Trinidad and Tobago.

Service utilization follows these same inequitable patterns. The number of births attended by trained personnel (medical doctors, nurses and trained midwives) varies dramatically between educational groups. This is a well-known finding: in Peru, individuals in rich and poor households have roughly equal chance of being ill at any given time; but of those who fall ill, individuals in wealthy families are twice as likely to obtain care (Baker and van der Gaag, 1993).



2 Education is strongly correlated with income. The "positive correlation between education and earnings is indisputable and universal." (Psacharopoulos 1994)

3 Rural residence is strongly associated with lower income levels. Although many countries are highly urbanized, the countries highlighted in this analysis vary. In 1990, Brazil's population was 26.1% rural, Bolivia's 47.6% rural, Peru's 30%, Guatemala's 61.9%, and Haiti's 69.4%. Furthermore, migration between rural and urban areas has plateaued since the 1970s; leaving interurban migration the primary population movement in the region.

4 Place of residence and educational attainment were used as proxy measures for socioeconomic status because Demographic and Health Surveys (DHS) data do not collect information on household income. However, the DHS does collect information on household characteristics that may be combined to form a household assets index. In a future version of this note, household assets will be used to complement place of residence and educational attainment descriptors. In any case, place of residence is strongly associated with income levels in LAC, with urban areas (including peri-urban areas) relatively well off when compared to rural areas. The same holds true for educational attainment. Higher levels of education are associated with higher levels of household income, the converse is also true.

Indigenous women. The Guatemala survey found that indigenous women had 2 more children on average than ladina women, that indigenous women experienced 5 additional infant deaths per 1,000 live births, and that only 11.7 percent of indigenous women received trained medical care during delivery compared to 52 percent of *ladina* women.

- Data for this note came from nationally and subnationally representative samples surveyed in the Demographic and Health Surveys program conducted in Brazil in 1996, Bolivia 1994, Peru 1996, Guatemala 1995 and Haiti 1994/5. Further work should be done on the burden of reproductive ill-health by socioeconomic status and further analyses of Demographic and Health Surveys data can provide us with an index of household assets that could be cross-tabulated with less examined measures such as pregnancy complications, sexually-transmitted disease reports, ethnic/language groups and other parameters.

Glossary

Maternal mortality ratio: the number of deaths to women due to pregnancy and childbirth complications per 100,000 live births in a given year (also called maternal mortality rate).

Perinatal mortality rate: the number of fetal deaths after 28 weeks of pregnancy (late fetal deaths), plus the number of deaths to infants under seven days of age, per 1,000 live births.

Total fertility rate (TFR): the average number of children that would be born alive to a woman (or a group of women) during her lifetime if she were to pass through her childbearing years conforming to the age-specific fertility rates of a given year.

DAVID MANGURIAN

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DAVID MANGURIAN

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Reproductive Health and Human Capital Development in Latin America and the Caribbean

- What is human capital? Human capital is a "non-material" factor in the economic growth production function that affects overall input quality and productivity. In other words, human capital is the knowledge and skills needed by individuals and nations to achieve their full economic and social potential.
- How does human capital — for example, good general health — contribute to economic growth? The 1993 World Development Report identifies three ways: (1) by reducing production losses caused by worker illness; (2) by increasing the enrollment of children in school and enhancing their ability to learn; and, (3) by freeing up public and private resources that would otherwise have to be spent on treating illness so that they may be invested in other kinds of human capital formation activities. Each pathway described above is enhanced by good reproductive health.

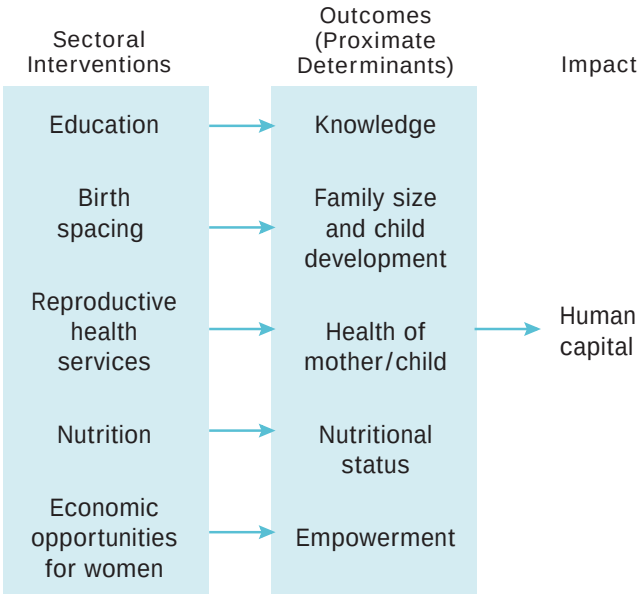
Improvements in reproductive health contribute directly to socioeconomic development by affecting individual outcomes and indirectly by diminishing resource constraints.

- Improvements in reproductive health have consequences at the individual, family and household level. Reproductive health directly contributes to socioeconomic development by increasing the human capital of women and their unborn children. Indirectly, reproductive health contributes to the human capital development of young children by keeping their mothers alive and healthy since a mother's health is directly related to her children's health.
- Safe, effective and affordable reproductive health services provide women with the opportunity to enjoy nonreproductive as well as reproductive roles in society, thereby contributing directly to socioeconomic development via increased per capita income. Expanding women's opportunities to assume nonreproductive roles contributes to socioeconomic development either through increases in their productivity in or outside the household or by enhancing the quality of time they spend with their children (see Schultz 1993).
- Promotion of a mother's reproductive health has an impact on the formation of her children's human capital by encouraging smaller family size and greater attention to child development[1]. Associated with smaller family size is a reduction in the number of unwanted births, which has independent effects on the health and development of children (see Jensen et al 1996). All other things being equal, parents with fewer children are more able to make greater investments of their time, typically mother's time, and other resources in each child than are parents with more children.
- Investments that promote reproductive health improve a woman's human capital by contributing to her knowledge, health, nutrition, and influence over resources and individual or household

1 As the value of a woman's time increases (measured by the wage she is able to earn in the marketplace or the estimated value of the wage she would earn were she to participate in the labor force), she may be motivated to have fewer children in whom she may invest greater resources, particularly the resource of her time. Education is the vehicle through which the wage value of one's time typically increases. Better educated women are also better equipped to seek out and use reproductive health services, including contraceptive services that allow them to have the number and spacing of children that they desire.

decision-making. In the figure below, the boxes on the left show categories of interventions that contribute to improved reproductive health: education, birth spacing, other reproductive health services, nutrition, and expansion of economic opportunities for women. Each box represents a bundle of sector-specific interventions.

A Human Capital Framework for Reproductive Health



Source: Seligman et al, 1997

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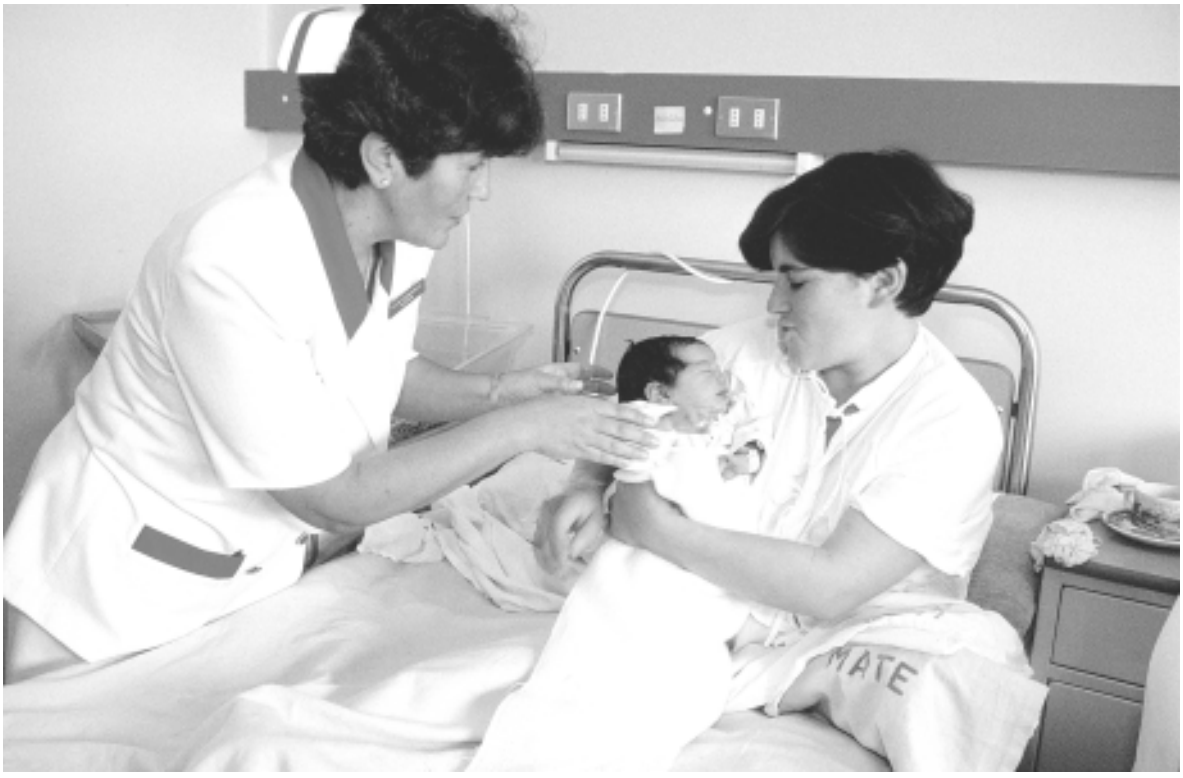

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Costs and Cost-effectiveness of Reproductive Health Interventions: Recent Evidence from the Region

- What is cost-effective? The World Bank defines health interventions as "highly cost- effective" if costing less than $100 per disability-adjusted life year (DALY) saved. Considering greater levels of prosperity and spending on health in LAC, a LAC-specific criteria for assessing cost-effectiveness is needed. This note adapts the World Bank cost-effectiveness "cut off" by using an inflation factor of LAC GDP per capita divided by world GDP per capita. This modification results in an average cut off of $160 per DALY saved. A similar inflation factor could be constructed on a country by country basis.
- Based on the adjusted LAC cut off, vis-a-vis other medical interventions, prenatal and delivery care ($35-72/DALY saved), Vitamin A supplementation ($8/YPLL in Bolivia), sexually-transmitted disease prevention and treatment ($55-134/DALY saved), family planning ($112-464/DALY saved), and HIV/AIDS prevention and screening ($165- 258/DALY saved) are either highly or moderately cost-effective in a diversity of settings. Under high prevalence cervical cancer countries, cervical cancer prevention and treatment can be moderately cost-effective ($160/DALY saved in Peru).
- Reliability. The reliability of cost-effectiveness methodologies depends on the use of local data on values, preferences, mortality rates, morbidity rates and costs. A result is driven by the sum of its parts and the prevalence of certain conditions. International studies provide important comparative information for global policy investments, but are no substitute for country-level analyses.
- Effectiveness. The impact each specific intervention has on mortality and morbidity varies according to local conditions, and this variation is taken into account in country- level studies through the introduction of coverage level, efficacy, and local program effectiveness. Effectiveness looks at the actual patterns of disease in the country under study, the current quality of services, and client behavior.
- Costs. Information on the unit costs of health services is difficult to obtain, yet crucial for a reasonable analysis of health policy. Many cost-effectiveness calculations reflect only direct recurrent costs. Fixed costs and indirect costs are frequently omitted for lack of data.

All cost-effectiveness ratios are expressed in constant 1994 US dollars.

Country	*Intervention*	*Result/ Measure*	*Measure Gained*	*Source*
Bolivia	Vitamin A supplementation	$/YPLL Gained	$8/YPLL	Cardenas et al, 1995
Bolivia	Family planning	$/YPLL Gained	$112/YPLL	Cardenas et al,1995
Bolivia	Prenatal and delivery care	$/YPLL Gained	$72/YPLL	Cardenas et al, 1995
Dominican Republic[1]	Prenatal and delivery care	$/DALY Saved	$35/DALY	Oficina de Coordinación Técnica, 1997
Dominican Republic	Prevention and treatment of sexually-transmitted disease	$/DALY Saved	$134/DALY	Oficina de Coordinación Técnica, 1997

1 The Dominican study only studied the cost-effectiveness of reaching the poor, defined as those persons residing in households with unsatisfied basic needs (NBI).

Country	*Intervention*	*Result/ Measure*	*Measure Gained*	*Source*
Dominican Republic	Family planning	$/DALY Saved	$402/DALY	Oficina de Coordinación Técnica, 1997
Dominican Replubic	Prevention and treatment of cervical cancer	$/DALY Saved	$5,135/DALY	Oficina de Coordinación Técnica, 1997
Dominican Republic	Prevention of and screening for HIV/AIDS	$/DALY Saved	$165/DALY	Oficina de Coordinación Técnica, 1997
Mexico	Prenatal care for high-risk pregnancies	$/DALY Saved	$43/DALY	FUNSALUD, 1994
Mexico	STD treatment (except HIV) for high-risk groups	$/DALY Saved	$55/DALY	FUNSALUD, 1994
Mexico	IUD Insertion	$/DALY Saved	$75/DALY	FUNSALUD, 1994
Mexico	Non-surgical family planning	$/DALY Saved	$96/DALY	FUNSALUD, 1994
Mexico	Non-targeted condom subsidy	$/DALY Saved	$258/DALY	FUNSALUD, 1994
Mexico	Tetanus immunization	$/DALY Saved	$294/DALY	FUNSALUD, 1994
Mexico	Pre-natal and pregnancy care for low-risk births	$/DALY Saved	$305/DALY	FUNSALUD, 1994
Mexico	Breastfeeding promotion	$/DALY Saved	$306/DALY	FUNSALUD, 1994
Mexico	Iron supplementation of food	$/DALY Saved	$313/DALY	FUNSALUD, 1994
Mexico	Vasectomy	$/DALY Saved	$376/DALY	FUNSALUD, 1994
Mexico	Cervical/uterine cancer detection	$/DALY Saved	$381/DALY	FUNSALUD, 1994
Mexico	Tubal ligation	$/DALY Saved	$464/DALY	FUNSALUD, 1994
Mexico	Treatment of complications resulting from abortions	$/DALY Saved	$817/DALY	FUNSALUD, 1994

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WILLIE HEINZ

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Public Sector Reproductive Health Laws, Policies and Programs in Latin America and the Caribbean

- Major and multiple laws and policies regulate maternal-child health and family planning[1] (see Annex), but there is poor quality of care and inequitable coverage. In general, policy and program objectives in the region focus on: the provision of reproductive health services to women at all stages of their reproductive lives; the reduction of unwanted pregnancies[2] and unsafe abortion[3]; the detection and treatment of cervical and breast cancer; the improvement of pre- and post-natal services; an increase in the proportion of births attended by medical professionals; the reduction of reproductive risk among adolescents; and the prevention of HIV/AIDS and other sexually-transmitted diseases. While program objectives are comprehensive, coverage is less so and service quality is poor. These phenomena are symptoms of larger health system shortcomings and systematic lack of attention to many of the major health problems of disadvantaged populations. Expenditure evidence confirms these patterns: it is estimated that out-of- pocket spending and external assistance finances up to 80 percent of all reproductive health services in the region.
- In practice, few national programs provide the full range of reproductive health services. Recent trends in policies and programs in Latin America and the Caribbean are towards integration of reproductive health including family planning programs[4]. In Bolivia, for example, the government has declared that family planning is but one component of reproductive health. However, implementation of this integration remains largely theoretical. Delivery care referrals are complicated because primary care services are not integrated with secondary and tertiary care. HIV/STI prevention occurs independently from maternal care, family planning, and education. Nutritional supplementation during pregnancy, especially for adolescents, is frequently omitted. Cost-effective screening and treatment for cervical cancer among 35-65 year old women is seldom included within primary care systems.
- Reproductive health laws and policies are not integrated into broader women's health policies. Although some countries place women's health at the center of reproductive health policies and programs, "gendered" and multisectoral approaches to reproductive health are few. Women's empowerment is set as an explicit objective in the Colombian and Peruvian reproductive health programs, but even these programs are poorly coordinated and of variable quality.

1 The region's laws and policies clearly establish that family planning should not be used as an instrument of demographic control, but rather for health reasons and under conditions of informed choice.

2 Although the Argentine government has established the right of citizens to family planning services and the State's responsibility to provide information on this issue, Argentina is the only nation in Latin America and the Caribbean that does not have a national family planning program.

3 Every country in the region allows abortion under certain circumstances (from ectopic pregnancies and genital tract cancers to cases involving rape or to save the life of the mother) and each country limits abortion in a variable manner. In spite of these limitations, more than four million women in Latin America undergo induced abortion each year. Because most abortions are illegal, these procedures are performed under clandestine and often dangerous conditions. As a result, the region faces a serious public health problem that threatens women's lives (almost half of the regional maternal mortality rate can be attributed to complications resulting from unsafe abortion), endangers their reproductive health (non-fatal complications generally result in sterility) and imposes a severe strain on already overextended health and hospital systems (AGI 1996).

4 Jamaica is the exception.

- Reproductive health policies have few provisions for rural and indigenous populations. Although rural and indigenous populations suffer disproportionately from reproductive morbidity and mortality, few national policies describe alternative service models for rural and indigenous communities. General health policies in Colombia and El Salvador and reproductive health programs in Peru and Mexico are exceptions.
- Legal and programmatic provisions for adolescent reproductive health education and services vary across the region. Few nations have policies and laws to promote the reproductive health of adolescents, although 6 countries have identified Adolescents & RH/as a high risk population within broader reproductive health programs. The availability of statistical information on adolescent reproductive health is also heterogeneous — making an assessment of adolescent reproductive health status difficult. Nevertheless, adolescent motherhood is a problem in every country and has an inverse relationship with contraceptive use among adolescents.
- *Little regulation of private sector providers and pharmacies in reproductive health.* Studies from the region have shown that most women and men seek out reproductive health services and products in the private sector. These services and products are generally unregulated, and as a result tend to be poor quality and sometimes dangerous (unnecessary and ineffective drugs for STI/RTI treatment, some traditional remedies, unsafe abortion).

DAVID MANGURIAN

- Limited data. While health statistics collection systems have been strengthened across the region, complete registration of illnesses, births and deaths is still a long-term goal and survey data on some reproductive health topics is available for only 13 countries in Latin America and the Caribbean. Epidemiological surveillance of AIDS and STIs is restricted to sentinel sites at best and occasional studies at worst.
- What are other agencies doing?

  Historically, the *US Agency for International Development (USAID)* has been the most important donor and provider of technical expertise in reproductive health in the region. It funds the International Planned Parenthood Federation and its local affiliates, US non-governmental agencies (NGOs) and firms (cooperating agencies), and its own missions in the beneficiary countries which, in turn, provide equipment, supplies, funding, technical assistance and training for national governmental agencies and local NGOs. However, its current program is limited to fourteen developing IDB member countries, which are found to be in special need of assistance in reproductive health matters. The latter is determined by the level of high risk fertility and/or the state of the HIV/AIDS epidemic.

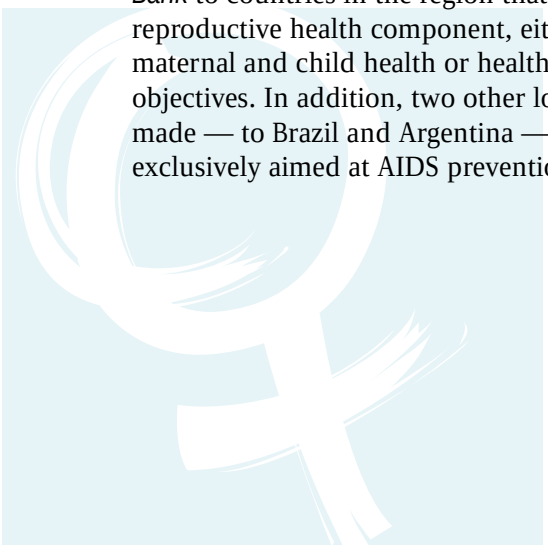
  The *Pan American Health Organization (PAHO)* has been working in the area of reproductive health for many years, both in the traditional areas concerning maternal and child health and with the newer, amplified focus spearheaded by the international agreements of the International Conference in Population and Development (Cairo, 1994) and the Fourth International Conference on Women (Beijing, 1995). These and other international agreements (Copenhagen, Vienna) have increased visibility for efforts in the social aspects of the reproductive health panorama. PAHO as the Regional office of WHO is a participant in the Safe Motherhood initiative, stimulating, through many different strategies, prevention of maternal mortality and promotion of healthy motherhood. PAHO's framework for reproductive health is within the focus of health promotion, considering the family and population elements; and emphasizing the life cycle, nutritional and human developmental aspects. In this context, the Organization works with the member country governments and other entities such as social security, NGOs and private institutions to stimulate development of policies, organizational structures and functional elements

which direct efforts to providing quality comprehensive care and the free, informed exercise of reproductive rights. Strategies which are presently being used include advocacy, participation, social communication, capacity building, reorientation of health systems and services, including strengthening management capabilities, human resource development, technical cooperation among countries, creation of healthy environments, and mobilization of resources.

The *United Nations Population Fund (UNFPA)* is represented in all developing member countries. It has been an important source of funds for reproductive health and a major provider of technical assistance, especially with respect to policy formulation and implementation. Medical and public health aspects of UNFPA-funded projects have usually benefitted from advice and management provided by PAHO. Funding by UNFPA has decreased during the last two years due to budgetary limitations caused by reductions in contributions from its most important donor countries.

The *United Nations Children Fund (UNICEF)* has recently developed reproductive health guidelines that are being implemented either as separate initiatives by its country offices, or within previous lines of action such as mother and child nutrition or children in especially difficult circumstances.

There are fifteen current project loans by the *World Bank* to countries in the region that have a reproductive health component, either under maternal and child health or health reform objectives. In addition, two other loans have been made — to Brazil and Argentina — to fund projects exclusively aimed at AIDS prevention.



- The *German Agency for Technical Cooperation* (Deutsche Gesellschaft fÅr Technische Zusammenarbeit, GTZ) has expanded funding and technical assistance for reproductive health in Latin America and the Caribbean over the last five years, following a successful experience with the University of the West Indies, in Jamaica, that was implemented in 1987. GTZ currently funds nine projects — concerning reproductive health as a whole or AIDS control — in seven countries (Bolivia, Colombia, Honduras, Jamaica, Nicaragua, Paraguay and Trinidad and Tobago).
- Over the last six years, the British government has funded *Marie Stopes International (MSI)* to implement twelve reproductive health initiatives in four countries in the region, with emphasis in Nicaragua (seven projects) and Bolivia (three projects). In all cases, MSI provides funding and technical assistance for a limited period to a local partner organization that is responsible for the ongoing self-reliance of the project.

The attached annex details legal and policy conditions in reproductive health in nine countries.

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Annex: Purposive Sample of National Laws and Policies on Reproductive Health: Argentina, Bolivia, Brazil, Colombia, El Salvador, Guatemala, Jamaica, Mexico and Peru[5]

Country: Argentina

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
1986: national decree establishing the right of persons to determine spacing and number of offspring MSAS (1987): measures to improve maternal and child health MSAS (1994): Maternal-Child and Nutrition Program BsAs Constitution: responsible parenthood, comprehensive care inn pregnancy, delivery and post-partum Chaco (1996): Education program for human health and responsible reproduction. (FP, MCH, STD/ HIV) Entre Ríos (1995): Program on reproductive health and responsible reproduction (FP, STD, STD/HIV) Mendoza (1996): Provincial reproductive health program (FP, MCH, STD/HIV) Rosario and Córdoba municipalities.	Provision of contraceptives and information in public and government-supervised health establishments still restricted in practice and, when provided, then irregularly and discontinuously. Nevertheless, contraceptives are supplied free of charge in many provincial and municipal hospitals and health centers. Most products are purchased in the private sector. National legislation contains no specific regulation of the provision and distribution of contraceptive methods, except sterilization, which is prohibited. INDEC: At the end of the 1980s, 43.8% of women were using contraceptives.	Law on Control of AIDS (1990) MSAS (1997): National Program for Control of Human Retroviruses and AIDS — TV prevention campaign; integrated into school curriculum; coverage of treatment in social security systems and the national health system.	No prevention programs on reproductive health for adolescents exist in the area of STDs, HIV/ AIDS or teen pregnancy. Catamarca (1992): free care for pregnant adolescents not covered by health insurance. No laws or policies at the national level on sex education.

5 No examination of how these laws and policies are administered and implemented, or of the legal or administrative procedures generated thereby.

Country: Bolivia

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
National Development Strategy (1992): specific objectives are to contribute to steeper reduction of maternal and child morbidity and mortality. National Plan for Accelerated Reduction of Maternal, Perinatal and Infant Mortality (PLAN VIDA) (1994): "to afford unrestricted access to educational, maternal and child health and feeding, and family planning services to all households where needed." National Secretariat for Health, Comprehensive Women's Health Care Program: offering services in prenatal control, delivery care, control in puerperium, care of obstetrical and perinatal complications, family planning, gynecological care, detection and control of uterocervical and breast cancer, STDs. Maternal and Child Insurance (1996): increases coverage of health services with priority to maternal and child care.	Bolivian government explicitly provides dissemination of information on reproductive health and promotion of fertility regulation methods, as well as family planning services.	Regulations for Prevention and Surveillance of HIV/ AIDS in Bolivia (1996): confidential tests, mandatory reports, prohibition of discrimination against carriers of the virus. All persons engaging in prostitution must receive IEC on AIDS prevention and control. National AIDS Program (1996): Prevention, surveillance, and services to victims.	The needs of adolescents are often ignored or neglected. Sex education is part of the Bolivian government's policy (included in the Law on Reform of Education).

Country: Brazil

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
Federal Constitution: Government must provide educational and scientific resources required to exercise the right to family planning, and prohibits abridgment of this right in any way. Law on Family Planning (1996): SUS shall provide reproductive health and family planning services, including prenatal, delivery, puerperal and neonatal care, STD control, control and prevention of cervical, breast and penile cancer. Program of Comprehensive Women's Health Care (PAISM) (1983): detection and treatment of STDs, breast and cervical cancer, care in pregnancy, delivery, postpartum and breast-feeding, fp services (contraception, sterility testing and sexuality).	See column 2.	The national STD/AIDS Programs (1985): prevention following strengthening of work in diagnosis and care of STDs and coordination of IEC campaigns for vulnerable groups. The programs promote free distribution of contraceptives to specific groups, mainly low-income earners. National AIDS Control Commission (1987): framing of national policy; each state has its own AIDS committee.	The Federal Constitution guarantees right of children and adolescents to health protection through implementation of public social policies to permit their healthy birth and development in decent living conditions free of discrimination of any kind. Adolescent Health Program (1983): integral health, with emphasis on growth and development, sexuality, mental health and reproductive health. Limited implementation. National Program of Comprehensive Care for Children and Adolescents (1993): Implementation of the foregoing.

Country: Colombia

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
Colombian legislation recognizes right of the couple and the individual to decide the number and spacing of their children. Health Min. (1992): Health for Women, Women for Health (SMMS). Development Plan (94-98): Policy for Participation and Equity for Women — Prevention, detection and management of risk of STDs and promotion and education for greater involvement of male population in sexual and reproductive health processes. Comprehensive Health Program for Women (1995): government should undertake measures required to reduce unwanted pregnancies, abortions, maternal and perinatal mortality, mortality from breast and cervical cancer, and STDs and HIV infection. Subsidized Social Security System establishes the right of women of child-bearing age to fp services, reproductive health counseling, uterocervical cytology and breast examination.	FP services provided by the government for many years under its health policies. In 1993, however, government coverage amounted to only 20%. In practice, most services are offered by the private sector through such organizations as Profamilia.	Medium-Term Intersectoral Plan for Prevention and Control of STDs/HIV/AIDS (1993), through the Program for Prevention and Control of STDs and HIV/ AIDS, which is composed of the National AIDS Council and National Executive Committee for Prevention and Control of HIV and AIDS infection. Promotes sexual health; equipment and infrastructure for blood banks and regional laboratories, epidemiological surveillance and research and reduction of economic impact on infection.	SMMS includes adolescents as target group for care. Policy for participation and equity for women includes prevention of abortions and unwanted pregnancies through design and implementation of family planning programs. Ministry of National Education has issued specific regulations mandating sex education: The National Sex Education Plan (PNES), whose purposes are to: foster change in values and behaviors relating to sexuality; a recasting of traditional sexual roles; promotion of modifications in old family structure to reach greater equity between spouses, and getting men and women to decide on the timing of their offspring. (Study programs and textbooks have been prepared.)

Country: El Salvador

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
Legislation and policies on reproductive health and family planning are covered primarily by the National Population Policy (PNP) 1993) and, to a lesser extent, the National Policy on Women (1996). PNP protects pregnant and breast-feeding women and supplies dietary supplements to them. It includes measures to extend coverage of health services with emphasis on maternal-child care. PNP establishes need to extent coverage and improve quality of fp services performed in public institutions. Strategic aims of PNM are to promote reproductive health of women by preventing health-risk practices, facilitating women's access to health services for care during pregnancy, delivery and puerperium, detection of breast cancer and violence against women.	FP services provided mainly through three entities: Ministry of Health and Social Action (MSPAS), Salvadorean Social Security Institute (ISSS), and a private agency (Salvadorean Demographic Association). Together they carry out the National Family Planning Program, with MSPAS covering 48.9% of the demand, ADS 15.3% and ISSS 14.5%. Almost half of all married women use contraceptives. No legal restriction on use of contraception. Quality control and marketing of contraceptives are regulated by the Constitution and the Health Code.	There is no articulated policy for prevention and treatment of HIV/AIDS. The National Policy on Women intends massive promotion of the prevention of STDs and HIV/AIDS.	There are no specific policies or legislation to provide for the health of the adolescent population even though the average age of females at first intercourse is 12 years. In its program of study for secondary schools (1996) the Ministry of Education includes sexuality among the subjects to be taught to pupils at that level. The main aspects of sexuality developed under the program are the psychobiology of adolescent sexuality, sexual identity and roles, responsibility of society and the individual in sexuality, consequences of sexual activities, and sexuality and culture.

Country: Guatemala

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
Current policies on reproductive health in Guatemala are found in the Government Program (1996), The Social Development Action Plan (PLADES 1996-2000) (1996), the Program on Women, Health, and Development (MSD) (1989), and the Plan of Operations for the MSPAS Reproductive Health Unit (USR) (1996). The Political Constitution (1985) contains norms relating to certain sexual and reproductive rights. It provides that the state will promote responsible parenthood and establishes the right of individuals to freely decide the number of children they wish to have and the intervals between them. The obligation is established to provide special maternity protection. The USR plan of operations provides that the MSPAS shall seek to improve the health of Guatemalan women and children by strengthening the delivery of integrated reproductive health services with emphasis on rural communities. The USR is at risk of being closed down due to a lack of support from the MSPAS.	The USR is responsible for offering family planning services in public health subsector establishments. The USR operates in eight of the country's 24 health areas. The prevalence of contraceptive use is 31.4%. Guatemalan law does not restrict the rights of women to access and use contraceptive methods, but the Physicians and Surgeons Code of Guatemala explicitly refers to the prohibition of sterilization, which nonetheless figures among the MSPAS's family planning services.	The National Commission for the Monitoring and Control of the AIDS (1987), composed of representatives from the MSPAS, the Medical College, universities, the Ministry of Education and Governance, social benevolence organizations, religious institutions, and social information organizations. Objective: to systematize the control and monitoring of AIDS and propose effective national policies and legal provisions. The MSPAS National Plan for the Prevention and Control of the HIV/AIDS (1996). Objective: to reduce the incidence of infections and disease through health promotion activities (epidemiological monitoring, health promotion, and counseling to prevent transmission of the disease).	To attack the problem of AIDS in the adolescent population, PLADES indicates that it will conduct preventive education campaigns, encouraging abstinence among the young and marital fidelity. Legislation to create a Children's and Adolescents' Code is currently being considered by Congress.

Country: Jamaica

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
The Law on Family Planning (1970) created the National FP Board as the main government agency distributing financial aid and subsidies to organizations and individuals engaging in FP. The Ministry of Health reports a decline in the percentage of pregnant women served by the public health care system (74% in 1994; 68% in 1995).	FP services are available throughout Jamaica through the public health care system. Sterilization is legal. FP services are provided through a network of health centers, hospitals, private physicians and NGOs.	The Jamaican Parliament has not approved provisions to address the problem of HIV/ AIDS and there are no regulations on the subject. National HIV/AIDS Control Program (1997). The Health Ministry has blamed its delay in implementing an AIDS policy on lack of public consensus. The Ministry offers condoms at low prices in bars and hotel rooms. The Law on Public Health authorizes the Health Ministry to require the local health boards to investigate any existing disease and to do "what may be necessary to stop the spread of the disease."	The government conducts few programs and provides few reproductive health services targeted particularly to adolescents. Condoms are not distributed in schools, although from the age of 15, young men and women may obtain them in any government clinic. The Women's Center of the Jamaica Foundation works with the Health Ministry in a center for adolescent girls which assists pregnant students so that they may continue their education.

Country: Mexico

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
The Federal Constitution recognizes the right to decide in a free, responsible, and informed manner on family size and the spacing between children. Reproductive health and family planning are considered by the Mexican government to be "key strategic factors in national development." The Reproductive Health and Family Planning Program (PSRPF) (1995-2000) is designed to integrate services with respect to reproductive health, family planning, maternal-child care, STI, cervical-uterine and breast cancer, and pre-conceptual risk. Six subprograms were created in each area to provide these services.	The objectives of the PSRPF subprogram on family planning are as follows: to strengthen and expand the coverage and quality of family planning information, education, and services, with special emphasis on rural areas; to help lower fertility rates; to reduce the number of unwanted, unplanned, or high-risk pregnancies; and to broaden activities for the diversification of modern contraceptive methods. The General Health Act assigns priority to family planning services within the framework of general health care delivery. There is an official set of service standards.	The Official Mexican Regulations on the Prevention and Control of HIV Infection (1995) are designed to standardize the operating principles and criteria of establishments within the National Health System. The objective of the PSRPF subprogram on the prevention and control of STIs and HIV/AIDS is to expand public access to appropriate information and quality services for the prevention, diagnosis, and control of STIs and HIV/AIDS.	One of the fundamental objectives of the PSRPF is to safeguard the sexual and reproductive health of adolescents. It seeks to expand the coverage of information on sexual and reproductive health; to raise the age level among adolescents experiencing their first pregnancy; to prevent unwanted pregnancies, abortions, and STI; and to provide high-quality contraceptive information and counseling services.

Country: Peru

Reproductive Health & Family Planning	*Contraception*	*HIV/AIDS & Sexually Transmitted Diseases*	*Adolescents & RH/ Sex Education*
The General Law on Health reaffirms the constitutional right of individuals to freely choose the contraceptive method of their preference and to receive adequate advance information on their reproductive health and their FP options. The Reproductive Health and FP Program 1996-2000 (1996), an instrument of policy setting forth the government's purposes, goals, activities and strategies in reproductive health and FP. The Program's functions are to provide services for the promotion, prevention, cure and rehabilitation of reproductive health, and especially "to care for the reproductive health of women at the different stages of their lives." It recognizes reproductive health as a fundamental human and social right.	FP services are provided through all the establishments of that sector. Contraceptives are supplied free of charge. The General Law on Health prescribes prior consent by the woman before the use of any contraceptive method (in writing, in the case of surgery).	The National Plan for the Control of AIDS and STDs (1996) provides legal protection for HIV victims and preventive services. "Doctrine, standards and procedures for the control of STDs and AIDS in Peru" (1996)	The Ministry of Health views the risk of reproduction in adolescents as a priority health problem and proposes measures to reduce the frequency of adolescent pregnancy, maternal mortality, the frequency and sequelae of induced abortions, the frequency of STDs, including HIV/AIDS, and increase in violence and sexual abuse in all their forms. There is in law no restriction on access for adolescents to reproductive health and FP services. The Comprehensive Schoolchild and Adolescent Health program (Health Ministry) offers sexual and reproductive health services. The Code of the Child and the Adolescent establishes the provision of care for the adolescent mother.

Women in Development Unit

Reproductive Health and Health Sector Reform (HSR)

- There is an on-going debate within the international development banks on the future of health loaning — will loans be exclusively HSR or some combination? If a combination, stand-alone projects (not meaning vertical) are feasible; but if strictly HSR, banks need to examine issues around the fit of reproductive health into HSR more carefully. It is clear that the agenda of HSR loans is tight, perhaps overloaded. There is a need to act on opportunities, but be pragmatic. This note examines issues regarding the fit of reproductive health into HSR. Comments are appreciated.
- Analysis of health service content within HSR loans has been restricted to the calculation of "packages" of cost-effective services to be publicly financed (Bobadilla et al 1994). Pre-natal care is usually analyzed and is always within the top five cost-effective interventions. Other reproductive health interventions, such as contraceptive services, AIDS prevention programs, cervical cancer screening, and treatment of STDs that are synergistic with pre-natal care, have yet to be systematically included within the package. Reproductive health is thus treated in an ad hoc manner or not at all.
- HSR loans generally incorporate a burden of disease approach (World Bank 1993) in the analysis of interventions to be subsidized by the state. Using the same methodology employed in HSR loans, the World Health Organization has recommended a minimum package of health interventions in both low- and middle-income countries that includes an AIDS prevention program, family planning, sexually transmitted disease treatment, and prenatal and delivery care (Bobadilla et al 1994). In spite of this recommendation, some IDB HSR loans have not estimated the burden of reproductive health problems or costed many of the associated interventions. Interventions not included in the

WHO publication have sometimes been omitted altogether. One example has been cervical cancer screening which has been shown to be highly cost-effective in field trials in Latin America (PAHO 1997). The packages defined in the HSR loans are important because they form the basis for reimbursable expenditures under social insurance schemes or subsidized services from ministries of health and social security institutes.

- Cost-effective packages have been politically difficult to implement in ministries of health. The "packaging" approach, as it has come to be known, has experienced variable success in loan execution. Inflexible application of "packaging" during HSR planning has been politically difficult. However, modified sets of health interventions defined in the HSR process in an ad hoc manner display the same features as "packaged" interventions: no systematic inclusion of reproductive health interventions. Further, packaging has been feasible within social security institutes more often than ministries of health. Cost- effectiveness analysis is a vital ingredient in the planning process (in determining the content of state-financed services), and one that must be managed better such that findings are applied in a politically feasible manner.
- In order to better construct HSR packages, it is important to conduct cost and cost- effectiveness studies of combined reproductive health services. Changing the service mix has implications for the effectiveness of services, and little information exists on the overall impact of integrated services on health status. Effectiveness of an entire package of services may be greater than any single component because of synergistic interactions, and women with multiple responsibilities and little time may make greater use of a range of services available at one service point. On the other hand, implementing the entire package may divert resources such as personnel time away from some services, rendering them less effective. The net effect is difficult to predict, and should therefore be studied more carefully. Adding other reproductive health components onto an existing health service is one option for combining services (adding cervical cancer screening onto family planning visits, for example). Another approach is to maximize the benefits of the health infrastructure and to implement as many activities in a hospital or health center as possible. Much could be done through the encouragement of beneficial traditional health practices (i.e., breastfeeding, some birth practices)

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and change of harmful ones (timely referral of complications, etc). Whatever the outcome, given the apparent magnitude of reproductive health problems in the region, the omission of selected reproductive health interventions from C/E analysis and thus from financing is unacceptable.

- Decentralization also has an impact on reproductive health services. In nations such as Brazil and Bolivia, where near total fiscal decentralization is taking place, there are cases of municipal governments selectively excluding the public provision of some reproductive health services, while others have actually banned the private provision of these services. These effects should be reviewed more closely.
- Social security institutes may not currently provide reproductive health services. Many region social security systems do not cover dependents; and, as a result, many women have little access to subsidized reproductive health care. Young men and women are even more constrained. Further, services financed under social security schemes may exclude reproductive health care, especially contraceptive services and low-cost gynecological cancer screening.
- Current reproductive health financing arrangements in LAC are cause for concern. In many countries, reproductive health services and products have been exclusively financed through external

assistance and out-of-pocket spending. There are several reasons for this: the provision of contraceptive services has been considered politically difficult in some countries, and external agencies have always been interested in investment in maternal health care and family planning because of their health impact. However, in an era of increasing financial constraints, other donors active in reproductive health have scaled back programs in favor of investments in other more economically disadvantaged regions. In this context, many national programs have almost ceased functioning, especially those totally reliant on non-governmental organizations; or have had to implement regressive cost recovery schemes. In practice, these schemes have tended to limit service access to the relatively well off; and little cross-subsidy has been achieved, as confirmed by studies conducted by International Planned Parenthood Federation affiliates in Colombia, Brazil and El Salvador. Current health reform loans will reinforce this situation because they may exclude the full complement of reproductive health services from government-provided services. Decisive investment in these services now will maintain health gains achieved through past donor efforts and promote further improvement.

- Within HSR and particularly with regard to reproductive health, there are major issues of access to care for poor, indigenous and youth populations. These groups may require a reconceptualization of existing models of service provision which again implies different and most likely greater costs. Many NGOs have experience in serving these groups; this includes, for instance, women's groups in Peru and Brazil and Save the Children and CARE in Bolivia, Ecuador, and Guatemala. These models could be more carefully examined for their cost-effectiveness in relevant countries. These issues must be studied and incorporated into HSR loans.
- The nature of reproductive health problems demands intensive interaction between government and civil society. In many countries, non-governmental organizations (NGO) have the most experience in reaching underprivileged communities while governments have more expertise in national-level planning and management of resources. Under HSR, however, government regulation of NGOs (intended to rationalize health planning) has sometimes resulted in government threats to eliminate accreditation and cut funding to these organizations. Government and NGO expertise can be united through the HSR process, beginning with a series of regional meetings on the topic.

Proposal: The IDB can innovate by integrating a set of specific interventions, reproductive health services, into larger health sector reform efforts by: (1) examining the cost-effectiveness of new clusters of reproductive health services specially designed for the region according to health needs and socioeconomic status; (2) assuring the inclusion of some combination of reproductive health services within MOH and social security financing and provision; (3) reviewing the impact that fiscal descentralization of health budgets has on financing and provision of reproductive health services; (4) exploring opportunities to strengthen government-NGO interaction through HSR; and (5) examining the use of conditionality in service content.

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Women in Development Unit

Innovative Programming in Reproductive Health in Latin America and the Caribbean

- Community definition and implementation of reproductive health: the Warmi Project in Bolivia. Motivated by the bleak health conditions of women and children in Inquisivi province, Bolivia, in 1990, a US NGO, Save the Children, launched Project Warmi, a comprehensive maternal and neonatal health project. A primary goal of the project was to develop and test a community-based approach to improving maternal and neonatal health in a remote setting with little access to adequate formal health services. Project Warmi employed staff from the area who spoke the local languages and were knowledgeable about community social and cultural norms. The project organized women's groups to raise women's awareness that their individual problems are often common to others and that together they are more likely to find solutions, but was careful not to exclude men from community meetings. Groups followed a four-stage "Community Action Cycle" to identify needs and practical solutions beginning with an "auto-diagnosis" where women themselves identified the three most important maternal and neonatal health problems to be addressed by the community, and followed by a "planning together" phase in which community plans were developed by men and women to address problems identified in the prior stage. The last two stages were the implementation and participatory evaluation stages. In 1993, at the end of its three year implementation schedule, the project could claim responsibility for halving the number of detected cases of perinatal and neonatal mortality, doubling tetanus toxoid coverage and the proportion of women seeking prenatal care, increasing contraceptive use from 1 to 27 percent of women of reproductive age, and increasing the use of trained birth attendants from 13 percent to 57 percent in the last year of the project. The project spent approximately $67.50 per woman to implement reproductive health care interventions. The project methodology is being replicated through a network of NGOs working on child survival issues, however, it remains to be seen whether the Warmi methodology, whose success is based on careful design and quality implementation, can be replicated on a larger scale.
- Adolescent pregnancy prevention: the Women's Centre Foundation of Jamaica. The Women's Centre Foundation of Jamaica runs a drop-in center for adolescent mothers and fathers ages 9-15. The organization provides sex education and family life education, parenting skills and nutrition education, prevention of sexually-transmitted disease, individual counseling, family planning, job training and placement, day care, and a special program to help teen mothers return to school. The program has been successful; a recent evaluation demonstrated significantly higher school retention rates among program participants than their counterparts and higher wages among teen fathers.
- Reproductive health care in the private sector: PROFAMILIA. PROFAMILIA, a Colombian non-governmental organization (NGO), has provided comprehensive reproductive health services to Colombian women and men since 1965. The organization provides clinical contraceptive services; runs a community-based counseling and distribution program; manages a condom social marketing program to confront rising AIDS rates and provide a source of income; operates three clinics exclusively for men; a teen reproductive health center which runs a peer counseling program; and provides a full range of reproductive health services including infertility diagnosis and treatment, pap smears, pregnancy tests, gynecological exams, lab work, and treatment of sexually- transmitted diseases. In addition, the organization offers legal services, advising women of their rights and dealing with domestic violence and child support cases. The organization is completely self-sufficient through cost recovery and a donor-created trust fund, and provides technical assistance to similar organizations in the field. According to evaluation data, 60 percent

of all couples of reproductive age in Colombia have used PROFAMILIA services to prevent unwanted pregnancies and receive reproductive health services.

- Reproductive health through empowerment and income generation: the ReproSalud project in Peru. Through a program of self-diagnosis of reproductive health problems, community action, and income generation activities, the ReproSalud project in implementation since 1995 works with women's organizations in rural and periurban areas to empower women to make informed use of existing reproductive health services. Six educational subprojects have been completed, and a comprehensive evaluation of the approach is anticipated for 1999.

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Women in Development Unit

Reproductive Rights

- The Program of Action adopted by the 1994 International Conference on Population and Development (ICPD) in Cairo, and the Action Platform of the Fourth International Conference on Women in 1995 in Beijing represent a new approach to population and development. The focus has changed from the development impacts of population growth to the implications of reproductive ill-health for human development. The primary goal is no longer fertility reduction, but rather promoting human rights and improving human welfare. In this new context, investments in people, in their health and education, are seen as the key to sustained economic growth and sustainable development. Greater efforts need to be made to advance women's equality in education, health, and economic opportunities.
- Implicit in this change is also a broader interpretation of universal human rights. Both conferences recognized reproductive and sexual rights as human rights, confirming that these rights constitute an integral part of universal human rights. Thus achieving reproductive rights is an end in itself.
- Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. At the ICPD 180 nations accepted universal access to reproductive health information and services as a goal to be reached by 2015.
- Reproductive rights are rights for both men and women and rest on the recognition of the basic right of all couples and individuals to:

  1) decide freely and responsibly the number, spacing and timing of their children. Implicit in this right is freedom to choose, which is contingent upon the state's fulfillment of certain social and economic rights that make genuine choice possible, and;

  2) have access to appropriate health care services that will enable women to go safely through pregnancy and childbirth. It applies to a woman's right not to be alienated from her sexual and reproductive capacity (e.g. through prostitution, sexual violence, denial of access to birth control, sterilization without consent, unsafe contraceptive methods, unwanted pregnancies, etc.), and;

  3) be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, a well as other methods of their choice for regulation of fertility which are not against the law. According to this formulation, governments cannot intervene to prevent people from obtaining or using a contraceptive method nor can one individual or group stand in the way of another.

  Reproductive rights also include women's and men's right to make decisions concerning reproduction free of discrimination, coercion and violence, and takes into account the needs of their living and future children and their responsibilities towards the community.

- Access to care is a social entitlement, and access to family health planning is an essential ingredient of this entitlement. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for policies and programs in the area of reproductive health, including family planning, supported both by governments and civil society.
- Preventing maternal death and illness is a question of social justice and women's human rights. Maternal mortality is redefined from a health problem to a social injustice, which provides the legal and political basis for governments to assure the provision of maternal health care for all women.
- Social empowerment of women both contributes to and depends on good reproductive health. Social, economic and political rights are closely interrelated. Discriminatory practices based on gender limit freedom of choice across and within nations, communities, and families. As a result, many women experience constrained access to reproductive health services. Poverty is another major factor limiting freedom of choice, preventing many women and men from exercising their reproductive rights. Therefore, education and economic opportunity are key factors to improve women's status and their reproductive health.

WILLIE HEINZ

- Women are claiming their right to have their health needs addressed both as women and mothers. Women's routine health care has often been available only through maternal and child health services. These services have generally put the emphasis on child health, and addressed only a restricted set of women's health needs. The needs of young, unmarried women and women past childbearing age have been largely ignored and need to receive more attention.
- At the ICPD, the international community for the first time recognized formally that adolescents have specific reproductive and sexual rights. To be able to protect their specific reproductive health needs, adolescents should be given greater control over their sexual and reproductive lives.
- The massive denial of reproductive rights cause the deaths and suffering of millions of people every year. Most of these people are women living in developing countries. Throughout Latin America and the Caribbean there is vast evidence of women being denied their most basic reproductive rights:
  - 23,000 women die each year of pregnancy and birth related causes. Complications during pregnancy, childbirth, and the puerperium is one of the five leading causes of death for women in all or some subgroups of the 15-44 year old age group in Latin America and the Caribbean.
  - 25,000 women die annually from cervical cancer.
  - 27 % of pregnant women in the region have no access to ante natal care.
  - 25 % give birth without the assistance of a skilled attendant. There are great disparities between countries. In Guatemala, 71 % of the women deliver without proper care, while almost all the deliveries in Chile are attended by trained personnel.
  - 25-50% of Latin American women- varying with country- are victims of some form of domestic violence, especially during pregnancy.
  - Women in need in the region lack access to family planning services.
  - About one-third of Latin American and Caribbean women give birth before the age of 20. This is one of the highest incidences of adolescent motherhood in the world, and places a particularly heavy burden on poor women.

- After Cairo and Beijing, many countries in Latin America are changing and reorienting their policies and programs in health care and family planning.
  - Chile and Mexico explicitly guarantee reproductive rights. Chile has created a new Health Program for Women, which includes all women's sexual and reproductive health needs. Mexico has created a new General Directorate of reproductive health.
  - Reduction of maternal mortality is the focus of reproductive health initiatives in countries like Bolivia, Paraguay, Guatemala, the Dominican Republic and Haiti.
  - Bolivia's new Maternity and Child Insurance gives women free access to prenatal care, delivery and post-natal care. Unsafe abortion was recognized as a major cause of maternal death at the ICPD, and Bolivia, for instance, includes management of complications of unsafe abortion in their reproductive health programs.
  - In El Salvador, the National Secretariat of the Family works to prevent adolescent pregnancy and sexually transmitted diseases of HIV/AIDS through information and counseling and services for adolescents.
  - Efforts to improve family planning services are taking place in several countries in the region. Federal budgetary allocations in Brazil now includes the whole range of contraceptive methods, increasing the choice of the users.

DAVID MANGURIAN

"The reproductive conduct is an inalienable right of every person, of every couple. It is part of their privacy and their dignity. It is a right which precedes over the authority of the State".

—Translated from the speech delivered by the President of the IDB, Enrique V. Iglesias, at the ICPD in 1994.

- Acceptance of the right to reproductive health has created an international standard against which practice can be measured. Many countries in the region have taken important steps to bring laws and practice into compliance with reproductive rights.
- The Latin American and Caribbean consensus from Mexico in 1993, recognized that the region has made important legislative reforms to eliminate gender inequality and discrimination that affect women in exercising their rights, and recommended that governments strengthen the dispersion of these rights and establish proper mechanisms to effectuate them.
- All the Latin American and Caribbean Countries have signed or ratified the Convention on the Elimination of All Discrimination against Women and the Inter-American Convention on the Prevention, Sanction and Elimination of Violence Against Women. These conventions are essential to women's reproductive rights. The countries are legally obliged to report to the corresponding monitoring human right treaty bodies on their compliance of these conventions. Brazil has, as the first nation in Latin America, has established a National Commission on Population and Development.
- There is a need for mechanisms to identify and seek to redress violations of sexual and reproductive rights. There are discussions going on between UN-agencies, WHO and the human rights and treaty bodies on mechanisms for monitoring reproductive and sexual rights within the context of human rights treaty mechanisms. UNFPA is developing indicators to measure national reproductive health conditions and the impact of policies and programs.

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Women in Development Unit

Prevalence, Costs and Consequences of Adolescent Pregnancy in Latin America and the Caribbean

- The timing of the initiation of sexual activity and marriage has serious implications for the quality of women's lives, especially their reproductive health; their family's well- being; and their own educational, social, economic, and personal development. In every society, an important consequence of prolonging the period between puberty and marriage is an increased likelihood that young women will become involved in sexual relationships before marriage.
- Roughly one-third of all women ages 20-24 in 10 of 11 Latin American countries have their first child before their 20th birthday, and in Guatemala one-half do so. Recent analyses suggest that out of ten countries in the region, adolescent fertility declined only modestly in three nations, and remained stagnant or increased in the others. Colombia, Guatemala and Paraguay recorded rises of at least two percentage points in the proportion of girls who had a birth before age 20 (Singh 1997).
- The proportion of women ages 20-24 who have sexual intercourse prior to their first union and who do so while they are still teenagers, hovers around 11-15% in the Dominican Republic, Guatemala, Mexico and Trinidad & Tobago and around 20% in Brazil, Colombia and Ecuador. It is as high as 27-33% in Bolivia, Paraguay and Peru. These levels differ little between urban and rural women, except in Bolivia, Ecuador, Paraguay and Peru. In these latter countries, adolescent premarital sex is more common among rural women, a pattern probably related to the customary practices of the large indigenous populations in rural areas.
- The incidence of adolescent fertility is higher among and the consequences are more severe for the poor. Rural, less-educated women are more likely to give birth as adolescents. In Peru, for example, the age-specific fertility rate for urban adolescents is half that of rural teens (Singh 1997). Secondary educated girls have a fertility rate less than one-third of that of their less-educated counterparts.
- Increasingly, adolescent fertility also takes place outside of marriage, leading to single motherhood and families with absent fathers (Singh 1997). In 7 of 10 countries studied in Latin America, the proportion of adolescent first births that occur before marriage ranges from 12 to 34 percent. In Chile, while adolescent fertility rates declined over a thirty year period, the proportion of births to unmarried teenage mothers rose sharply, from 29 percent of all teen births in 1960 to 60 percent in 1989. In rural Spanish- speaking Guatemala, after a pattern of stable rates for the past forty years, the rate of initiation of childbearing without a partner doubled, from 6 to 12 percent, in the last generation of women.
- Adolescent pregnancy and childbearing can have detrimental outcomes for both mothers and their children, contributing to the intergenerational transmission of poverty and disadvantage.

Investing in Women Is Investing in Children

The well-being of mothers and their young children are closely linked. Investments in women are investments in children, especially among the poor. Mothers' health, education, life choices, and economic opportunites matter for themeselfes and their offspring. Children among the poor are also healthier when their mothers work and contribute to household income, although the mechanisms for that account for this finding are not clear.

Adolescent childbearing, especially at very young ages (under 18), has documented negative consequences on the well-being of women and their children. In countries where anemia and malnutrition are common and where access to health care is poor, childbearing can bring disproportionate risks to the health of a young mother and her infant child. Infants born to young mothers face mortality risks that are on average 33 percent higher than those of adult mothers (PRB 1992). Older children of adolescent mothers face nutritional and other risks. Studies in Chile and Mexico found more stunting among children of adolescent mothers than among children of adult mothers. In addition, children of young mothers in Mexico had lower scores on a language development test, and more reported behavioral problems than children of adult women (Buvinic et al 1997).

- Teen pregnancy and childbearing also limit the educational and economic opportunities available to young mothers, and are strongly associated with low levels of educational achievement for women. In the Caribbean, for example, pregnancy is the most common reason for school drop out (PRB 1992). A review of four studies in the region found that adolescent motherhood is associated with adverse socioeconomic conditions and poor earning opportunities for young mothers, especially for those who are poor (Buvinic 1997).
- Because the consequences of adolescent childbearing affect mothers and their children, investing in remedial and especially preventive measures targeted to at-risk adolescent women and their children should have sizeable social benefits, especially in poor countries and in poor populations (See Box).

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Women in Development Unit

Mistimed and Unwanted Births in Latin America and the Caribbean

- What are “mistimed and unwanted births”? Two definitions are used in this analysis: (a) a birth is considered unwanted if the number of surviving children is more than a woman's stated ideal number of children and (b) those births that occurred 3-5 years before the survey and which mothers reported as unwanted or mistimed. The interpretation of the results are identical.
- According to recent surveys in the region, women report high levels of mistimed and unwanted pregnancies independently of educational attainment. Total desired fertility is, without exception, lower than actual fertility levels. A multidimensional phenomenon, the gap between desired and actual numbers of children emerges from power differentials in couples' negotiation of contraceptive use, access to reliable information, availability of contraceptives, buying power of women, sexual violence, and the influence of religious and sociocultural values.\
- Mistimed and unwanted births range from a low of 19.4% of total births in Ecuador (1989-94) to a high of 37.5% in Haiti (1992-94). Undesired fertility shows important differences according to educational attainment, with women without any education at all reporting the largest discrepancy between desired and actual family size. In Colombia, women without any education report that 48% (1992-95) of births were unwanted or mistimed. In Bolivia, this figure is almost half of all births: 49.2% (1991-94). In contrast, Colombian women with the highest levels of education report that only 11.1% of births were mistimed or unwanted.
- Unwanted and mistimed births reflect social and gender inequities in reproductive health, and dramatically illustrate that many women, especially among the poor, have little choice over the timing or duration of motherhood and its attendant responsibilities.

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Total Fertility and Proportion of Undesired Fertility (Selected Countries)

Country	Year	Total Fertility Rate	Estimation Period	*Unwanted or Mistimed Fertility*				
					LEVEL OF INSTRUCTION			
				Total	NONE	LOW	MEDIUM	HIGH
Belize	1991	4.5	1989-91	13.0	–	13.9	15.6	7.7
Bolivia	1989	5.0	1985-89	36.0	37.7	38.3	31.1	24.1
	1994	4.8	1991-94	43.8	49.2	46.7	32.7	25.9
Brazil	1986	3.5	1983-86	*19.8*	*38.5*	*27.1*	*13.6*	*11.6*
	1996	2.5	1991-96	28.0	46.0	38.2	25.0	12.5
Colombia	1990	2.9	1987-90	24.1	24.5	25.0	16.7	12.5
	1995	3.0	1992-95	26.7	48.0	31.6	23.1	11.1
Costa Rica	1993	3.1	1990-93	*49.8*	*61.0*	*57.7*	*49.8*	*43.2*
Dominican Rep.	1991	3.3	1988-91	21.2	36.5	32.6	20.0	17.7
	1996	3.2	1993-96	21.9	38.0	25.6	20.6	12.5
Ecuador	1987	4.3	1982-87	20.6	16.1	19.0	10.4	3.5
	1995	3.6	1989-94	19.4	29.0	20.9	12.3	9.5
El Salvador	1985		1982-85	27.0	25.7	32.3	25.7	18.4
	1993	3.8	1988-93	*47.6*	*54.0*	*50.1*	*47.0*	*41.7*
Guatemala	1987	5.6	1983-87	12.5	11.4	12.5	17.9	7.4
	1995	5.1	1993-95	21.6	21.1	21.6	11.1	3.6
Haiti	1989	5.0	1989	55.0	59.3	56.6	46.6	41.7
	1994-95	4.8	1992-94	37.5	34.4	35.4	–	28.0
Jamaica	1993	3.0	1988-92	*19.0*	*26.9*	*18.0*	*13.9*	*14.2*
Nicaragua	1992-3	4.6	1987-92	*8.9*	*15.6*	*9.6*	*8.3*	*4.4*
Paraguay	1990	4.7	1986-90	25.5	23.9	25.8	28.9	18.8
Peru	1991-92	3.5	1989-91	42.9	47.9	51.0	35.5	15.8
	1996	3.5	1993-96	37.1	42	44	33.3	14.3

Source: DHS and CDC surveys: UNFPA categorization of education levels

Note: Values in italics are not strictly comparable with other values used for the same country in other years..

Women in Development Unit

Malnutrition, Micronutrient Deficiences and Reproductive Ill Health in the LAC Region[1]

Protein-energy and micronutrient malnutrition are proximate determinants of women's reproductive morbidity and mortality.

- Throughout the developing world women die during pregnancy and in childbirth from hemorrhage (20-35%), unsafe abortion (10-15%), eclampsia or hypertension (10-15%), infection (10-15%), and obstructed labor (10-15%) (see Technical Note 1). Those that survive spend their reproductive years suffering from chronic anemia and the debilitating consequences of complications associated with reproductive events. This note describes how nutritional deficiencies in women of reproductive age set them up for these tragic outcomes and presents evidence of nutritional deficiencies among women in the LAC region.

The links:

- Short stature can lead to obstructed labor: Stunting (low height for age) in childhood leads to short stature in adult life. Stunted women have greater risk of obstructed labor due to cephalo-pelvic disproportion. The risks of death from obstructed labor increase when women give birth without skilled attendance or far from emergency obstetric services. A critical feature of short adult stature due to malnutrition is that it can only be modified during the first two years of life.
- Undernutrition during pregnancy contributes to adverse outcomes including low birth weight (LBW): Women who are undernourished prior to and during pregnancy (measured by low BMI[2]) tend to have babies with intrauterine growth retardation leading to low birth weight (less than 2500 g). About 80% of LBW cases in developing countries are due to intrauterine growth retardation. LBW infants are at higher risk of dying during the perinatal period than babies born with normal weight. LBW infants whose birth weight was low for gestational age have higher risk of anemia and other micronutrient deficiences. Furthermore, LBW is an important determinant of morbidity and motor development up to age two. Small for gestational age babies are at increased risk of growth retardation as children. LBW children may also be at higher risk of developing chronic diseases as adults. Undernutrition due to insufficient protein/calorie consumption may become complicated by the fact that many poor women, especially in rural areas, are not capable of reducing the levels of physical activity during the last months of pregnancy, exacerbating their energy imbalance.
- Nutritional anemia intensifies delivery complications: Women suffering from anemia (iron, folate and B12 deficiencies) are more likely to die from spontaneous abortions and postpartum hemorrhage than women whose blood hemoglobin levels are adequate[3]. They are also at higher risk of pregnancy complications such as urinary tract infections and eclampsia. Anemia decreases the body's ability to fight infections. It increases the chances a woman will have LBW babies and endangers the survival of these infants. Severe anemia is an associated cause in over 50% of cases of maternal deaths in the developing world. The situation is complicated by the fact that iron requirements typically increase for women during pregnancy and lactation.

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1 Thanks to Chessa Lutter of the Food and Nutrition Division of the Pan American Health Organization for serving as external reviewer for this note.

2 BMI: In adults nutritional status is not assessed with reference to age, as it is in children. Body-mass index is a measure that relates an adult's weight to his/her height squared. Cut off points for thinness and obesity provide guidelines for interpretation of index values. Although no international guidelines have been adopted, WHO criteria defined female obesity as being equal to or greater than BMI 25.

3 Anemia is defined as hemoglobin <110 g/l in pregnant women, <120 g/l in non-pregnant women.

- Vitamin A deficiency (VAD) increases susceptibility to infection: Infection during pregnancy and the postpartum period is a danger to all women, but especially to those who are malnourished. Death during the postpartum period[4] is just as high or higher than death during delivery, due to bleeding and infection. VAD reduces the body's capacity to fight infections. Inadequate vitamin A status appears to hasten the progression of AIDS. VAD during pregnancy increases the risk of HIV transmission by infected women to their fetuses three or fourfold. Unsafe abortions can be deadly to women with VAD due to heightened vulnerability to infection.
- Obesity tends to increase with parity among urban women and predisposes them to cardiovascular and other chronic diseases: Urban diets and sedentary lifestyles in Latin America have precipitated the epidemiological transition. High intakes of fat, refined sugars and processed foods, and little physical activity contribute to problems of obesity, diabetes, high blood cholesterol levels, and hypertension. Poor, urban women are at greatest risk of obesity. Overweight and obesity increase with each successive pregnancy. Pregnancy outcomes, both maternal and infant, are endangered by obesity. Cardiovascular and other chronic diseases, including cancers of the reproductive organs are causally related to obesity.

The evidence:

- Short stature: In the absence of data on low adult female height (<145 cm) and thinness, stunting in childhood (low height-for-age[5]) can be used. There is a strong positive relation between growth retardation in the first three years of life and short stature in adulthood. Unfortunately, height-for-age data are not reported by sex. In the LAC region two different trends emerge with regard to stunting in children 5 years and under:
  - South America in general has the lowest rates of stunting in the developing world. Yet Bolivia (26.8%, 1994-95), Ecuador (34%, 1986), and Peru (25.8%, 1996) are flagged as having extremely high prevalences for their subregion. Subregional average stunting prevalence stands at 12.9% (1995). Brazil accounts for the largest share of stunted children in the subregion-41%.
  - In contrast, Central America, Mexico, and the Caribbean experienced the least improvement in stunting rates over the last 10 years or so of the five developing regions. Overall, stunting rates are considerably higher among these countries than in South America, 27.8% (1995), with wide inter-country variation. Thus, Guatemala reports 49.7% of children with low height for age (1993) whereas Costa Rica reports 9.2% (1989) and Panama 9.9% (1992). Rural Mexico, with a stunting prevalence of 35.1% (1989) accounts for two thirds of the stunted children in the subregion. (Source: ACC/SCN, 1997.)
- Undernutrition during pregnancy and LBW: Data on protein-energy undernutrition, weight gain, and food intake during pregnancy are scant for the LAC region. LBW data can be used instead; although, this method will frequently underestimate the prevalence of maternal undernutrition since a mother generally acts as a buffer to the growing fetus, and her stores will be mobilized to depletion to protect fetal growth. National LBW data are available for 30 countries, albeit of variable quality. A full half of these countries have LBW rates of 10% or higher. A LBW rate of 10% or more is considered a signal of serious levels of malnutrition in pregnancy. Rates of 15% and up should trigger immediate public health actions according to the World Health Organization. The poorest countries in Sub-Saharan Africa exhibit LBW prevalences of 15-16%. In the LAC region, Brazil and Peru stand out as having LBW rates at odds with their level of economic development.

4 Postpartum or puerperium is a four-to eight-week time interval starting 24 hours after delivery.

5 This measurement reflects linear growth achieved both intra-uterus and post-natally. Deficits in height for a given age are indicative of long-term, chronic and cumulative effects of inadequate food intake, care and health. Stunting is defined as 2 or more SD below the median of the international growth reference curve.

LBW Rates 10% or Higher by Country, 1990-1994, LAC Region

Country	*LBW Percentage Rate*
Guyana	19
Haití	15
Guatemala	15
Nicaragua	15
Ecuador	13
Suriname	13
Bolivia	12
Brazil	11
Dominican Republic	11
El Salvador	11
Peru	11
Barbados	10
Belize	10
Jamaica	10
Trinidad and Tobago	10

Source: UNICEF, 1998

- Nutritional anemia: Nutritional anemia is the most prevalent nutritional deficiency in the LAC region, especially among women of reproductive age, pregnant and adolescent women. Forty five million women in LAC suffer from iron-deficiency anemia. A third of the countries exhibit levels of nutritional anemia in pregnant women similar to those of Sub-Saharan Africa, that is, over 40%. In contrast, Canada has an astoundingly low 3%.

Anemia in Pregnant Women by Prevalence Group, 1985-1997

Group 1 40% and more*	*Group 2 between 20-39%*	*Group 3 below 20%*
Peru (highest)	Panama (highest)	Chile
Belize	Honduras	
Jamaica	Paraguay	
Bolivia	Nicaragua	
Guatemala	Dominican Republic	
El Salvador	Bahamas	
Ecuador	Venezuela	
Colombia	Guyana	
Brazil (lowest)	Trinidad & Tobago	
	Barbados	
	Suriname	
	Costa Rica	
	Argentina	
	Uruguay	
	México (lowest)	

* Although no data are available for Haiti, it probably falls in this group.

Source: Mora & Mora, 1998

- Vitamin A deficiency (VAD): Information available is not specific to women of reproductive age or disaggregated by sex. The estimations presented, prevalence of subclinical VAD in children <5 years[6], most likely underestimate the level of deficiency among women alone and certainly underestimate vitamin A deficiency among pregnant and lactating women.
- Obesity: Using the WHO definition of obesity (see footnote 2), prevalences among Latin American women of reproductive age, with the exception of Haiti, are between 34% and 49%. More conservative definitions of the condition lower prevalences to 17 to 23%. Most of these women live in cities (except in Brazil, Mexico, and Colombia where they are

LAC Countries Classified by Degree of Public Health Significance of Subclinical VAD in Children, 1997

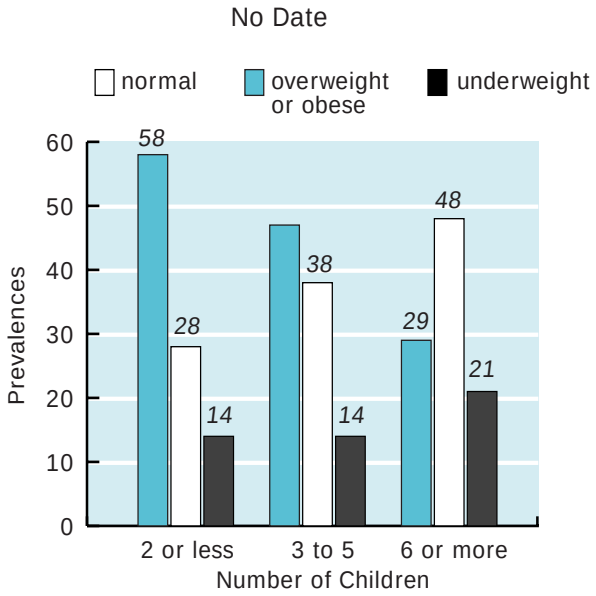
Severe >20%	*Moderate 10-19%*	*Mild 5-9%*	*No Problem*	*Insufficient Information*
Brazil	Bolivia	Argentina	Chile	English Caribbean
Dominican Republic	Colombia	Belize		Haiti
El Salvador	Ecuador	Costa Rica		Paraguay
Nicaragua	Guatemala	Panamá		Uruguay
Peru	Honduras	Venezuela		
	Mexico			

Source: Mora & Mora, 1998

6 Percentage of the population with serum retinol levels <20µg/dl.

equally distributed in rural and urban settings). In all countries, except Guatemala and Haiti, there is a tendency for higher prevalences of obesity in poorly educated women. In the Dominican Republic, Guatemala, and Peru; girls have a greater tendency than boys to develop obesity. (Source: Martorell, et al., 1998.)

Parity and Women's Nutritional Status in Salvador, Bahia, Brazil



Source: de Nóbrega, n.d.

- Recent data from Brazil (previous figure) illustrate the direct relationship between obesity and parity. It also illustrates how, in one same setting, repeated pregnancies are associated with maternal undernutrition in one sub-population and with obesity in another.

What can be done?

- Design projects with both short- and long-term impact horizons: Take into account that one intervention or set of interventions at one point in the life-cycle of one generation of women cannot break the cycle of malnutrition, poverty, and disease. In order for women to reach reproductive age with adequate nutritional status and to prevent stunting, they have to be well-nourished, especially intra-uterus and during the first two years of life. Commit to financing countries with the worst female nutritional problems for the long-term and plan consecutive and progressive health and nutrition projects to improve infant and child nutrition cross-generationally.
- Finance essential drugs procurement programs that include iron-folate and vitamin A tablets.
- Target adolescent girls through multisectoral programs or through health, nutrition, and education projects: Provide services to delay first pregnancy, distribute micronutrient supplements (iron-folate and vitamin A), administer anthelminthics, offer education and treatment for STDs, treat malaria, provide immunization for or treat TB, involve the male partners. School-based nutrition programs should target pre-puberal and adolescent girls for micronutrient supplementation. Promote physical activity among adolescents, especially girls living in cities.
- Target pregnant adolescents: Pregnant adolescents should be targeted for promotion of improved diets and micronutrient supplements. In populations with undernutrition problems, balance diets should be promoted. If food supplements are available, they should be targeted to pregnant teens. These women need to increase their daily caloric intake to cover their physical growth needs and those of the growing fetus as well as the nutritional demands of lactation postpartum. In populations with obesity problems, weight and physical activity should be managed. Introduce family planning education and referral during the prenatal period; provide family planning referrals and services to women and their partners during the post-partum period.
- Use windows of opportunity to reach pre-pregnant women with nutritional services: Reproductive health programs for non pregnant women (family planning, STD screening and treatment, sexual education, pregnancy prevention for adolescents, etc.) are adequate but little utilized "entry points" for nutritional interventions at critical life-cycle stages in order to address maternal nutrition issues before women become pregnant, including issues of overweight and obesity. The latter are particularly relevant to reproductive health programs to space or limit births.

Women require active and effective support to breastfeed. All working women, but especially those that work outside the home, face serious logistical and social obstacles to maintain breastfeeding for months at a time. Male partners, employers, the media, the legal system, and international organizations all have unavoidable responsibilities to support and assist women at the same time that they promote breastfeeding.

- To combat anemia: Promote pregnancy prevention; promote the delay of first pregnancy until past 18 years. Provide iron-folate supplementation to pre-pregnant women, especially adolescents who are anemic or borderline; provide iron-folate supplements during the second and third trimesters of pregnancy (if daily, provide one ferrous sulphate tablet of 60mg elemental iron + 400µg folic acid). Explore possibilities for Bank financing of national iron food-fortification programs. Provide deworming drugs in schools, health centers, etc.; especially treatment for hookworm. Introduce effective IEC projects to change household-level dietary patterns. Promote and actively support lactation to extend lactational amenorrhea, reduce iron loss, and delay next pregnancy. Pay attention to the micronutrient composition of complementary foods fed to girls and boys 4-6 to 24 months.
- Promote and support breastfeeding: Help women initiate and sustain exclusive breastfeeding for as long as feasible up to 4-6 months and promote lactation up to 2 years. Lactation benefits women by lowering the risk of post-partum hemorrhage, pregnancy, anemia, and breast and uterine cancer. By increasing child spacing (exclusive), breastfeeding increases the inter-gestational period and decreases the exposure to maternal mortality risks. Although breastfeeding also increases a woman's nutritional demands, the known benefits of lactation to women and their children outweigh the risks of maternal malnutrition. Breastfeeding may also influence post-partum weight and reduce the tendency for obesity with increased parity.
- Integrate nutrition services in prenatal and post-partum care: Incorporate focussed and highly effective nutrition measures in safe motherhood programs. Key services include iron supplementation (daily or weekly iron-folate tablets); supplementation with vitamin A (one 200,000 IU megadose) only during and up to the 6th week postpartum; anthelminthics (single dose during second or third trimesters); screening for and treating malaria (or presumptive treatment of pregnant women in high endemic areas), especially in primigravidae with a safe antimalaria drug; measures to reduce physical activity and workload during the last trimester (appropriate technologies for household work, transportation to health establishment, targeted income transfers); and improved IEC measures to ensure adequate weight gain during pregnancy, especially in adolescents and promotion/support of breastfeeding. This is also the time to promote adequate and active complementary feeding for infant girls and boys 4-6 to 24 months, including supplementary foods and fortified complementary food mixes, to promote optimal longitudinal growth and, eventually, reduce adult stunting in women.
- Integrate, integrate, integrate: Integrate key nutrition/health services for women in programs targeted to their children. Child survival programs and integrated management of childhood illnesses initiatives are little used opportunities to provide women with nutrition services between and during pregnancies. Deworming; TB; malaria and STD prevention; screening and treatment; micronutrient supplementation; lactation promotion; IEC for improved food intake and targeted food supple-

Girls should be targeted in all education programs. Keeping girls in school will have a significantly positive nutritional impact on the next generation of girls and boys as well as positive effects on their own reproductive health.

ments to malnourished women, pregnant adolescents, and undernourished lactating mothers are all measures whose integration in child-centered programs do not posit insurmountable logistical challenges given that most of these programs already provide these services to children. Diet-based weight management and promotion of physical activity among overweight and obese women post-partum can also be adequately addressed in this type of program.

- Target, target, target: IEC to promote and support balanced diets should effectively target women. Supplementary feeding should effectively target malnourished women, pregnant adolescents, and women who are lactating. Food supplements should go to the lactating mother, not to the infant less than 6 months. Ensure targeting is effective by involving male partners to promote adequate intra-household food distribution; presenting food commodities in ways more appealing to women (snacks, cookies); encouraging consumption of supplements as "between meals" foods; installing feeding sites near residential districts to directly deliver them to women; and/or distributing food supplements in "ready-made" form to be consumed immediately.

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Women in Development Unit

IDB Support for Reproductive Health

Approved loan operations[1]:

NI-0024
Modernization of Hospital Networks of the Ministry of Health
Loan amount: US$48.6 million
Approved November 1998
Supports subsidy for emergency obstetric care among low income groups.

DR-0078
Health sector modernization and restructuring
Loan amount: US$61.2 million
Approved October 1997
Finances an essential package of cost-effective health services for the poor, including maternal care, family planning, cervical cancer screening and treatment, and AIDS prevention programs.

JA-0051
Health sector reform program
Loan amount: US$17.7 million
Approved June 1997
Includes health promotion component that specifically addresses high impact reproductive health issues in Jamaica, such as cervical and breast cancer.

BO-0029
Social Investment Fund
Approved 1995
Loan amount: US$60 million/US$6.5 million for health center component
Supports preventive and curative care programs that are intended to reduce infant and maternal mortality, increase levels of prenatal and delivery care, and increase the percentage of women of childbearing age receiving information about contraception.

ME-0187
Program of Essential Social Services
Approved 1995
Loan amount: US$500 million
Improves maternal and child health through strengthening of priority prevention programs in family planning and reproductive health and maternal and child health, including pre- and post-natal care. A nutrition program, co-financed with the World Bank, delivers vitamin supplements and counseling to pregnant and lactating women in the poorest states.

ES-0053
RE2/SO2
El Salvador Proyecto de Apoyo a la Modernización del Ministerio de Salud y Asistencia Social
Monto de préstamo: US$20,7 millones
Aprobado en 1999
El objetivo del proyecto es mejorar las condiciones de salud de los grupos de bajos ingresos de El Salvador.
Financia un conjunto básico de servicios de salud para los pobres, incluidos la atención materno-infantil, planificación familiar, atención al adolescente y el cancer cervico uterino y de mama.

Approved technical cooperation operations:

TC-9705130-BH
RE3/OD6
Approved 1998
Adolescent Reproductive Health Project
Executing agency: Bahamas Family Planning Association (BFPA)
IDB contribution: US$970,000 (JSF)
Supports training and peer counseling in reproductive health for Bahamian youth.

1 For a comprehensive review of IDB focus on women's health issues, see the document "IDB Focus on Women's Health Issues (1991-95)."

TC-9712086
SDS/WID
Approved October 1998
Reproductive Health
Executing agency: Population Council, Mexico
IDB contribution: US$150,000 (FSO)
Sets an agenda for integrated reproductive health interventions within health sector reform initiatives in the region.

TC-9809297
RE2/SO2
Final stages of approval, October 1998
Maternal and child health for indigenous populations in Mexico
Executing agency: Instituto Mexicano de InvestigaciÛn en Familia y PoblaciÛn (IMIFAP) and Instituto Nacional Indigenista (INI)
IDB contribution: US$500,000 (JSF)
Develops best practices in the provision of maternal and child health services for indigenous populations in Mexico.

TC-9507247-VE
RE3/OD5
Approved 1997
Promotion of Youth Health
Executing agency: AsociaciÛn Venezolana para la EducaciÛn Sexual Alternativa (AVESA)
IDB contribution: US$350,000 (FSO)
Supports training and peer counseling in reproductive health for Venezuelan youth.

DAVID MANGURIAN

TC-9601221-RG
SDS/SOC
Approved July 1997
Regional Support for Use of Demographic Information in Social Investment Projects
Executing agency: AsociaciÛn Venezolana para la EducaciÛn Sexual Alternativa (AVESA)
IDB contribution: US$400,000 (FSO)
Supports use of demographic data for social policy-making in the region, as identified in 1994 ICPD Regional Plan of Action.

Pipeline loans:

PE-0146
RE3/SO3
Support to health sector reform
Loan amount: US$50 million
Executing agency: Ministry of Health
Finances a maternal-child health insurance scheme on a declining basis that would provide subsidies for maternal care for poor women.

AR-0120
RE1/SO1
Modernization and reform of the health sector
Loan amount: US$40 million
Executing agency: Ministry of Health and Social Welfare
Reforms provincial health systems through re-emphasis on primary care, including a strong women's health component.

Pipeline Technical Cooperations:

TC-97-12-19-3-RG
SDS/SOC
Pending approval
Essential social services for young women
IDB contribution: US$250,000 (FSO)
Establishes best practices in the provision of essential social services for young women, including reproductive health.