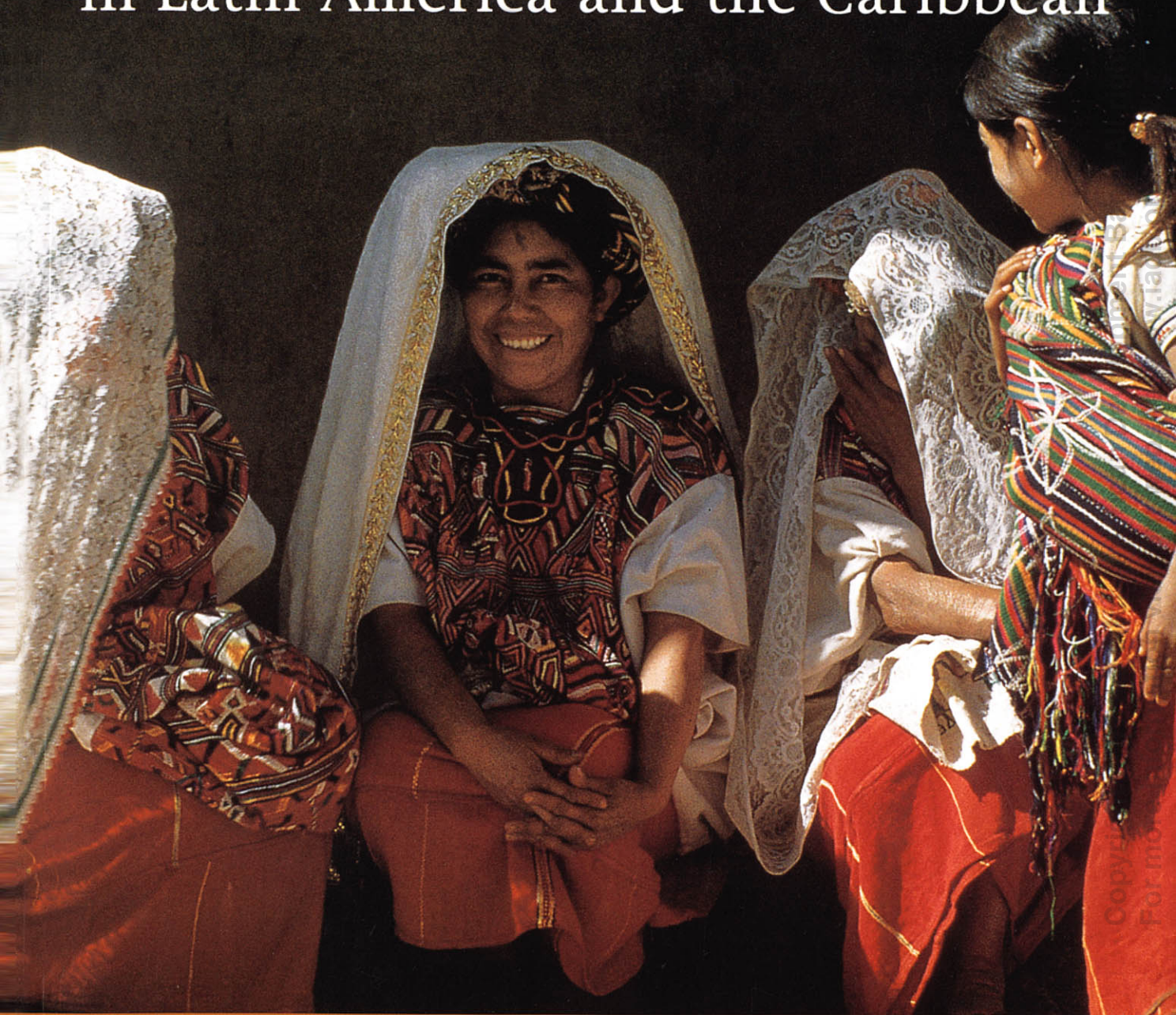




The World Bank

The Health of Women in Latin America and the Caribbean



Ruth Levine, Amanda Glassman, and Miriam Schneidman

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The Health of Women in Latin America and the Caribbean

Ruth Levine
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2001

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BMI	Body Mass Index
DALYs	Disability Adjusted Life Years
DHS	Demographic and Health Survey
DTP	Diphtheria, Tuberculosis, Polio Immunization
DRG	Diagnostic Related Group
GDP	Gross Domestic Product
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
IARC	International Agency for Research on Cancer
IBRD	International Bank for Reconstruction and Development
ICPD	International Conference on Population and Development
IDB	Inter-American Development Bank
IMSS	Mexican Social Security Institute/Instituto Mexicana de Seguridad Social
ISAPRE	Private Health Insurance/Instituto de Salud Previsional
ISSSTE	Social Security Institute for Public Sector Employees (Mexico)/ Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado
LAC	Latin America and the Caribbean Region
MMR	Maternal Mortality Rate
NGO	Nongovernmental Organization
PAHO	Pan American Health Organization
PPP	Purchasing Power Parity
PSRH	Public Spending on Reproductive Health
PSWH	Public Spending on Women's Health
SSA	Federal Secretariat of Health (Mexico)/Secretaría de Salud
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
THE	Total Health Expenditure
USAID	United States Agency for International Development
WDR	World Development Report
WHO	World Health Organization
YPLL	Years of Potential Life Lost

Executive Summary

The health sector in Latin America and the Caribbean is under pressure to achieve better health outcomes, particularly among the poor, within severely constrained budgets. Countries are attempting to meet this challenge by establishing new priorities for public spending, changing the locus of decisionmaking, reorienting major institutions, and introducing productivity- and demand-oriented management and financial mechanisms. As this process is implemented, yields results, and requires adjustment, policymakers are more likely to achieve their objectives if they pay careful attention to the topic of women's health, and base their decisions, in part, on a solid empirical understanding of the health, economic, and social conditions of women.

This report seeks to contribute to the debate about health policy and program design in Latin America and the Caribbean by focusing on the special topic of women's health. It aims to provide governments and program designers with information about priority needs in the region, and on how policies can yield optimal results. The report, which summarizes more than a dozen original background studies, represents the collaborative effort of three partners—the World Bank, the Inter-American Development Bank (IDB), and the Pan American Health Organization (PAHO). In addition, three regional consultations, sponsored by the IDB, were conducted in collaboration with the Population Council, Latin America and the Caribbean Office, to gain a deeper understand-

ing of the issues related to reproductive health policy in the region.

The study has two main objectives:

- ✦ To analyze trends and differentials in women's health; examples of good practices in delivery and financing of women's health programs; and the key dimensions of women's health that are relevant for the health reforms currently underway in Latin America.

- ✦ To provide guidance for governments and program designers in addressing the most pressing causes of women's ill health, within the context of broader sectoral and national policies.

Women's Health Conditions in Latin America and the Caribbean

Women's health in Latin America and the Caribbean tells a story of diversity. Reflecting underlying differences in socioeconomic conditions and policy responses, the countries of the region are characterized by vast differentials in the status of women's health and services. In Haiti, maternal mortality is estimated to be about 600 per 100,000 live births, and nearly 80 percent of women deliver in the home. In Colombia, maternal mortality has been reduced to 100 deaths per 100,000 live births, and less than 20 percent of women have home deliveries. Still further along the broad continuum, Chile's maternal mortality rate rests at 65 per 100,000, and health service providers find that

providing cost-effective care for chronic conditions among older women is an increasing challenge.

Looking at reproductive health indicators, we see persistent, clear patterns of poor reproductive health associated with poverty, and low coverage of basic services. In the poorer countries, there is evidence of longstanding and widespread poor nutritional status, high (and unwanted) fertility levels, high-risk childbearing, and low use of prenatal services. But the majority of women in these countries have much in common with the poorer women in the better-off countries, who are at equally high risk for poor reproductive health outcomes, despite the good reproductive health enjoyed by a large share of the women in those countries.

But reproductive health is only part of the story of women's health. Overall, the disease burden represented by some chronic or noncommunicable illnesses is higher for women than for men. The relative female burden is higher for cardiovascular disease between the ages of 15 and 44 and among those 60 years and older. Women assume a larger overall burden for cancers. Breast and cervical tumors in women occur at an earlier age than the most common malignant tumors do in men (PAHO 1998). Breast cancer takes a toll on women from the age of 15 onward. The burden for colorectal cancers is higher among women 45 and older than it is for men in these age groups. Although diabetes-related mortality is increasing among men, the disability-adjusted life years lost among women are still substantially higher; the disparity is maintained from the age of 15 onward. Musculoskeletal diseases, which can dramatically affect physical function and mental health, take a much larger toll on women than on men. The differential begins at age five and is maintained throughout the life span.

The pattern of incidence and prevalence by socioeconomic conditions is complex. Cardiovascular disease, diabetes, and cervical cancer tend to be more problematic among poorer populations. Conversely, breast cancer tends to account for a larger share of mortality among better-off populations, probably because of patterns of reproductive risk factors, such as delayed childbearing among richer and better-educated women.

Delivery and Financing of Women's Health Services

Public sector provision is the most common source of women's health services, although the private sector does provide a sizeable share of services, even in poor communities. In a special analysis for this report that looked at seven countries of the region studied, we found that, having perceived a medical problem, most women seek care in the public sector or from publicly financed private providers—from 42 percent of all visits in Paraguay to 76 percent of all visits in Brazil. Insurance coverage is concentrated in the upper income quintiles and urban areas, is mostly public, and women and men benefit equally.

Wealthier women are more likely to seek care in the private sector, although there is significant use of public services by the upper-income households. Even in the poorest 20 percent of the income distribution, women are more likely than men to seek care in private health facilities or pharmacies. The use of private facilities as the first site of care among the poorest 20 percent of households ranges from lows of 5 percent of females in Brazil (where universal access is mandated and the use of private facilities paid for by the government is included in the category

of “public” services) to highs of 29 percent of first visits among females in Paraguay.

Our analyses demonstrate wide variation in total health spending—it is 147 times greater in Brazil than in Jamaica, for example—and in spending as a share of gross domestic product. In general, however, spending on women’s health services accounts for about one-quarter of public health spending and nearly half of household spending on health. Not surprisingly, the volume of public spending on women’s health is highly associated with a country’s wealth, and its distribution across institutions and inputs is similar to that of total expenditures on health.

The analyses examine the gap between current spending on reproductive health and the resource requirements for the delivery of a package of core reproductive health services. For the seven countries for which data are available, this assessment indicates that there is little or no funding deficit in Brazil, Mexico, and Jamaica. In Paraguay and the Dominican Republic, marginal additional resources—from 11 to 15 percent of current public spending on reproductive health—would be required to finance the core reproductive health services for the entire population. In contrast, in the poorer countries of Guatemala and Peru, public spending on reproductive health services—exclusive of external support—would have to increase by about 25 to 50 percent to achieve the target.

Women’s Health and Health Sector Reform: Synergies and Risks

To tackle the challenge of improving persistently poor health indicators among vulnerable women in the face of resource limitations—and expand-

ing demands on the health system—policy-makers, technical specialists, advocates, community leaders, and others interested in women’s health issues can take advantage of a major opportunity: Well-designed and well-implemented efforts to reform the health systems in Latin America and the Caribbean, which are now underway, can increase the quantity of, improve the quality of, and stimulate demand for women’s health services. At the same time, it is essential to recognize that poorly designed and poorly implemented reform initiatives—those that ignore some of the critical gender-specific dimensions of the supply of and demand for health services—can erode past progress in improving women’s health in the region. This is true for both the better-off countries—where the challenge lies in greater efficiencies, better targeting, and stimulation of demand among the poor—and the poorer countries, where the primary objective is directing a greater volume of resources to meet persistent needs for essential, basic reproductive health services.

The first step toward using health reform processes to promote improvements in women’s health is to understand that women’s health advocates and health “reformers” have common aims, despite differences in professional training, ideology, politics, and even vocabulary. In its most stripped-down form, health sector reform (as manifested in developing countries) typically seeks to achieve three overarching objectives.

First, it aims to improve the efficiency of the overall allocation of public resources within the health sector, so that public funds are directed toward the health services that will have the greatest positive impact on health conditions, but that the market would not otherwise provide. Second, health sector reform seeks to provide incentives for the efficient production of services in

both the public and private spheres, so that a given level of inputs devoted to an essential determinant of human capital formation (and a large player in the national economy) yields the greatest possible output. Third, it tries to improve the lot of the poor—or at least counteract historically regressive public expenditure policies—by focusing public spending on services that disproportionately benefit lower-income and other vulnerable households. As demonstrated in this report, meeting each of these objectives requires attention to women's health.

Just as policymakers and others promoting health sector reform can meet their objectives most effectively by focusing attention on women's health, it is also the case that advocates of women's health can achieve their goals by recognizing the opportunities presented by particular aspects of health sector reform. Many health services for women have long been characterized by poor quality and lack of responsiveness to demand. Within health sector reform, instituting contracting arrangements, new demand-side financing mechanisms, strengthening of regulatory mechanisms, and decentralization of decisionmaking have the potential to address these concerns. In addition, as documented in this report, finishing the reproductive health agenda requires more financial resources and better use of those resources that already are invested in reproductive health. Again, health sector reform initiatives that seek both efficiency and equity improvements can serve to free up and refocus financial resources for this purpose. Finally, financing non-health services is a complex task that will require mechanisms that include, but also go far beyond, traditional public sector-resource outlays. In particular, expansion of both public and private insurance systems is likely to be needed.

Despite the commonalities between those interested in improving women's health outcomes and the efficiency- and equity-oriented health sector "reformers," communication is often limited by the lack of formal channels and mechanisms to involve women's health advocates in the reform processes. In a few countries of the region—notably Mexico, Brazil, and Colombia—efforts are underway to incorporate women's health advocates and gender specialists in the dialogue about the direction of health sector reform. But these countries are the exception. In general, formal participation mechanisms have been limited, and both national governments and development partners have done relatively little to ensure that issues of women's rights and other gender-specific concerns are discussed during debates on health sector reform.

The outcomes for women of four common health sector reform strategies—decentralization, public sector priority setting, financing changes, and adjustments in the roles of the public and private sectors—can be enhanced if attention is paid during the design stage to lessons learned from experience, as outlined below in brief, and as further detailed in this report.

Decentralization can have positive effects on women's health services when (1) women's health advocates (and women patients) have a voice in the local decisionmaking process; (2) coherent national policies and "rules of the game" are in place that favor the delivery of women's health services of acceptable quality; (3) formula-based transfers are used to ensure sufficient funding based on need, and to redress historic inequities; and (4) support is provided to bolster technical and managerial capacity at the local level.

Strategies for *public sector priority setting* that employ analysis of cost-effectiveness often

favor core reproductive health services. The challenge, as seen in several countries, is to obtain and stimulate the use of reliable and up-to-date information about both costs and efficacy.

Broadening *financing options* to mobilize resources, control unnecessary demand, and promote risk-pooling will have better outcomes for women's health if the design takes into account the possibility that women have less access to and control over household income than do men. In particular, a variety of studies have confirmed that core maternal and child health services are best funded by means other than user fees.

Contracting with nongovernmental organizations and public-private collaboration have tremendous potential to increase access to and the quality of women's health services in the region, although, to date, experience is limited. The key ingredients for success include (1) putting in place a legal and regulatory framework that protects service providers, financiers, and, above all, consumers; (2) minimizing transaction costs and incorporating incentives for productivity and quality; (3) ensuring continuity in service provision and minimizing delays in payments; and (4) strengthening management information systems, monitoring results, and making required adjustments.

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Chapter Summary

- ✦ Health systems in Latin America and the Caribbean are under pressure to improve performance.
- ✦ Improving our ability to understand and respond to women's health needs and demands—including those not related to reproduction—is essential to achieving goals of enhanced equity and increased efficiency.
- ✦ Responding to women's health needs requires recognition of gender-specific determinants of health and health-service use.

Objectives and Organization

The health sector in Latin America and the Caribbean is under pressure. While the countries of the region have achieved notable progress in delivery of both public health and individual health services over the past several decades, the accomplishments are not as great as would be predicted by the level of spending in the sector (IDB 1997). Low-income households continue to suffer from preventable diseases and are vulnerable to the financial insecurity associated with illness. In addition, health services in the region are often inefficient. The sector is characterized by wasteful spending practices. Many countries recognize these shortcomings and realize they face increasing demands to make the economies of the region more globally competitive by investing effectively in human capital within restricted bud-

gets. As a result, they are engaging in a process of health sector reform: establishing new priorities for public spending, changing the locus of decisionmaking, reorienting major institutions, and introducing new management and financial mechanisms that are designed to promote productivity and responsiveness to consumers.

As this process is implemented, yields results, and requires adjustment, policymakers are more likely to achieve their objectives if they pay careful attention to the topic of women's health, and base their decisions, in part, on a solid empirical understanding of the health, economic, and social conditions of women. Just as it has been demonstrated that the aims of health sector investment are closely tied to addressing the problem of poverty and inequity in Latin America and the Caribbean, it is also the case that better outcomes from the health sector depend in large part

on the extent to which the health system understands and responds to gender differences.

Objectives. This report seeks to contribute to the debate about health policy and program design in Latin America and the Caribbean by focusing on the special topic of women's health. It aims to provide governments and program designers with information on priority needs in the region, and on how policies can yield optimal results. The report, which summarizes more than a dozen original background studies, represents the collaborative effort of three partners—the World Bank, the Inter-American Development Bank (IDB), and the Pan American Health Organization (PAHO). In addition, three regional consultations were conducted in collaboration with the Population Council, Latin America and the Caribbean Office, to gain a deeper understanding of the issues related to reproductive health policy in the region.

The study has two main objectives:

- ✦ To analyze trends and differentials in women's health; examples of good practices in delivery and financing of women's health programs; and the key dimensions of women's health that are relevant for the health reforms currently underway in Latin America.

- ✦ To provide guidance for governments and program designers in addressing the most pressing causes of women's ill health, within the context of broader sectoral and national policies.

Organization. The report is divided into five sections. This overview highlights the rationale for focusing on the topic of women's health, along with a conceptual framework for understanding the determinants of women's health and the role of health policy. Chapter One describes major trends

and differentials in women's health in Latin America and the Caribbean, grouping countries into four broad categories according to trends in health, demographic, and socioeconomic indicators. This analysis illustrates how countries have performed relative to one another over the past decade and suggests the priority needs at this stage. Chapter Two turns to a discussion of access, utilization, and spending on women's health, providing the results of new analyses for seven countries. The third chapter provides an overview of the links between women's health and health reform. It emphasizes potential synergies and opportunities to integrate women's health concerns in broader reform initiatives and points out risks to be avoided. The chapter includes examples of good practices in the provision and financing of women's health services in the region. The final chapter presents concluding remarks and recommendations.

Background papers are available on the Web site, www.worldbank.org/lachealth/. This site includes both the background materials for the women's health study and a series of cases prepared for a conference on health reform in 2000, which focused, in part, on policy and programmatic innovations to foster more effective delivery of maternal and child health services to poor communities.

What Is Women's Health?

Women's health constitutes a wide range of conditions, which are influenced by socioeconomic status, educational attainment, and the availability, cost, and quality of services. It includes reproductive health, which was defined broadly in the Fourth World Conference on Women (Beijing 1995) and the International Conference on Population

and Development (Cairo 1994) as "... a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes." It also includes concerns related to chronic diseases (such as cardiovascular problems, cancers, diabetes), mental illness, and occupational and environmental health problems. The following criteria can be used to distinguish between women's health and men's health. Women's health issues (1) are unique to all women or some groups of women; (2) are more prevalent among all women or some groups of women; (3) have more serious consequences or implications for all or some groups of women; and (4) imply different treatment for all or some groups of women.

The Latin America and Caribbean region presents a mixed picture of women's health conditions. The priority attached to expanding access to family planning in many countries has generated impressive results, with the total fertility rate declining from 5.0 to 2.7 children per woman, and with one-third of the countries having reached replacement-level fertility over the past 25 years (Loganathan 1999). In spite of these impressive regional gains, progress has been uneven across countries: Women's lifetime risk of dying during pregnancy and childbirth, for example, ranges from 1:17 (Haiti) to 1:510 (Panama). Female life expectancy averages are about 57 years in Haiti, 63 years in Bolivia, and close to 80 years in Costa Rica.

At the same time, new health concerns and challenges are emerging. On the one hand, the growing problem of HIV/AIDS puts pressure on reproductive health programs to expand attention to specific services and populations. On the other, coupled with an aging of the population, many

countries are experiencing a shift in epidemiologic patterns away from infectious diseases and toward chronic conditions.

In short, the countries of the region face a triple challenge: (1) an unfinished reproductive health agenda, which affects disproportionately the lower-income countries, and the poor across all countries; (2) new infectious diseases, including HIV/AIDS; and (3) emerging health problems, including chronic and degenerative diseases, injuries, and mental and occupational health, particularly in the higher-income countries.¹ While these emerging health concerns affect both men and women, women have special needs, given their greater vulnerability to the HIV/AIDS infection, a variety of biological and social susceptibilities, and women's relatively greater representation in the older population.

Why Do We Need to Pay Attention to Women's Health?

Making sound policies to improve health sector performance requires attention to the determinants and characteristics of women's health, and the allocation of public and private resources to women's health services. This statement does not imply that women's health is intrinsically more important than men's health, but rather that successful health policy recognizes and responds to gender-based differences in biology and in social and economic conditions.

Several features of women's health are worth noting:

✦ *Women are the primary beneficiaries of health services in Latin America and the Caribbean, and particularly of publicly financed health*

services. Women use both general services—those services that benefit men and women—and women-specific services associated primarily with pregnancy and childbearing. As shown in chapter three, women are more likely to experience and report illness and more likely to seek care than men. They interact with the health system more frequently than do their brothers and husbands, both as patients themselves and as the primary caretakers of children who are patients. The outcome of virtually all policy or programmatic decisions in the health sector will be determined largely by the response of, and the impact on, women.

✦ *Women's health has important externalities.* Women in their own right deserve the opportunity for excellent health and the associated ability to participate in education, employment, and other endeavors. Women's health has a broader impact, as well. First, the health of women before and during their reproductive years is a powerful determinant of their children's well being. Women who are severely undernourished during pregnancy, for example, are more likely to have children who suffer from low birth weight, and who are physically and cognitively impaired. Second, women typically are the primary caretakers of children, and often take on the role of caring for other household members who are sick or infirm. When these women—the caretakers—are ill themselves, their dependents suffer. The death of a mother usually has catastrophic effects on the physical and psychological well being of her young children.² Finally, employed women tend to occupy a narrow range of occupations in the service sector, which brings women into direct contact with many people. The health and welfare of a community rest, in part, on the health of its teachers, nurses, food service workers, and childcare providers.

✦ *The equity and efficiency objectives of health sector reform can be achieved only with attention to women's health in general and reproductive health in particular.* From an equity perspective, the almost invariable association between socioeconomic vulnerability and particular health problems experienced by women, such as risky childbearing and nutritional deficiencies, means that improving some types of women's health services will disproportionately benefit the poor. On the other hand, ignoring these problems—and failing to devote adequate resources to resolving them—reinforces the high levels of inequity that characterize most of the societies of Latin America. From an efficiency perspective, one of the primary means of achieving better health outcomes with the same level of health sector spending is by focusing public resources on a particular set of women's health services that are unlikely to be produced in adequate volume by the private sector and are inexpensive relative to their effectiveness.³

✦ *Women's health issues represent an opportunity for establishing a shared interest among diverse actors in the health sector.* By looking at women's health, we can see a clear convergence of interests between individuals and groups that emphasize human rights and public health and those that emphasize the importance of economic criteria for priority-setting. This convergence of interests can be an important force in advancing the reproductive health agenda in the poorer countries of the region, and working toward better health among the relatively older population in the better-off countries of the region. At the same time, given the overwhelming importance of women as patients and health-care decisionmakers, understanding how to serve women better is part of the agenda for both pub-

lic and private health-care planners and service providers.

Despite this rationale, the health concerns of women have not yet received adequate attention. Historically, the medical and public health fields have equated women's health concerns with those of men, even though there are important biological and physiological differences that need to be taken into account in identifying appropriate interventions.⁴ From a policy perspective, the overarching focus has been on women's reproductive and maternal capacities, rather than on the needs of women in their own right, typically to the exclusion of non-reproductive health needs.

A Framework to Understand Women's Health and Health Policies

Men and women differ in their physiological vulnerability to ill health, and in their interaction with the health system and general environment. It is useful, then, to identify where—in the chain of events from policymaking to individual health practices—those differences are manifested. In this section, we present a framework for looking at the determinants of health, and then use that framework to identify the ways in which women may face different constraints, make different choices, and experience different health outcomes than men.

The General Framework. Health conditions are a function of a combination of biological factors and behaviors at the individual, household, community, and national levels. The complex chain of events leading to a health outcome can be envisioned in many ways. One way—although by no means the only way—is to consider health to be

the direct product of a set of inputs, such as food, medical care, and so forth, and to identify the variety of individual, household, and community or societal factors that influence the combination of inputs. With this type of framework, we can analyze the proximate and indirect determinants of health systematically, and identify how policy choices might affect health outcomes.^{5 6}

Individuals and households make choices by balancing the value placed on good health against the value placed on other aspects of individual and household welfare, taking into account financial, information, and other constraints.⁷ Each day, individuals (or, in the case of children, their parents or other caretakers) must choose between pursuing better health or other objectives that may also improve welfare. In other words, they choose between health-generating inputs or behaviors, on the one hand, and consumption that creates other types of benefits, on the other. For example, with growing economic pressures and larger numbers of women entering the labor market in Latin America, women often face difficult choices in allocating their time between income-generating activities, child-care responsibilities, and seeking health care when ill.

We see here the first instance where men and women may differ. The degree to which particular inputs lead to health is affected to some extent by immutable individual characteristics, including age, genetic make-up, and gender. Men and women differ in their vulnerability to different diseases; nearly all health problems have gender-specific patterns of incidence and severity, and obviously most of the reproductive concerns of women do not directly affect men at all. More subtly, health is affected by education and information: better-informed individuals generally are better able to determine when a particular health

condition requires medical attention, how to use medications, and so forth. In settings where men and women differ in their educational level or their access to information, or both, these asymmetries can contribute to health differences between males and females.

The inputs or behaviors about which individuals and households make choices can be thought of as (1) those that are directly related to health, including medical treatment for ailments, immunization, and other preventive actions, and others; (2) those that are health-related, yet also provide other types of benefits, such as housing, water source, food, risk-taking behaviors, exercise, and so forth; and (3) those that are generally not thought of as health-related, including employment, household activities, and transportation. The choices made are influenced by individual characteristics, such as education; household characteristics, including income; and community features, including the availability and prices of health services, cultural norms, legal factors, environmental conditions, and so forth.

The relative values placed on good health and other outcomes that people want may differ depending on gender (as well as other characteristics). For example, households may place less value on women's or girls' health than on men's or boys' health due to discriminatory factors. Alternately, households may expect that women will earn less income for the household than do men, due to characteristics of the labor market. If so, they might invest less time and fewer monetary resources in girls' medical care.

In this context, it is important to note that household decisionmaking may not be based on preferences and values shared by all members. Households tend not to be monolithic—there may be disagreement over priorities within a house-

hold. The key decisionmakers may be persons other than those whose health is being affected. The most obvious example is children, whose health is affected by decisions made by their parents. For example, parental decisions about prenatal care, breast-feeding, first supplemental foods, and vaccinations affect children's health. Moreover, since household resources are limited, the household may not be able to spend all it would like on every household member and may have to decide among activities that affect different household members.

The earliest economic models of household behavior (such as Becker 1964) assumed that all households jointly maximized some household level of welfare, and that the household should be treated as if it acted as a single individual. More recent research has recognized that preferences may differ among members across a household. This research has investigated how alternative decisionmaking styles might affect the allocation of resources within the household (see Thomas 1989). For example, whereas in one family members may act unselfishly toward one other, in another one individual may act as a dictator, perhaps discriminating against other members, such as females or the aged, while another family may engage in cooperative or noncooperative bargaining over the allocation of resources.

Variation in preferences and gender roles within the family are important factors that affect the investment that one generation will make in the next. For instance, an important study by Thomas (1994), using data from Brazil, showed that daughters were taller in households where mothers controlled more of the economic resources, and sons were taller in households where fathers controlled more of the economic resources. This comparison was made holding the overall level

of economic resources constant in the household. The hypothesis is that mothers and fathers have different preferences over their sons' and daughters' health. The extent to which the preferences affect decisionmaking is related to the extent to which the parent controls resources. The study's findings are consistent with the opinion that strengthening the mother's hand is likely to result in daughters being treated more fairly within the family.

At the community level, decisions are made regarding the quality of the environment (housing, sanitation, transportation, work opportunities) and the nature of health services, again by making trade-offs in the face of constraints. Gender differences are evident at this level, as well. Women's relative social and economic disadvantages can affect the responsiveness of community decisionmaking to women's needs. In some societies, the occupations and preoccupations of women are explicitly considered less important than those of men. A family member's contributions to the formal economy, for example, may be seen as more important than another member's reinforcement of domestic life. In most societies, women are less active and vocal participants in public life than are their brothers and husbands, so decisions taken in even nominally democratic environments can fail to take women's needs and demands into account.

At the national or subnational level (wherever the relevant policies are made and programs designed), decisions both within the health sector and across sectors ultimately affect health conditions. Policies related to the financing, structure, and management of health services determine the availability and characteristics of care available to the population. Policies in the realm of education and the environment, as well as in

macroeconomic dynamics, play a large role in determining the constraints communities, households, and individuals face in reaching, using, and gaining benefits from health services.

At this level, it is possible to see some clear gender-related differentials: frequently women's disadvantage as participants in public life is evident. However, policymakers have the potential to minimize inequities that may be harder to tackle directly at the household and community levels. Some policies, such as those promoting girls' education, can be used to redress existing differentials in social and economic status, which will have a long-lasting positive effect on women's health. Others, such as those which increase the effective use of public funding for women's health services, can have a direct and relatively immediately positive impact on women's access to services and health outcomes.

The gender-specific effect of policies on prices of education and health services is of particular note. Some work has shown that women's demands for medical services and their demand for education are more sensitive to prices than are men's demands. Alderman and Gertler (1998) show that increases in the prices of primary care lower the treatment of girls' illnesses more than the treatment of boys' illnesses in Pakistan; Gertler and Glewwe (1991) show that increases in schooling costs reduce the enrollment of girls more than boys. This has important implications for co-payment policies. Increases in direct patient costs to finance improvements in health services will tend to reduce access to care more for girls than for boys. Similarly, increased school fees will reduce female enrollment more than male enrollment.

Both studies also found that girls' demands for medical care and education are more income-

elastic than are boys' demands. Consequently, girls' access to medical care and schooling is inversely related to income and more vulnerable to economic shocks. Hence special attention is warranted in order to ensure girls' access to education among poorer households and during economic crisis. In addition, it means that girls are more likely to benefit from general economic growth than are boys, although they start from a lower level.

It is important to see relationships as dynamic, existing within the context of the life cycle, and changing over a lifetime. Children and young adults have different health needs and different

choices to make (or to have made for them, in the case of children). Similarly, young adults face different health conditions, choices, and constraints than do the elderly. Yet the human capital investment decisions made early in life—such as those about nutrition, education, and preventive health care—have profound implications for health later in life.

In Chapter One, we present an overview of women's health conditions in Latin America and the Caribbean, attempting to identify opportunities for critical investments that have the potential to improve the welfare of women and their families.

Women's Health Conditions

CHAPTER ONE

Chapter Summary

- ❖ Women's health conditions vary widely, both across and within countries of the region. Four distinct patterns can be identified.
- ❖ There is an unfinished agenda for reproductive health among poorer populations, and an emerging problem of chronic diseases throughout the region.
- ❖ In countries where women's health conditions are poor, policymakers should focus on general improvements in basic services that yield better reproductive health: early and reliable prenatal care; birth attendance by trained personnel; nutritional support, particularly to address iron-deficiency anemia; and appropriate contraception for women who wish to space or limit births.
- ❖ In countries with better health conditions, on average, for women, reproductive health services should be strengthened in poorer communities, and governments should consider ways to counteract market failures in the provision and financing of care for noncommunicable diseases. Given differences in prevalence rates for men and women, gender-specific strategies may be required.

Women's health in Latin America and the Caribbean tells a story of diversity. Reflecting underlying differences in socioeconomic conditions and policy responses, the countries of the region are characterized by vast differentials in the status of women's health and services. In Haiti, maternal mortality is estimated to be about 600 per 100,000 live births, and nearly 80 percent of women deliver in the home. In Colombia, maternal mortality has been reduced to 100 deaths per 100,000 live births, and less than 20 percent of women have home deliveries. Still further

along the broad continuum, Chile's maternal mortality rate rests at 65 per 100,000, and health service providers find that providing cost-effective care for chronic conditions among older women is an increasing challenge.

The differentials are striking not only across national boundaries, but also within them. The poorest women in Haiti are about two-and-a-half times as likely to be undernourished⁸ as the women from the richest households. In Colombia, about 60 percent of the poorest women are attended by medically trained personnel at deliveries, compared to more than 98 percent of the wealthiest women.

This chapter contains contributions by Paul Gertler.

In this chapter, we explore the patterns and differentials of health conditions in Latin America and the Caribbean, with a primary but not exclusive focus on reproductive health outcomes. First, we group countries of the region into a simple typology, based on key indicators of health status and services. Second, we examine reproductive health conditions in several countries in the region for which relatively recent household-level data from the Demographic and Health Surveys exist.⁹ Third, we present information on the prevalence of emerging noncommunicable diseases.

The Typology

While each country represents unique challenges, there is value in attempting to categorize, or group, the countries to develop a more generalized strategy. To this end, a typology of women's health was developed for this study. The typology employed eight variables—GNP per capita, adult illiteracy rate, female life expectancy, total fertility rate, total health expenditure, access to sanitation, births attended by trained health staff, and child immunization (DTP)—to group countries, using the cluster analysis technique.¹⁰ The analysis incorporates 21 countries from the region for which sufficient data were available.

Based on data from 1990–96, the country groupings are:

✦ **High status:** Argentina, Chile, Costa Rica, Panama, and Uruguay

✦ **Medium-high status:** Brazil, Colombia, Dominican Republic, El Salvador, Jamaica, Mexico, Paraguay, Trinidad and Tobago, and the Republica Bolivariana de Venezuela

✦ **Medium-low status:** Bolivia, Ecuador, Guatemala, Honduras, Nicaragua, and Peru

✦ **Low status:** Haiti

Table 1 shows the average values of the key variables for each of the country types. There is wide divergence across all indicators, with the high status countries having conditions that, on average, are not much different from many industrial countries, and the medium-low and low status countries having characteristics of extreme disadvantage. For the most part, the country types correspond simply to levels of GNP per capita: the higher the income, the higher the status in this typology. However, several countries do not fit neatly into this pattern. Costa Rica and Panama, for example, have a higher status than would be predicted based on per capita income alone. Good women's health, health resources, and health service conditions place those countries in the high status category. Brazil is more similar in income to the high status group, but lower health, health resources, and health service conditions place it among the medium-high status countries. In the descriptions of health conditions that follow, these country groupings are used to facilitate understanding of the information. With caution, the policy and programmatic inferences drawn from the data for the selected countries can be applied to others in the same country grouping.

Poor, Rural, and Uneducated Women Face Extreme Reproductive Health Risks

The definitions of reproductive health outlined at various United Nations conferences in the 1990s extend beyond maternal health to encompass complete sexual and reproductive well being.

Table 1 Average Values for Indicators by Country Grouping

	High status	Medium-high status	Medium-low status	Low status
Female Life Expectancy (years)	77.5	73.9	69.0	56.7
Total Fertility Rate (children per woman)	2.5	2.9	3.9	4.3
Access to Sanitation (% of population)	86.6	59.4	53.2	24.0
Illiteracy (% of population over age 15 and above)	5.1	12.9	24.0	55.0
GNP per Capita	4,944	2,650	1,210	310
Delivery by Trained Staff	95.0	70.2	40.2	40.0
Health Expenditure (total spending as % of GDP)	8.32	5.68	5.22	3.6
DPT (% of children under 1 year)	87.6	86.4	86.2	30.0

Source: Loganathan 1999.

Given its broad definition, and as discussed in chapter one, many factors influence reproductive health, including socioeconomic status, educational attainment, cultural and social norms governing female sexuality, power relations within a marriage or other union, domestic and sexual violence, and the availability, cost, and quality of reproductive health services. In this section, our scope is more limited—to describe the epidemiological and service utilization patterns related to a set of reproductive health outcomes for which data are available, with an eye toward identifying key targets for policy and programmatic action.

Looking at reproductive health indicators, we see persistent, clear patterns of poor reproductive health associated with poverty and low coverage of basic services. Generally, in the low status and medium-low status countries, there is evidence of longstanding and widespread poor nutritional status, high (and unwanted) fertility levels, high-risk childbearing, and low use of prenatal services. But the majority of women in these countries have much in common with the poorer women in the medium-high status and high status countries, who are at equally high risk for poor reproductive health outcomes, despite the good

reproductive health enjoyed by a large share of the women in those better-off countries.

Maternal Morbidity and Mortality. Despite weak data sources, Murray and Lopez (1996) have estimated that approximately 2.2 million disability-adjusted life years (DALYs) among women are lost annually to conditions associated with pregnancy. Maternal mortality ranges widely in the region, from 65 per 100,000 live births in Chile, to over 600 per 100,000 in Haiti. Table 2 shows recent maternal mortality estimates for several countries, by placement in the typology.

Overall, mortality due to maternity-related causes has dropped substantially in most of the region in recent decades. From 1980 to 1994, maternal mortality decreased by 42 percent in the Southern Cone, 38 percent in Mexico, 35 percent in Brazil, and 35 percent in the English-speaking Caribbean. However, some parts of the region continue to struggle with persistently high levels of maternal mortality. In many Central American countries, for example, maternal mortality declined by only about 4 percent between 1980 and 1994.

As described in detail in the sections that follow, a constellation of factors—most of them

Table 2 Maternal Mortality by Country Grouping

Country	MMR (deaths per 100,000 live births), 1990–97
High Status	
Argentina	100
Chile	65
Costa Rica	55
Medium-High Status	
Brazil	160
Colombia	100
Dominican Republic	110
El Salvador	300
Jamaica	120
Medium-Low Status	
Guatemala	190
Peru	280
Honduras	220
Nicaragua	160
Low Status	
Haiti	600

Source: Loganathan 1999.

strongly associated with poverty and social vulnerability—confer high risk of poor reproductive outcomes. Mothers at high risk include those at the very beginning or end of childbearing years, with high parity, and who have poor past or current nutritional status. These factors are compounded when prenatal or obstetric care is inadequate. By not having access to (or not using) family planning methods that are consistent with their reproductive aims, women are also vulnerable to unintended pregnancy, and the consequences of an unsafe abortion, or an unplanned (and potentially unwelcome) child. The data reveal that the women most likely to face these risks are those in poor households—disproportionately

rural and uneducated. In the medium-low status and low status countries, this represents the majority of women; even in the other countries of the region, at least one-fifth of the population confronts serious reproductive health risks.

Nutrition and Reproductive Health. Poor nutrition—both a cause and a consequence of ill health—represents a major risk factor for poor birth outcomes for both mother and child. Iron-deficiency anemia, an important problem among many women of the region, is estimated to play a contributing role in up to half of all maternal deaths (ACC/SCN 1997), and is linked to premature delivery and low birth weight (PAHO 1998). Chronic protein-energy malnutrition can result in short stature, which in turn is a risk factor for obstructed labor.

Iron-deficiency anemia, the most common nutritional disorder in the world, affects between one-third and one-half of the pregnant women in the Latin America and Caribbean (LAC) region. Among national surveys conducted in Belize, Bolivia, Guatemala, Nicaragua, and Paraguay, prevalence of anemia in pregnant women ranges from 26 percent in Paraguay to 52 percent in Belize. Half or more of these cases are probably due to nutritional iron deficiency. Anemia is also related to poor iron absorption or uptake, blood loss through menstruation and childbirth, low intake of other food and nutrients that promote iron absorption and availability, and repeated bouts with infectious disease (PAHO 1998).

Research suggests that anemia is more common among poor women and women who are lactating. National survey findings from Bolivia reveal substantially higher levels of anemia among less-educated and rural women, compared to their educated and urban counterparts.

Overall, however, levels of anemia are relatively high among all women: even one-fifth of the most-educated women have some degree of anemia (Loaiza 1997).

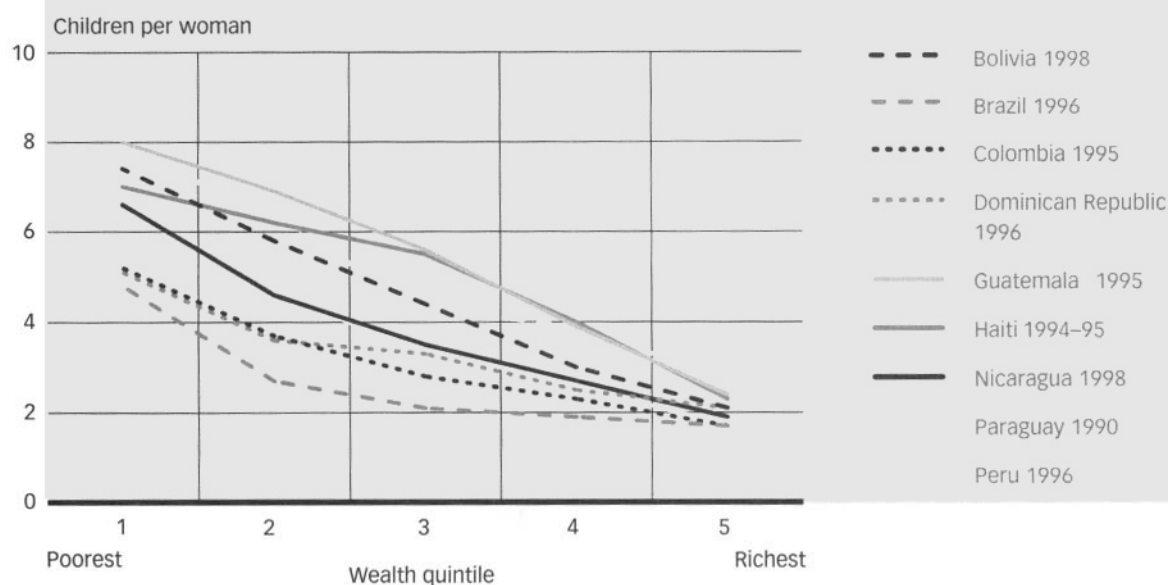
With respect to chronic energy deficiency, adolescent mothers are at the greatest risk in the LAC region. Young Haitian mothers are particularly vulnerable due to poor nutrition. Low maternal height—a risk factor for various poor reproductive and functional outcomes—is a serious problem among mothers in Guatemala, Bolivia, and Peru.

High Fertility Levels. Although average family size has declined dramatically in the region, some countries—and some populations within low-fertility countries—still have relatively high fertility rates. Countries in the region where the total fertility rate (TFR) exceeds 4 children per woman include Belize, Guatemala, Honduras, Nicaragua, Haiti, Bolivia, and Paraguay. Among women with

less education and those residing in rural areas, the rates are substantially higher. In Colombia, for example, a country with a national TFR of 3.0, the TFR in urban areas is 2.5 children per woman and the rural TFR is 4.3. Among women with no education, the total fertility rate is 5, compared with 1.8 among women with the highest educational level (PROFAMILIA and DHS 1995). In Guatemala, which has the highest fertility rate in the region, DHS data indicate that the urban TFR is 3.8, the rural TFR is 6.2, and the TFR among indigenous women is 6.8.

In Latin America and the Caribbean, as elsewhere, economic status is a strong and consistent correlate of fertility. In Peru, the poorest 20 percent of women have an average of 6.6 children during their lives, while the richest 20 percent of women have, on average, only 1.7 children. As shown in figure 1, regardless of the national fertility level, across the region the poorest households have the most children, and the best-off

Figure 1 Total Fertility Rate by Wealth Quintile



segment of the population maintains relatively low fertility, converging across countries at around two children per woman.

Adolescent Childbearing. In most Latin American countries, between one-quarter and one-third of women 18 years old or younger are pregnant or have already had a child. Contraceptive use among sexually active adolescents tends to be relatively low; even among those adolescents using contraception, discontinuation (especially due to method failure) is higher than among older women. Up to half of the pregnancies in young women are unplanned. Many of the children are born outside of marriage, making both the mothers and their babies particularly vulnerable to social and economic risk (Way and Blanc 1997).

Contraceptive Use. Compared with other parts of the developing world, the Latin America and the Caribbean region exhibits relatively high use

of modern contraceptive methods—and the use of contraception has increased significantly over the past 15 years or so. At the same time, large gaps exist in contraceptive use, and choice of methods is often severely limited.

As shown in table 3, the contraceptive prevalence rate ranges from about 13 percent of currently married women in Haiti to more than 70 percent in Brazil. In parallel, nearly half of all sexually active Haitian women in the reproductive ages who wish to wait more than two years before becoming pregnant, or who wish not to become pregnant at all, are not using modern contraception, compared to only 7 percent of Brazilian women with this “unmet need” for contraception.

The correlation of contraceptive use with age, educational level, residence, and household income is almost invariable. Higher-educated, urban women are vastly more likely than their less-educated, rural counterparts to use modern contraception. Correspondingly, the women from

Table 3 Contraceptive Prevalence and “Unmet Need” for Contraception by Country Grouping

Country/Year	Women 15–49 years using modern contraception (%)	Women 15–49 years with “unmet need” for contraception (%)
Medium-High Status		
Brazil 1996	70.3	7.3
Colombia 1995	59.3	7.7
Dominican Republic 1996	59.2	12.5
Medium-Low Status		
Bolivia 1998	25.2	26.1
Guatemala 1995	26.9	24.3
Nicaragua 1998	57.4	14.7
Peru 1996	41.3	12.1
Low Status		
Haiti 1994–95	13.2	47.8

Source: DHS various years.

households with the highest incomes use modern contraceptives in higher numbers than do women from the poorer households.¹¹

In many cases, the match between women's reproductive desires and the type of contraceptives used (or not used) is imperfect. For example, women who do not wish to have additional children may be using short-term, "spacing" methods, instead of longer-term contraception or sterilization. A background analysis for this report examined the extent to which women in selected countries were using appropriate contraceptive methods. Answers to the following questions were sought: Of women using modern contraceptive methods, what proportion were using spacing methods that correspond to their reproductive aims—that is, want to become pregnant in the future and are using oral contraceptives, barrier methods, or other spacing methods? What proportion were using spacing methods but do not want to become pregnant at any time? And what proportion were using limiting methods appropri-

ately if they want to limit all future births? The results, shown in table 4, indicate a substantial mismatch between reproductive goals and methods used, particularly in medium-low status and low status countries.

Unintended Pregnancy and Abortion.

Throughout the region, regardless of development status, unplanned pregnancies are common. The percent of recent births women report as mistimed or unwanted ranges from 29 percent in Guatemala to 54 percent in Haiti. Of particular concern for the welfare of women and children are the unwanted births (those occurring to women who later say that they wanted no more children at the time they became pregnant). In both Bolivia and Peru, for example, about 37 percent of women who had given birth during the five years prior to the DHS indicated that they had not wanted any more children. Even in the relatively developed Colombian setting, about 23 percent of women report that they had wanted to end

Table 4 "Appropriate" Contraceptive Use by Country Grouping
(percent of women using modern contraception)

	Appropriate Spacing	Inappropriate Spacing	Appropriate Limiting	Inappropriate Limiting
Medium-High Status				
Brazil 1996	18.2	22.6	59.2	0.0
Colombia 1995	19.1	32.7	47.8	0.4
Dominican Republic 1996	14.4	24.8	25.4	0.0
Medium-Low Status				
Bolivia 1998	18.7	52.1	29.2	0.0
Guatemala 1995	15.4	21.9	62.7	0.0
Peru 1996	25.2	49.5	25.0	0.2
Low Status				
Haiti 1994–95	25.8	38.4	32.9	2.9

Source: DHS various years.

childbearing before their most recent pregnancy. Mistimed births tend to be more common among adolescent mothers, while unwanted births are more typical among older women (see table 5).

Women seeking to terminate an unwanted pregnancy have few safe options in Latin America and the Caribbean. Although abortion is legally restricted in all countries in the region with the exception of Cuba, it is common and is typically performed under unsafe conditions. The most authoritative report on this topic indicates that abortion is common in Peru and Chile, with almost one out of every 20 reproductive-age women each year having an abortion, on average. Mexico is estimated to have among the lowest incidence of abortion in the region—about one woman in 40 is having an abortion annually, on average. Nevertheless, the average Mexican woman will have had at least one abortion by age 50 (AGI 1996).

The high abortion rates, combined with often unsafe and unregulated conditions under which abortions are performed, result in devas-

tating health outcomes. In LAC, an estimated one-fifth of maternal deaths are attributed to abortion-related conditions, and an estimated 40 percent of women undergoing abortions experience serious complications.

Maternity Care and Caesarean Section. The proportion of women who receive adequate prenatal care—defined as being three or more visits, starting before the seventh month of pregnancy—varies dramatically among countries, from 38 percent in Bolivia to nearly 90 percent in the Dominican Republic. Throughout the region, basic health services fail to reach the women who are at highest risk for pregnancy-related problems. Rural women are substantially less likely to receive prenatal care. Prenatal care coverage is lower among women with little or no formal education and among lower-income women (see figure 2). The differentials are particularly striking in Bolivia and Peru: In Bolivia, only about 32 percent of the lowest-income but more than 92 percent of the highest-income women report two or more prenatal visits. In Peru, prenatal coverage ranges from about 34 percent among poor women to more than 95 percent among the wealthiest fifth of the population.

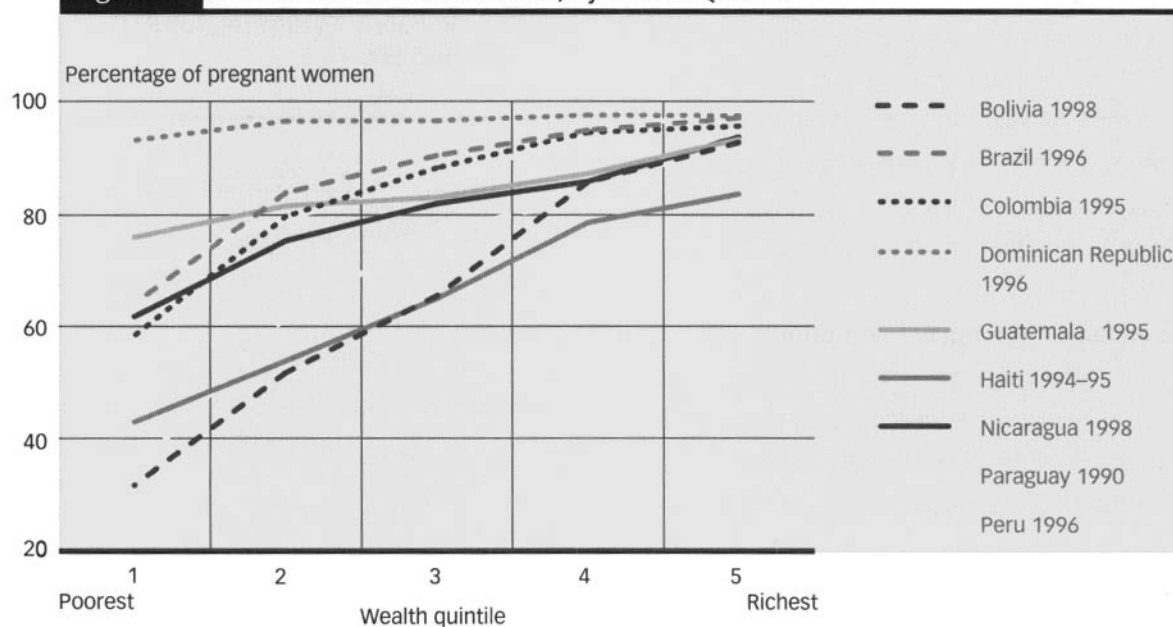
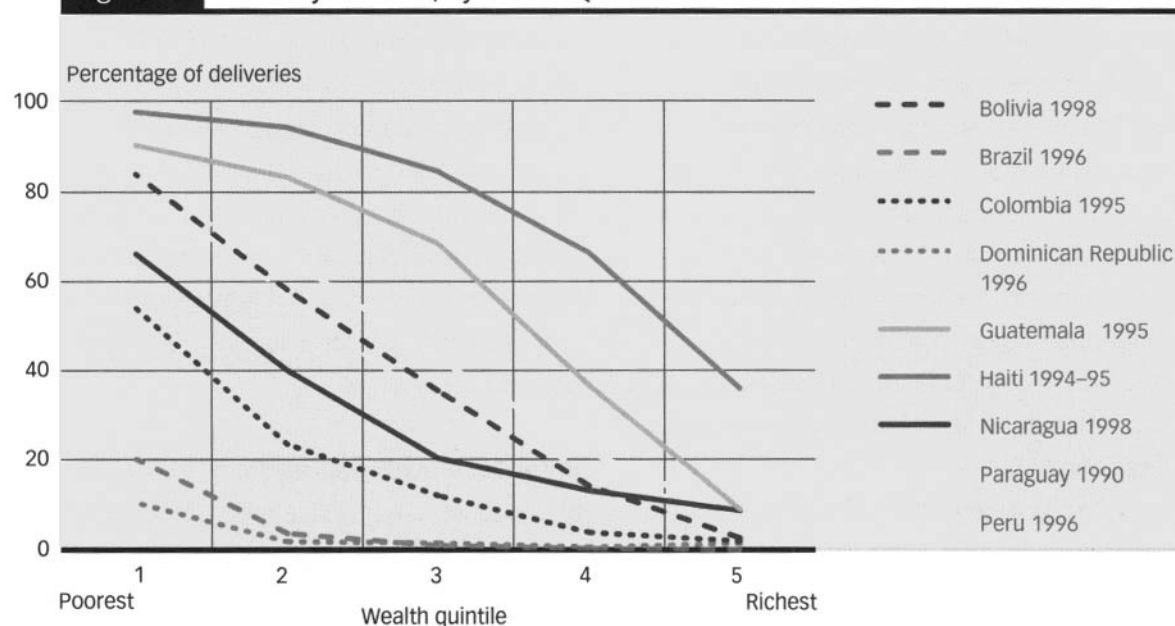
Professional assistance during delivery, a strong marker of adequate obstetric care, is also highly variable in the region, following roughly the same patterns as prenatal care. In Haiti, only about 21 percent of births are attended by a nurse-midwife or a physician; in Brazil, nearly 9 out of every 10 births are assisted by a physician or nurse-midwife. The majority of births in Guatemala, Bolivia and Haiti occur at home—a phenomenon highly correlated with income (see figure 3).

Although commonly performed, delivery by Caesarean section (C-section) is associated with

Table 5 Unplanned Pregnancies by Country Grouping

Country	Unplanned pregnancy (%)
Medium-High Status	
Brazil 1996	48.4
Colombia 1995	45.5
Dominican Republic 1996	36.8
Medium-Low Status	
Bolivia 1998	51.9
Guatemala 1995	29.3
Nicaragua 1998	33.2
Peru 1996	58.0
Low Status	
Haiti 1994–95	54.3

Source: DHS various years.

Figure 2 At Least Two Prenatal Visits, by Wealth Quintile**Figure 3** Delivery at Home, by Wealth Quintile

higher risk to mothers—3 to 30 times higher risk than a normal birth—and substantially higher costs than normal births. Risks include higher infection rates, hemorrhage, lesions to other organs, and maternal mortality. Perinatal mortality and

morbidity also increase with C-sections. In addition, human rights and health concerns have been raised regarding the overuse of medical procedures at the expense of women's well being (Coe and Hanft 1993).

In a number of countries, more than 10 percent of births are facilitated by C-section: in the Dominican Republic (22.3 percent), Colombia (16.9 percent), Paraguay (13.1 percent), and Bolivia (10.6 percent). The levels tend to be higher in urban areas and among women with a secondary or higher level of education (Stewart and Stanton 1997).

Sexually Transmitted Infections. Sexually transmitted infections (STIs), considered a “hidden epidemic” in the United States, have a major impact on women’s health and well being. Potential health consequences include infertility, cancers, ectopic pregnancies, spontaneous abortions, stillbirths, low birth weight, neurologic and physical abnormalities in children, and death. Sexually transmitted infections, excluding HIV/AIDS, have a more severe impact on women than on men for four major reasons. First, women are more biologically susceptible to certain sexually transmitted infections than men. Second, women are more likely to have asymptomatic infections that delay diagnosis and treatment. Third, STIs are often more difficult to diagnose in women because the anatomy of the female genital tract makes clinical examination more difficult. Finally, women often do not control the use of condoms and the circumstances under which sexual intercourse takes place.

This is largely borne out in the estimated disability-adjusted life years (DALYs) lost among women for curable sexually transmitted infections. Women assume a substantially larger burden for chlamydia and gonorrhea. Cervical cancer, which is related to infection with certain types of a sexually transmitted human papilloma virus, accounts for a higher level of DALYs lost for females than any other single sexually transmitted infection, including HIV. Given the concentration of syphilis-

Table 6 DALYs Lost, 1990 and 2000
Baseline Estimates for STDs
and HIV
(thousands)

	Female	Male
STIs excluding HIV	925 (668)	544 (255)
–Syphilis	392 (122)	443 (143)
–Chlamydia	389 (404)	35 (40)
–Gonorrhea	145 (142)	66 (72)
Cervical Cancer	705 (483)	
HIV	375 (895)	1,283 (3367)

Source: Adapted from C. J. L. Murray and A.D. Lopez, eds. 1996.

related DALYs among young children, mother-to-child transmission of syphilis appears to account for much of the impact of this disease on mortality and morbidity. Although HIV continues to exact enormous costs on the male population, the level of burden is projected to rise among women. Notably, the burden for HIV is slightly higher for 5- to 14-year-old females than it is for 5- to 14-year-old males (see table 6).

HIV/AIDS. According to data from 1991 to 1996, the incidence of AIDS in the region is increasing, especially in the English-speaking Caribbean and Central America. Men who are infected continue to outnumber women: the ratio for reported cases in 1996 was 3.2 in Latin America and 1.7 in the Caribbean. However, the “gap” is narrowing, reflecting the increasing numbers of HIV-positive women, especially in the Caribbean. Additionally, the current female prevalence estimates—based largely on women in prenatal care clinics—may

underestimate the levels of infection among all women. Some evidence indicates that levels are higher among all women than they are among those in prenatal care clinics (PAHO 1998).

The primary transmission mechanism is unprotected sexual contact. In Latin America, homosexual or bisexual behaviors are implicated in 45 percent of the cases while heterosexual contact figures as the major risk factor in 75 percent of the Caribbean cases (PAHO 1998). In some countries, intravenous drug use is having a major impact. In Brazil, for example, research conducted since 1990 indicates that one-third of all injecting drug users in major urban areas are HIV positive.

The epidemic is increasingly concentrated among the most disadvantaged population groups, especially those with low education and poor access to basic health-care services. HIV prevalence levels are especially high among some commercial sex workers; in San Pedro Sula, Honduras, HIV prevalence among commercial sex workers has ranged from 15 to 20 percent since 1989. Research findings also suggest that HIV/AIDS is occurring among increasingly younger population groups, with infection acquired during adolescence. In the Southern Cone, for example, the median age among AIDS cases was 32 from 1983 to 1989. The median has dropped to 27 years of age, according to data from 1990 to 1992 (PAHO 1998). As the epidemic matures, even if it started among intravenous (IV) drug users or men who have sex with men, it moves aggressively into the poor and female populations.

Cervical Cancer. On average, the countries of Latin America and the Caribbean have the highest cervical cancer incidence and mortality levels in the world, according to estimates from the International Agency for Research on Cancer

(IARC).¹² In general, incidence is high across many of the countries in the region, regardless of development status. Mortality levels, however, tend to be higher in the medium-low status and low status countries. Among regions, both incidence and mortality levels are highest in Central America, as compared with South America or the Caribbean. According to IARC data, Haiti has the region's highest incidence level, while Nicaragua has the highest mortality level (among the countries depicted in table 7). The trends for the region overall suggest that mortality related to cervical cancer has not declined significantly.

Early diagnosis of cervical cancer is essential for successful treatment. In North America, dramatic declines in cervical cancer are largely due to the widespread availability of routine vaginal cytology screening or Pap smears. In the Metropolitan Region of Santiago, Chile, 10 years of sustained screening have led to a decline in cervical cancer mortality from 13.9 per 100,000 in 1985 to 8.7 per 100,000 in 1997. Screening programs in Cali, Colombia, have also shown measurable decreases in mortality.

Overall, an estimated 63 percent of Latin American women have had a Pap smear at least once in their lifetime. Large differences in coverage, however, have been documented across countries. For example, survey data suggest that 35 percent of women in Nicaragua have had a Pap smear at least once, compared with 70 percent of women in Costa Rica (PAHO 1998). Evidence also indicates large differences in Pap smear coverage by age, education, income, and residence. Various studies conducted in the region—in Brazil, Chile, and Mexico, for example—indicate that women from lower socioeconomic levels are less likely than their better-off counterparts to know of the Pap test or to have undergone a test (Robles 1996).

Table 7 Incidence of and Mortality Due to Cervical Cancer per 100,000 Women, Age-Standardized Rates by Country Grouping, (1990 Estimates)

	Incidence	Mortality
High Status		
Argentina	27.60	9.50
Chile	28.52	12.13
Costa Rica	24.96	12.13
Panama	42.58	13.92
Uruguay	25.64	7.87
Medium-High Status		
Brazil	30.55	16.36
Colombia	31.58	16.10
Dominican Republic	23.59	20.45
El Salvador	33.99	19.34
Jamaica	44.12	21.31
Mexico	45.32	16.19
Paraguay	41.10	22.04
Trinidad and Tobago	22.39	13.89
Venezuela, R. B. de	26.78	15.17
Medium-Low Status		
Bolivia	51.40	26.19
Ecuador	28.45	23.46
Guatemala	43.95	23.65
Honduras	43.95	23.65
Nicaragua	61.33	32.83
Peru	39.45	21.46
Low Status		
Haiti	91.46	21.96

Source: Parkin and others 1999. International Agency for Research on Cancer; WHO GLOBOCAN I database.

In Honduras, survey data also confirm that women from lower socioeconomic levels and rural areas are much less likely to have undergone a Pap smear than are women from better-off groups. Among those who have undergone a Pap smear, poorer and rural women are also less likely to know the results of their last test. Older women, at higher risk for the disease, are more likely than younger women to have *not* had a Pap smear for

at least four years (screening is often recommended at intervals of once every three years, after two consecutive annual negative results).

Poor or uneducated women are less likely to have had a Pap smear than better-off groups, and research indicates that mortality levels are higher among poor or uneducated women than among their better-off counterparts. In Quito, for example, researchers found that less-educated women (with a primary education or less) had nearly twice the incidence of cervical cancer of those with secondary or higher education (Corral and others 1996). The authors also found that women with the lowest educational levels tended to be diagnosed with later stages of cervical cancer (III or IV), which are associated with poor survival prospects. In contrast, women with higher education were diagnosed earlier (PAHO 1998).

Women Face a Large Burden from Chronic Disease, and the Poor, Rural, and Uneducated Individuals Are Most Affected

The disease burden represented by a number of chronic or noncommunicable illnesses is higher for women than men. The relative female burden for cardiovascular disease is higher for women between the ages of 15 and 44 years old, and among those 60 years old and older. Women have a larger burden for cancers, with cancer DALYs peaking at younger ages for females (45 to 59 years old) than for males (60 years old and over). Breast and cervical tumors in women occur at an earlier age than the most common malignant tumors do in men (PAHO 1998). Breast cancer takes a toll on women from the age of 15 onward. The burden for colorectal cancers is higher among women aged 45 and older than men in the same

group. Although diabetes-related mortality is increasing among men, the DALYs lost among women are still substantially higher; the difference is maintained from age 15 onward. Musculoskeletal diseases, which can dramatically affect physical function and mental health, take a much larger toll on women than men (see table 8). The differential begins at age 5 and is maintained throughout the life span.

The pattern of incidence and prevalence by socioeconomic conditions is complex. Cardiovascular disease, diabetes, and, as seen above, cervical cancer tend to be more problematic among poorer populations. Conversely, breast cancer

tends to account for a larger share of mortality among better-off populations, probably because of patterns of reproductive risk factors, such as delayed childbearing among richer and better-educated women.

Cardiovascular Disease. Among noncommunicable illnesses, cardiovascular diseases account for the highest amount of DALYs lost among women.¹³ Projections suggest that 31 percent of deaths from all causes in the year 2000 will be due to cardiovascular diseases.

Premature mortality from cardiovascular diseases varies from one country to another. For women, the country with the highest years of potential life lost (YPLL) is Argentina, followed by Trinidad and Tobago, Brazil, and El Salvador. The lowest rates for both women and men are in Canada, Chile, and Costa Rica. Trend analyses conducted by PAHO indicate that 6 out of 13 countries studied have had a significant decline in YPLL: Argentina, Mexico, Chile, Colombia, Costa Rica, and Trinidad and Tobago. Rates in El Salvador appear to have been increasing since the 1970s. Generally, rates for cerebrovascular disease have declined except in Cuba, El Salvador, and the República Bolivariana de Venezuela. Hypertension is a major risk factor for the development of cardiovascular disease. In most countries, the YPLL rates are higher for men than women. Women, however, had consistently higher YPLL rates in Barbados, Colombia, Mexico, and Nicaragua (PAHO 1998).

Chile, one of the countries with the most favorable mortality statistics, illustrates male-female and socioeconomic-related differences in cardiovascular disease. Overall, the rate of mortality from stroke is slightly higher for men (71.2 per 100,000) than for women (69.5 per 100,000)

**Table 8 DALYs Lost (thousands)
Selected Chronic Illnesses
1990 and 2000, Baseline
Projections (in parentheses)**

	Female	Male
Noncommunicable Disease	33,378 (26,719)	33,014 (29,077)
Cardiovascular Disease	7,345 (4,454)	7,451 (5,323)
–Ischaemic heart disease	2,666 (1,663)	3,019 (2,213)
–Cerebrovascular disease	2,404 (1,502)	2,267 (1,658)
Chronic Obstructive Pulmonary Disease	779 (663)	965 (768)
Malignant Neoplasms	4,647 (3,106)	3,706 (2,631)
–Breast cancer	806 (552)	
–Colon and rectum cancers	251 (168)	204 (152)
Diabetes Mellitus	1,450 (832)	1,032 (683)
Musculoskeletal Disease	2,764 (2,370)	1,740 (1,493)

Source: Adapted from Murray and Lopez 1996.

for the period 1994–96. Looking across socioeconomic groups, however, it is clear that the overall male-female differential obscures some female disadvantage among the lowest-income (and least-educated) populations: On an age-adjusted basis, Chilean men with no education have a stroke mortality rate of 84.5 per 100,000, compared with 32.9 per 100,000 among highly educated Chilean men. Among women, those with no education die from stroke at the rate of 93.6 per 100,000, compared to 27.4 per 100,000 among women with more than 13 years of education.

Hypertension, one of the primary risk factors for stroke, affects an average of one-quarter of adults in Latin America and the Caribbean, according to PAHO estimates. The high prevalence represents an important challenge for the health system because proper control of hypertension can reduce five-year mortality from stroke by 51 percent among those under age 60.

Diabetes Mellitus. The number of people with diabetes in the Americas—currently estimated at 13 million—is projected to rise 45 percent by the year 2010. Projections suggest that dramatic increases will occur in Central America and the Caribbean Islands (PAHO 1998). Throughout the region, female mortality exceeds male mortality: the ratio is 1.2 to 1 in Latin America, unadjusted for age. Two major factors are associated with greater relative female disadvantage: First, women are more likely to develop Type II (non-insulin dependent) diabetes than men. Second, women live longer, with a higher lifetime probability of developing the disease. Socioeconomic factors, however, are also probably involved. In general, persons with diabetes in the region are about twice as likely to die from the disease than are those with diabetes in North America (PAHO 1998).

Risk factors for Type II diabetes include a number of modifiable factors amenable to primary prevention, including hypertension, obesity, a sedentary lifestyle, and upper-body obesity. The level of complications among those with diabetes can be lowered by addressing risk factors such as smoking and high blood pressure (PAHO 1998). Diabetes-related mortality increases with age (Brownson and others 1998).

Primary prevention measures for diabetes include a well-balanced, low-fat diet; weight control; and consistent physical activity (Brownson and others 1998). Obesity is increasingly common among women, especially with age. In the United States, research suggests that women tend to be less physically active than men in leisure time; self-estimates of physical inactivity during leisure time are 26.5 percent for men, compared with 30.7 percent for women. The differences are especially striking at age 75 and older, when 50.5 percent of women report physical inactivity during leisure, compared with 38.2 percent of men (Brownson and others 1998). Recent survey data from Chile suggest higher levels of inactivity and larger disparities between women and men: 93 percent of women reported physical inactivity, compared to 78 percent of men.

Cancers. In general, mortality levels related to cancers are rising in the region. PAHO analyses indicate that increases are registered at earlier ages (25 or 30 years old) and are more widespread among women. Population aging is implicated in cancer-related mortality increases. In the region, there were an estimated 344,000 cancer-related deaths in 1990. Female deaths exceeded male deaths (176,000 and 168,000, respectively). According to projections for the 50-year period beginning in 1990, however, the number of deaths

from cancers is supposed to reach parity among women and men in the year 2000 (PAHO 1998).

According to PAHO, the leading causes of cancer deaths among women in 1990 were colorectal cancers, followed by breast cancer and uterine cancer. Breast cancer mortality levels were higher in the more developed countries in the region, while uterine cancer was more common in less developed countries. This may, however, be partly an artifact of different recording procedures (PAHO 1998). In the region, among malignant neoplasms, breast cancer accounts for the single highest number of DALYs lost for women.

Breast cancer incidence is highest in Uruguay (88 per 100,000), with a level exceeding that of Canada and on par with incidence in the United States. The next highest incidence levels in the region are found in the high status country of Argentina, followed by Jamaica and Trinidad and Tobago. The lowest incidence levels per 100,000 are found in Haiti (5), El Salvador (13), and Nicaragua (16).

The mortality rate is highest in Uruguay (26 per 100,000), exceeding the rates found in Canada or the United States. The next highest rates are found in Jamaica (25), Haiti (24), Argentina (22), Brazil (21), and Trinidad and Tobago (19). Despite having the lowest incidence level, Haiti—the region's only low status country—has one of the highest mortality rates (23.61 per 100,000). Breast cancer mortality is generally higher among women aged 50 and older, and increases with age (Gomez 1997).

Although mortality rates in the region are generally lower than those found in North America, the rates of increase are high in many countries in the region. From 1965 to 1985, for instance, the mortality rate increased by approximately 4 percent in Uruguay and Chile and 17

percent in Costa Rica. Among subregions, breast cancer mortality rates exceed cervical cancer rates in the Caribbean and South America.

There is still much controversy over breast cancer screening methods, in particular their cost-effectiveness and positive predictive value in countries with low prevalence of disease. In industrial countries, only mammography screening for women aged 50 and above has demonstrated a significant reduction in mortality (approximately 23 percent), and there is increasing evidence of the efficacy and cost-effectiveness of treatment in early stages of the disease (Galani and Robles 1998).

Multiple Risk Factors. It is now clear that risk factors tend to cluster in certain population groups, and that the behaviors to which they are associated are complex in nature and change over time. Thus the best way to learn about the distribution of those risk factors in the population is through surveillance, which by definition requires continuous data collection. Along the same lines, interventions to prevent and control risk factors, among those both with and without associated conditions (such as diabetes and hypertension), need to be multifactorial, targeting sets of risk factors in various ways, through health services based on prevention as well as on health-promotion strategies.

It has been suggested that the higher rates of diabetes among women and the difficulties in hypertension and diabetes control are associated with higher levels of obesity and physical inactivity. Recent PAHO surveys indicate that in Bolivia 56.6 percent of males and 64.7 percent of females are overweight, while 26.1 percent of males and 30.3 percent of females are obese.¹⁴ In Chile 60.3 percent of males and 63.1 percent of females are

overweight, and 17.3 percent of males and 23.4 percent of females are obese.

Physical activity is considered to be the single behavior that can lead to modifications of the other two major risk factors (diet and smoking). In a survey in Chile, 93 percent of women and 78 percent of men were reported to be physically inactive. Physical inactivity also has economic consequences—in the United States, the costs associated with physical inactivity and obesity accounted for 9.4 percent of the national health expenditure in 1995 (Colditz 1993).

Tobacco consumption is the major risk factor for noncommunicable diseases. According to available data in North America and Latin America, between 1996 and 1999 tobacco prevalence in the population ranged from a high of approximately 40 percent in Argentina and Chile to a low of 22 percent in Colombia. In some urban areas, more than half of young people smoke. Among men, the percentage of the population who smokes ranges from 47 percent in Argentina and Chile to 26 percent in Colombia. Among women, the high is 36 percent in Chile, with a low of 16 percent in Peru.

Table 9 Prevalence of Smoking by Sex and Country

(per 100 inhabitants, for latest available year)

Country/year	Males	Females
Argentina 1999	46.8	34.0
Chile 1998	47.2	35.5
Uruguay 1999	38.0	26.0
Bolivia 1998	42.7	18.1
Colombia 1996	25.2	12.1
Peru 1998	41.5	15.7
Costa Rica 1995	28.6	6.6
Mexico 1993	38.3	14.2

Source: PAHO 2000.

In Latin America and the Caribbean, countries in which the prevalence of smoking is high, the male-female ratios are lower; in low prevalence countries these ratios are higher. Among women, the prevalence of smoking increases with educational status, but among males this trend is not as clear. There is evidence that the epidemic has taken a different course among women than among men, which may reflect differences in marketing strategies. Women exhibit a higher prevalence of smoking in higher-income countries and in countries with more women in the workforce, which is likely related to a greater capacity to purchase tobacco products and the greater social acceptability of women smoking (Robles 1993).

What Does This Information Tell Policymakers and Program Managers?

Drawing inferences for policymakers and program managers over a large number of countries with varied health-care settings and resource constraints (and inadequate data) is risky, but several messages stand out. The foregoing review demonstrates that there are serious gaps in policies as they affect the health of women, particularly of poorer and less-educated women. Simple and fairly obvious recommendations are the following:

- ✦ Countries now falling into the low status and medium-low status categories should focus resources on improving basic reproductive health conditions. The interventions required are relatively low cost, in general, and yet have major pay-offs in terms of health conditions and human welfare. Provision of appropriate family planning methods to women who want to control their fertility, providing early and reliable prenatal and es-

sential obstetric care, fostering good nutrition, and developing specially targeted services for women at high risk for sexually transmitted infections, should all be very high on the public priority list. These services have broad benefits for households and society at large, and are arguably among the most cost-effective investments that governments can make.

✦ In medium-high and high status countries, the government also has a role in ensuring the availability of these core services. For the same reasons as above, the public sector should focus on reaching the poorest 20 to 40 percent of the population with precisely these basic reproductive health services, to reduce the large gap in women's health conditions between the poor and the better-off segments of the population.

✦ At the same time, there is clearly room for specific types of public action to address the growing problems of chronic disease that affect both men and women, although the nature of these health problems—potentially very high cost, particularly given technological advances, and with limited benefits to society at large—requires careful thought about the level, distribution, and mechanism for public investments. For example, governments have an important role in promoting cost-effective screening and preventive interventions, such as cervical cancer screening directed at women who are at high risk of contracting the disease, and supporting cardiovascular disease-prevention programs, particularly for low-income populations that are at disproportionate risk and have few resources.

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Delivery and Financing of Women's Health Services

Chapter Summary

- ❖ Spending on women's health services accounts for about one-quarter of public health spending and nearly half of household spending on health. Thus, making this spending more effective can improve the overall efficiency of the sector.
- ❖ The volume of (and growth in) spending on women's health services shows large pay-offs, particularly in reproductive health outcomes: fertility decline, more births attended by professionals, and contraceptive use. However, there are big differences in the extent to which spending meets needs by income level: women from the lowest-income households report the most illness, but taking "need" into account, poor women obtain lower levels of health care than do their better-off counterparts.
- ❖ There is little evidence that women are more disadvantaged than men with respect to household resources for health services, and insurance coverage is equal between men and women (although concentrated in highest-income households).
- ❖ To address the unfinished agenda for reproductive health, the poorer countries will need to mobilize substantially more resources for reproductive health from outside or within the health sector—a difficult task in times of declining external support and growing attention to other public health concerns (such as HIV/AIDS). In both better-off and poorer countries, the demand by poorer women must be stimulated and made effective.

The information presented in the previous chapter demonstrates some of the central challenges facing the health systems of Latin America and the Caribbean in responding to the health-care needs of women. This chapter addresses the question of who is currently using health services, how those services are financed, and how to estimate the public and private resources that would

be required to meet the growing demand for women's health services.¹⁵

This analysis has both conceptual and empirical limitations, but it represents a step toward formulation of appropriate national and donor policies. Little empirical research exists in the region on the gender dimensions of perception of health problems, the decision to seek care, or health-service utilization and spending. This chapter seeks to employ the rich data sets provided

This chapter contains contributions by Dara Carr.

by nationally representative household surveys, institutional budgets, and expenditure studies in seven countries (Brazil,¹⁶ the Dominican Republic, Guatemala,¹⁷ Jamaica, Mexico, Paraguay, and Peru). These countries were selected because of the availability of household survey data and geographical representativeness; all correspond to either the medium-high or medium-low countries in the typology. The discussion that follows refers only to data from these seven countries.

Characteristics of Women's Health Services

Types of Providers and Services Provided.

Health-care delivery systems in Latin America and the Caribbean can be categorized in four sectors. The *public sector* includes government and social security-run hospitals, clinics, and health posts. The *not-for-profit sector* includes charitable and nongovernmental organizations (NGOs). Private individual practitioners, private hospitals, clinics, and pharmacies make up the *organized private sector*, while an *informal private sector* of traditional healers and lay midwives also exists. Each sector comprises a greater or lesser share of utilization and spending in each country depending on the organization of the health system and socio-cultural practices, but all exist in every country.

Public sector provision is the most common source of women's health services, although the private sector does provide a sizeable share of services, even in poor communities. In the countries studied, having perceived a medical problem, most women seek care in the public sector or from publicly financed private providers—ranging from 42 percent of all visits in Paraguay to 76 percent in Brazil. Insurance coverage is concentrated in the upper-income quintiles and ur-

ban areas, is mostly public (except in Paraguay), and women and men benefit equally.

Wealthier women are more likely to seek care in the private sector, although there is significant use of public services by the upper-income quintiles. Women, even in the poorest 20 percent of the income distribution, are more likely than men to seek care in private health facilities or pharmacies. The use of private facilities as the first site of care among the poorest quintile ranges from lows of 5 percent among females in Brazil¹⁸ to highs of 29 percent of first visits among females in Paraguay.

Need, Access, and Utilization. Recognizing the complexity of using self-reported illness, in these seven countries more females report health problems than do males, across age and income groups, and this difference is highly significant. For both sexes, health problem reporting decreases as income increases. Country effects are also statistically significant. Jamaica, the country with the fewest reported health problems, was used as the reference country, so that all results are relative to Jamaican figures. The results show that health problem reporting in Mexico is 8 percentage points higher than in Jamaica, while in Peru it is 26 points higher. While survey question design may be playing a role in these results, these differences in reporting also reflect underlying health conditions, institutional settings, and the availability of public and private resources.

To assess how sociodemographic and economic factors influence the decision to seek care, the case of the Dominican Republic was examined in greater detail (see box 1). The odds that a female will seek care in the event of a health problem are about 25 percent greater than they are for her male peers. Females from 0 to 14 years

old and over 65 years old, in urban areas, wealthy, and insured are the most likely to seek care, by large and significant proportions. Health status and the perceived severity of the health problem also have strong and highly significant effects on the probability the person will seek care.

Women's greater perceptions of illness have been viewed as a function of greater objective need for care. Other information, such as the burden of disease studies and mortality data, shows that higher levels of morbidity and mortality are present among boys and men in the region up to age 60. However, male reporting on health problems is well below what might be expected, given these statistics. This may reflect that the male burden of disease has different characteristics (accidents and violence), which may lead to health problem reporting or, as will be seen later on, which may lead to more intensive use of health services. Alternative explanations interpret

women's higher levels of illness perception as a function of learned behavior patterns.¹⁹

Nevertheless, women do report more illness, and this has an impact on the use of services: females consume more outpatient and inpatient health services than do males across all the countries studied. After accounting for pregnancy and childbirth,²⁰ which generates health-service use by most women, women consume more health care than men of comparable age and income.

The household surveys analyzed provide mixed evidence of higher rates of health-care use during the reproductive years, which might be partly related to data deficiencies. In Peru and Jamaica, women in the 15- to 45-year-old age group are most likely to use services, after children who are 0 to 15 years old. However, in Paraguay, Brazil, and the Dominican Republic, women between 15 and 45 years old are the least likely to seek care.

Explanations for females' more intensive use of health services are similar to those presented for health-problem perception, with the addition of a hypothesis regarding the health-care delivery system. The health-care delivery system may contribute to women's greater perception and use of health services through, for example, funding mechanisms supporting specific women's services or increasing "medicalization" of menstruation, pregnancy, birth, and menopause. A tradition of vertical programming in maternal and child health and family planning in the region may encourage greater utilization of services by females. Moreover, if females make more visits, they are also exposed to more opportunities for symptom-reporting; testing and diagnoses; false-positive test results; and iatrogenic conditions, all of which may, in turn, contribute to greater subsequent utilization.

BOX 1

What increases the odds of seeking care?

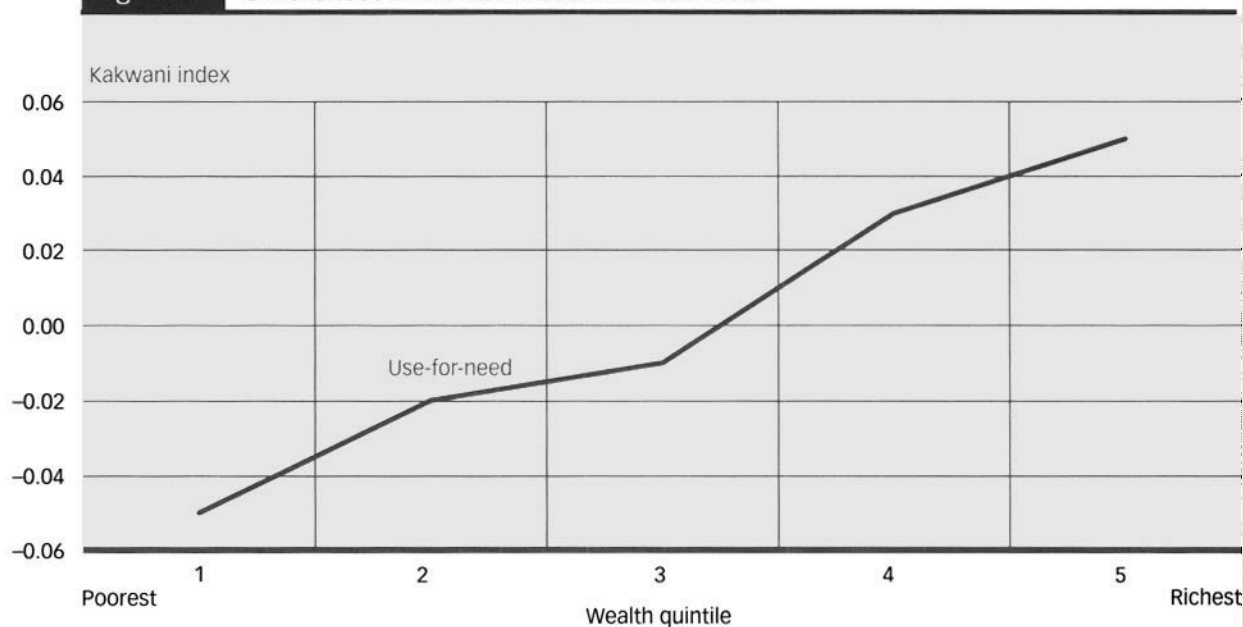
To assess how sociodemographic and economic factors influence the decision to seek care, the case of the Dominican Republic was examined in greater detail. The odds that a female seeks care in the event of a health problem are about 25 percent greater than the odds that her male peers will seek care. Females aged 0 to 14 years old and over 65 years old, in urban areas, the wealthy, and the insured are the most likely to seek care, by large and significant proportions. Health status and the perceived severity of the health problem also have strong and highly significant effects on the probability of seeking care.

As suggested in the first chapter, several factors determine whether or not women have access to and take advantage of health-care services: household income, opportunity costs, cost of services and transport, availability and quality of services, cultural preferences, and an awareness of the need to seek treatment. Reasons for non-use are one means to explore access constraints and explain utilization patterns. In response to questions on reasons for non-use given the presence of a health problem, most women reported that they considered treatment unnecessary, presumably because the severity of the health problem did not warrant a visit, or because they were unaware of the need to seek treatment. The exception to this pattern is in Paraguay, where self-medication was given as the most important reason for non-use, perhaps due to the limited availability of services. The cost of services and transport were the second and third most common reasons for non-use in all countries studied. However, the impact of cost, transport, availability, and quality of care on the likelihood of health-service use appears to affect women and men equally.

Upper income groups are much more likely to seek care in the case of a health problem. This highly significant difference is about 18 percentage points on average for the sample of countries studied. This phenomenon is observed in both sexes, though a significant difference exists between women and men in the lowest-income quintile, and it is likely that access and cost are factors driving this differential. Place of residence also has a dramatic effect on the decision to seek care, with rural females 11 percent less likely on average to use services once a health problem has been identified. The greatest gaps in use between rural and urban residents exist in Peru, the Dominican Republic, and Jamaica.

Another means to explore the need-utilization relationship among females is in the analysis of equity,²¹ using methods developed to measure whether persons with equal health "need" are obtaining similar amounts of care.²² Figure 4 illustrates the degree of inequality in the distribution of medical care among women in Brazil, a pattern that holds in the other countries studied. Controlling for the effects of age and health need, women in the lowest-income quintile use fewer services than their need would suggest. The opposite is true of upper-quintile women who use more services than they "need." Need-based use is most equitable in Jamaica, followed by the Dominican Republic, Paraguay, Peru, and Brazil.

In the countries studied, household surveys offer little evidence of gender bias unfavorable to girls and women as a group, in terms of access to and utilization of health services, a finding that has been confirmed by other research in the region.²³ However, the results differ somewhat from those found in studies carried out in other regions,²⁴ particularly with regard to spending, as will be seen in the next section. Across age and income groups, females report more health problems (chronic and in the last 30 days), and seek treatment for these problems, more often than do males. However, the profound differences in access to care related to income, place of residence, and insurance coverage set the gender issue in context. Females in the lowest-income group report the highest burden of health problems relative to both males and females in other income quintiles. Although a greater proportion of these women have a health problem, they are the least likely to seek treatment. Inequity is concentrated in this group: at the same level of

Figure 4 Differences in Women's Use-for-Need Brazil

need, poor women do not receive similar levels of care.

Financing of Women's Health Services

Total Health Spending and Its Impact on Spending on Women's Health.

The analysis of health expenditure should be interpreted in the context of a regionwide transition, in which the role of the state as a service provider is being modified to a regulatory role, and many political and administrative functions are being decentralized. Public health expenditure in the countries studied has fallen to a weighted average of less than half (44 percent) of total health expenditure. In the Dominican Republic, public expenditure is least important, which may be associated with recent growth in private care-seeking, especially private hospital care. In Guatemala, where health reform has increased public spending substan-

tially, government spending accounts for 60 percent of the total. These changes include women's health services.

Public Spending on Women's Health. For our purposes, public spending on women's health consists of public spending on services and products among whose objectives are the maintenance or improvement of women's health. This includes programs that target women specifically, such as maternal care, as well as any curative or preventive care utilized by women. On average, it accounts for 24 percent of all health spending in the seven countries studied, ranging from 16 percent in the Dominican Republic to 35 percent in Guatemala (see table 10).

Public spending on women's health per female inhabitant shows marked differences, from US\$150 to US\$25 in the extreme cases, with per capita spending six times larger in Brazil than in Guatemala. The growth of public spending on

Table 10 Public Spending on Health and Total Public Spending on Women's Health by Type of Institution, 1997

Country	Public Health Spending as percent of GDP	PSWH (millions of US dollars) ^a	PSWH as percent of GDP	PSWH as percent of Public Health Spending	PSWH per woman (US dollars)	PSWH per woman (US\$ at PPP)	Percent PSWH provided by Social Security Institutes
Brazil	3.0	12,045	1.6	24	151	201	100
Mexico	2.0	3,960	1.2	23	84	166	77
Peru	2.0	705	1.1	26	59	104	33
Paraguay	2.5	131	1.3	18	55	75	38
Dominican Republic	1.8	144	1.1	16	53	111	34
Guatemala	1.4	139	0.8	35	34	89	51
Jamaica	2.7	68	1.4	20	25	61	NA

PSWH: public spending on women's health; GDP: gross domestic product; PPP: purchasing power parity dollars.

Source: Hernandez and others 2000.

a. Includes expenditure on reproductive and non-reproductive health.

women's health is strongly and significantly associated with fertility decline, greater coverage of obstetric care by trained medical professionals, and contraceptive use up to a certain level of spending.

Public spending on health primarily includes two types of institutions—ministries of health and social security institutes—which together execute approximately 85 percent of all public spending on women's health. Frequently, other public institutions provide services to specific population groups, but the amount of their resources and services is much smaller. This is the case with institutions whose primary function is not the production of health services, but that provide coverage to workers through their own infrastructure or through contracting mechanisms (see box 2). Similarly, there are special funds for activities or coverage of specific population groups (such as indigenous peoples, the elderly, and the poor) which form part of public budgets

but provide a group of interventions including, but not limited to, health services. These institutions account for 14 percent of public spending on women's health, on average.

Unmet Needs and the Spending Gap

If many countries in Latin America and the Caribbean are spending large sums on women's health—and they are—and if, as shown in chapter two, significant portions of the female population experience poor health and are not using basic health services, then the question arises: Should governments in the region spend more to increase coverage, or should they allocate their current spending differently, or both? The question can perhaps best be answered by looking in depth at a specific country's spending and service delivery patterns, health conditions, and

population characteristics. The question can also be addressed, in a limited way, by comparing what is currently spent on women's health services with the recommended amounts for a package of core reproductive health services.²⁵

For the countries included in the present analysis (see table 11), this "rough" assessment of the spending gap indicates that there is little or no funding deficit in Brazil, Mexico, or Jamaica, all of which are medium-high status countries. Financing of the core reproductive health services²⁶ might require reallocation and improved efficiency, but no significant influx of funds. In Paraguay and the Dominican Republic, also medium-high status countries (although with lower GDPs), marginal additional resources—from 11 to 15 percent of current public spending on reproductive health—would be required to finance the core reproductive health services for the entire population. In contrast, in the medium-low status countries of Peru and Guatemala, public spending on reproductive health services would have to increase by about 25 to 50 percent in order to achieve the target.

It is important to note that these estimates do not fully take into account the current and expected declines in external assistance to reproductive health services. The LAC region received 13 percent of international reproductive health financing in 1996, amounting to approximately US\$195 million, with half of the funds going to NGOs. A third was channeled bilaterally, principally through the U.S. Agency for International Development (USAID), and 16 percent was provided through multilateral agencies, such as the United Nations (UNFPA 1996).

About half of reproductive health spending in the LAC region is financed through external assistance. National spending as a share of total

BOX 2

Other public institutions can be important actors in the health sector.

- ✦ In the Dominican Republic, the presidency of the republic finances 16 percent of PSWH through infrastructure investment and equipment purchases for health facilities, and the Program of Essential Medications is responsible for the purchase, storage, and distribution of medication to ministry of health hospitals, the primary care network, and the "popular pharmacies."
- ✦ In Mexico, in addition to the ministry of health, there are four institutions that provide services to the uninsured, and social security is offered by five institutions. These latter organizations (SSA, IMSS, and ISSSTE) represent 88 percent of public health expenditure in the country. The institutional complexity of health systems does not necessarily generate higher levels of expenditure.

spending on reproductive health is on the increase, but does not fill the financing gap caused by withdrawal of multilateral and bilateral reproductive health funding from the LAC region to support more economically disadvantaged regions. For instance, USAID, a major player in the health field and one of the principal supporters of reproductive health in the LAC region, has reduced health funding to the region as a whole and closed down its health, nutrition, and population programs in several countries. Funding for population and reproductive health programs in the LAC region declined by 15 percent between fiscal years 1997 and 1998, and has remained

Table 11 Public Spending Gaps for a Basic Reproductive Health Package, 1997

Country	Public Spending on Reproductive Health per woman (PPP US\$)	Package as percent of 1997 PSRH	Gap (millions US\$)
Brazil	34	52	No gap
Mexico	33	63	No gap
Paraguay	8	139	15
Jamaica	11	94	1
Peru	12	100	23
Dominican Republic	27	117	11
Guatemala	26	170	54

PSRH: public spending on reproductive health; PPP: purchasing power parity.
Source: Hernandez and others 2000.

stable since then (from US\$74 million in 1997 to US\$63 million in 1999). In contrast, funding for child survival programs in the same period first declined by 26 percent but later was replenished in full, to begin and end with approximately US\$53 million. Furthermore, USAID closed all of its health operations, with the exception of HIV/AIDS, in Mexico and Colombia. Aid to Brazil ended in 2000 and health support to Ecuador will end in 2001. Retrenchments by USAID will continue in future years in countries that have not yet been identified.

Private Spending on Women's Health. To determine the variations in the share of spending that can be attributed to sex, income level, and country of origin, group averages were analyzed. Independent of income level or country, household spending on female health exceeds that of males by about 1 percentage point of total household spending. Women report more health problems, and seek care for those problems, more often than men. All else being equal, household expenditure should be higher for females.

In this sample of females and countries, the percent of income spent on health care falls as income increases. The wealthiest quintiles spent between 1 and 2 percentage points less on health out of their total household budget than does the first quintile, while the second and third quintiles are not significantly different from the poorest. This result may reflect the confounding effects of insurance coverage, which is most prevalent among the upper-income quintiles. Most other studies have found health care to be income-elastic, which is reflected in a rising share of expenditure on health as income increases.

As a share of total household expenditure, low-income households spend slightly more for health-care needs of females than do households in higher-income quintiles. In the Dominican Republic and Paraguay, this effect is more pronounced, perhaps due to the limited coverage of public subsidies in these countries.

The composition of health spending by women 15 to 45 years old shows that women in this age group are most likely to spend on medicines, from 48 percent of all expenditures in Brazil

to a high of 92 percent in Paraguay.²⁷ In all countries studied, the share of expenditure allocated to medicines is highest in the lower-income quintiles. There are several possible explanations for this phenomenon. It may reflect higher levels of self-medication but may also show that medication is less likely to be subsidized at the point of service as compared to the costs of the visit itself. This is the case for uninsured and low-income women, for whom relative expenditures on medicines are thus likely to be higher.

Outpatient and inpatient expenditures are the next largest categories of spending, and vary greatly depending on the health system. In Jamaica and in the Dominican Republic the greatest share of expenditures is allocated to outpatient care, largely due to the importance of the private sector in the provision of outpatient treatment. In Jamaica, 64 percent of expenditures went to outpatient care, 37 percent specifically to private providers, reflecting that public outpatient services are heavily subsidized through the National Health System. In the Dominican Republic, 74 percent of expenditures are in outpatient care, with 67 percent going to private providers, reflecting a different phenomenon of lack of availability of services and quality of care in the public sector.

The share of expenditures devoted to hospitalization is relatively small, a surprising finding within the reproductive ages. On average, hospitalization consumes less than 15 percent of out-of-pocket spending in Brazil, Jamaica, and the Dominican Republic. In Peru, hospitalization represents the second largest expenditure category after medicines, but the share rises sharply from 9 percent of expenditures in the first quintile to 27 percent in the fifth quintile. Of the 21 percent of private spending going to hospitals in Peru, about two-thirds goes to public hospitals, while 8

percent goes to private facilities, though this ratio is reversed in the upper-income quintiles.

Households at all levels of income are utilizing public and private health services, and households at all levels of income are receiving some level of subsidy in the public sector. This is due in part to the participation of social security services in the public sector, which include upper income groups; it is also related to the fact that often the most complex and technologically advanced services are available only at large public hospitals.

What Does This Information Tell Policymakers and Program Managers?

These analyses, although limited, carry both good news and bad. The good news is that in many countries in the region the public sector is demonstrating the priority it gives to improved women's (and particularly maternal) health by devoting a considerable share of all government spending to women's health programs. Good health conditions for women—and particularly dramatic improvements in reproductive health outcomes over the past 15 years—demonstrate the effectiveness of such spending. The absolute levels of spending on reproductive health are likely to be close enough to finance a relatively comprehensive set of cost-effective services that are unlikely to be provided by the market without government action. In addition, although insurance coverage is concentrated in the upper-income groups, there is little evidence that it is biased against women. These are indications that policies of both donors and national governments in much of the region have had positive outcomes.

The bad news is twofold. First, in the countries where spending on women's health services and service utilization is relatively high, the evidence shows that poorer women are missing out to a large extent. A combination of inadequate targeting mechanisms on the supply side, and important demand-side constraints, leads to serious and systematic gaps in coverage, and poor health outcomes.

Second, most countries in the region underspend on reproductive health (and non-reproductive women's health) services, relative to what would be needed to achieve coverage of a core package of cost-effective interventions that are unlikely to be provided if left to the market alone. The diminution in donor investments

in such health programs will soon amplify this problem. For these countries,²⁸ close analysis is required to determine the feasibility of, and mechanisms to achieve, a significant expansion of total resources for the health sector or a shift of existing resources toward the most cost-effective and needed reproductive health services, or both.

Reinforcing the actions that result in the "good news" and redressing the policy lapses that lead to the persistent "bad news" are potential outcomes of health sector reform efforts currently underway in the region. The following chapter discusses the links between health sector reform initiatives and women's health generally, and reproductive health specifically.

Women's Health and Health Sector Reform: Synergies and Risks

Chapter Summary

- ❖ To mobilize resources to complete the reproductive health agenda in poorer countries in the region, to better target reproductive health initiatives in better-off countries, and to finance chronic and emerging women's health problems require attention to the current direction of health reform.
- ❖ Health reform actions have better results when women's health concerns are carefully considered.
- ❖ Decentralization, public sector priority-setting, reorientation of financing arrangements, and modification in the roles of the public and private sectors all have the potential to benefit women's health, if appropriately designed.

The previous chapters highlighted the achievements and remaining challenges in improving women's health in Latin America and the Caribbean. To tackle those challenges, policymakers, technical specialists, advocates, community leaders, and others interested in women's health issues can take advantage of a major opportunity: Well-designed and well-implemented efforts to reform the health systems in Latin America and the Caribbean, which are now underway, can increase the quantity of, improve the quality of, and stimulate demand for women's health services. At the same time, it is essential to recognize that poorly designed and poorly implemented reform initiatives—those that ignore some of the critical gender-specific dimensions of the supply of and demand for health services—can erode past

progress in improving women's health in the region. This is true for both the better-off countries—where the challenge lies in greater efficiencies, better targeting, and stimulation of demand among the poor—and the poorer countries, where the primary objective is directing a greater volume of resources to meet persistent needs for essential, basic, reproductive health services.

This chapter focuses in two ways on the relationship between women's health and health sector reform. First, it provides a brief conceptual overview of the links between the two issues. Second, it draws upon regional (and international) experiences to extract insights about how four common elements of health sector reform—decentralization, public sector priority-setting, financing changes, and adjustments in the roles of the

public and private sectors—can have either positive or negative effects on women's health.

Women's Health and Health Sector Reform Are Two Sides of the Same Coin

Differences in professional training, ideology, politics, and even vocabulary between women's health specialists and advocates, on the one hand, and health sector reform specialists and advocates, on the other, often have had the unfortunate effect of limiting the discourse between two groups that have much in common. In this section, an explicit argument is made for the interdependence of women's health and health sector reform.

Why Should "Health Sector Reformers" Pay Attention to Women's Health? In its most stripped-down form, health sector reform (as manifested in developing countries) typically seeks to achieve three overarching objectives. First, it aims to improve the efficiency of the overall allocation of public resources within the health sector, so that public funds are directed toward the health services that will have the greatest positive impact on health conditions, but would not otherwise be provided by the market. Second, health sector reform seeks to provide incentives for the efficient production of services in both the public and private spheres, so that a given level of inputs devoted to an essential determinant of human capital formation (and a large player in the national economy) yields the greatest possible output. Third, it tries to improve the lot of the poor—or at least counteract historically regressive public policies—by focusing public spending on services that disproportionately ben-

efit lower-income, and other vulnerable, households. Meeting each of these objectives requires attention to women's health:

- ✦ Ill health among women, and particularly problems associated with reproduction, constitute a large share of the preventable morbidity and mortality in developing countries, and yet many of the health-care services to address those problems will not be provided in sufficient volume by the private sector, under current conditions.

- ✦ Many health interventions that fall into the category of reproductive health are highly cost-effective. This is particularly evident when taking into consideration both direct and indirect effects of maternal ill health on the woman and her family.

- ✦ Poor women are disproportionately affected by ill health, and targeting specific types of services serves as a relatively straightforward means of focusing resources on poor populations. In addition, given the intergenerational effects of poor maternal health, appropriate targeting to women's health services can have enduring positive effects in reducing poverty, or at least in reducing its effects.

Why Should "Women's Health Advocates" Pay Attention to and Participate in Health Sector Reform? Just as policymakers and others promoting health sector reform can meet their objectives most effectively by focusing attention on women's health, it is also the case that advocates of women's health can achieve their goals by recognizing the opportunities presented by particular aspects of health sector reform:

- ✦ Many women's health services have long been characterized by poor quality and lack of responsiveness to demand. Within health sec-

tor reform, instituting contracting arrangements, new demand-side financing mechanisms, strengthening of regulatory mechanisms, and decentralization of decisionmaking all have the potential to address these concerns.

✦ Finishing the reproductive health agenda requires more financial resources and better use of resources that already are invested in reproductive health. Again, health sector reform initiatives that seek both efficiency and equity improvements can serve to free up and refocus financial resources for this purpose.

✦ Financing nonreproductive health services is a complex task that will require mechanisms that go far beyond traditional public sector resource outlays. In particular, expansion of both public and private insurance systems is likely to be needed. As insurance coverage is extended, the benefits packages need to be reviewed for inclusion of reproductive health services and cost-effective care for women. Financial incentives to reduce unneeded procedures, such as inappropriate Caesarean sections, need to be reviewed as well.

Despite the common interests of those interested in improving women's health outcomes and the efficiency- and equity-oriented health sector "reformers," communication is often limited by the lack of formal channels and mechanisms to involve women's health advocates in the reform processes. In a few countries of the region—notably Mexico, Brazil, and Colombia—efforts are underway to incorporate women's health advocates and gender specialists into the dialogue about the direction of health sector reform. But these are the exceptions. In general, formal participation mechanisms have been limited, and both national governments and development part-

ners have done relatively little to ensure that issues of women's rights and other gender-specific concerns are discussed during debates on health sector reform.

The Links Between Four Elements of Health Sector Reform and Women's Health in Latin America and the Caribbean

This section highlights the relationship between women's health and four elements of health sector reform that are prominent in the region of Latin America and the Caribbean—decentralization, priority-setting, financing changes, and adjustments in the roles of the public and private sectors. The examples provided present a clear picture of the ways in which health sector reform can successfully address women's health needs in both better-off and poorer countries. At the same time, there are cautionary tales regarding the problems that can emerge when gender-specific financing and service delivery issues are not taken into account during policy formulation.

Decentralization. A common feature of reform programs is an emphasis on decentralization, which is intended to improve responsiveness to local needs, ownership, and accountability. However, whether these goals are realized and whether decentralization can have a positive impact on women's health care depend on *why* decentralization occurs, *how* it is carried out, and *who* is involved in its design and implementation. Decentralization in Latin America, as in the rest of the world, is often motivated by political considerations rather than by the need to improve efficiency and equity in the health sector. As Kutzin (1995) argues, this may exacerbate inequities,

because power is transferred from the center to regional elites, wealthier districts are able to raise more funds, and central governments transfer the burden of financing to lower levels of government, or a combination of the three.

Decentralization in the LAC region has taken on different forms. In Chile, primary health care has been devolved to municipalities, while hospital and public health programs have been deconcentrated to autonomous health-service areas (see box 3). Nicaragua has deconcentrated responsibilities to lower levels of the health system. Colombia has devolved responsibilities to departments and municipalities, while transforming hospitals into public corporations. The strategies and instruments used in conjunction with decentralization are critical to averting the risks mentioned above, and to facilitating the attainment of women's health objectives.

First, *formula-based transfers* have an important potential in redressing inequities in health-care access, and in improving coverage of primary health care, including women's health services. The use of transfer mechanisms varies tremendously across the region.²⁹ Mechanisms for transferring resources do not always take into account existing service capacity, which may leave some facilities poorly funded and unable to deliver the required package of women's health services. For example, in Bolivia the use of a simple per capita formula left tertiary referral hospitals in some regions short of funds (Aitken 1999).

Second, decentralization has also involved strategies aimed at *diversifying sources of funding* and improving resource mobilization, strategies which appear to have generated important benefits in primary health care.

Third, when resources are targeted for a well-defined *essential package of services*, which

reflects patterns of disease and takes into account cost-effectiveness criteria, this can also have a potentially positive impact on women's health services. By contrast, where the definition of women's health-care needs is left to the discretion of local authorities, this may not necessarily yield good results. Conservative attitudes among local leaders and reluctance of health workers may impede the integration of some interventions (such as STI screening and treatment) with other reproductive health services.

Fourth, in cases where decentralization has resulted in increased *NGO participation* in service provision (such as Brazil or Mexico), this opens up opportunities for expanding women's health services.³⁰

The active participation of those who represent women's interests is also critical to attainment of women's health objectives. The issue relates to whether women's interests are represented on local health committees, and whether their preferences and needs are reflected in resource allocations. Evidence suggests that women's views are often not well represented, particularly in local settings.³¹ While local authorities are, in principle, closer to beneficiaries and more responsive to their needs, evidence suggests that local preferences may favor curative care rather than longer-term gains from preventive and public health interventions, which tend to form the majority of women's health services (Standing 1999). In cases where women's interest groups are actively involved, these issues emerge high on government agendas, even in decentralized settings (Aitken 1999; Langer and others 2000). For example, in Brazil the feminist movement promoted the establishment of state and municipal women's councils, with a mandate for a broad range of women's issues. This repre-

sented the first true involvement of the state in women's health and resulted in expanded collaboration with the NGO sector and greater attention to increasing coverage and quality of a wide range of women's health services. In Nicaragua, community participation through social audits has given the local population an effective voice in health care (Langer and others 2000).

Decentralization may not necessarily provide an enabling environment for women's health programs, which have traditionally been organized in a vertical fashion. Some of the main issues that have emerged include:

- ❖ *Fragmentation.* Decentralization runs the risk of leading to fragmentation in national health programs to the extent that it increases the number of institutions and stakeholders involved. First, there may be a loss of economies of scale, particularly for the relatively small municipalities. Some functions (such as procurement, staff training, strategy development, and norm and protocol design) may need to remain centralized in order to reap economies of scale and benefit from a stable flow of resources.³² Centralized procurement may also avoid some of the liquidity problems of a large number of decentralized units. Second, responsibility for primary health care may be fragmented between state and central governments without effective power to manage personnel (such as Colombia, Mexico, Bolivia) at the regional level. In Bolivia, previously well-developed systems of integrated regional and health administrations were broken down by decentralization so that the referral hospitals ended up as part of a separate local government from the primary care services (Aitken 1999). Third, there may arise situations where central level mandates are parachuted onto decentralized units without commensurate resources for these activities.

Finally, countries may lack coherent population, reproductive health and/or women's health policies that would help to guide local action, and set the framework for national-level laws and regulations. Such is the case, for example, in Paraguay and Argentina (Langer and others 2000).

- ❖ *Poor local capacity.* Transfer of responsibilities to lower levels of government is also rendered difficult by the variable quality of technical and managerial capabilities, which runs the risk of compromising the provision of primary health care, including women's health services. In Mexico, for example, capacity weaknesses at the local level have proved a serious hindrance to the decentralization of a system that has a long history of having power concentrated at the central level (Langer and others 2000). These shortcomings underscore the importance of setting up organizational and management structures and providing staff training to decentralized authorities. While it may be in the interest of women's health programs to slow down the pace of decentralization to allow time to strengthen these capabilities, this is often not possible.

- ❖ *Skewed incentives.* Decentralization may impede the functioning of the referral system and the integration of primary health services with secondary level hospital care, which are essential for the provision of a comprehensive range of women's health services. Experience has shown that service providers may face skewed incentives, to the extent that provider payment mechanisms are not consistent across levels of care in decentralized settings. While these issues may not be unique to decentralized systems, they become more complex to tackle since responsibility for different levels of health care is spread across administrative lines. For example, in cases

where primary health facilities are remunerated on a per capita basis and secondary level facilities operate on a fee-for-service structure, this will create perverse incentives to shift costs to the secondary level of care. In situations where fees are not well differentiated by levels of care, women may tend to bypass the primary level, which overburdens the secondary level.

Priority Setting. Many health reform programs in the region have defined minimum health-care packages along the lines spelled out in the 1993 *World Development Report*. The introduction of such packages as part of broader health reform programs has potentially positive implications for the provision and financing of women's health ser-

vices, particularly as the majority of women's health interventions are cost-effective. The effectiveness of such packages depends on whether women's health needs are adequately reflected, whether this theoretical benefit actually translates into effective access, and whether it is financially sustainable. The definition of needs is often carried out by technicians. There is scope for improving the participation of women's health specialists in validating these results. In some cases access may not necessarily translate into improved use, either because the financial incentives are not in place to provide the services, or because service capacity and quality have not kept pace with the increase in benefits. Incorporating women's health concerns into essential

BOX 3

Chile: Women's health and decentralization

Chile offers an interesting case for looking at the links between women's health care and health reform, and highlights the types of issues that may arise. Nevertheless, it also suggests that it is virtually impossible to establish causality, particularly as many of the health gains predate the launching of the decentralization process in 1979. Chile's outstanding record in improving maternal and reproductive health can be largely explained by the following factors: a national health system with high coverage and a strong emphasis on primary health care and on public health interventions; a policy of targeting the most vulnerable groups, using clinical audits to tackle maternal mortality; providing free access to preventive and promotional activities, and using food supplements to address nutritional problems and to increase attendance at health facilities.

Decentralization appears to have permitted better adaptation of programs to local conditions and has facilitated the introduction of innovative interventions. Following the municipalization of primary health care in the 1980s, the maternal health program received a new boost, with a substantial infusion of resources and an expansion in coverage.

Decentralization has led to a new set of issues: (1) the lack of coordination and fragmentation across institutional boundaries; (2) resistance at the central level to defining a basic package of services and assigning resources according to need and sex; (3) possible perverse effects of provider payment mechanisms, which encourage shifting of costs to the next level of care. For example, concerns have been raised about the financial incentives to screen for cervical cancer at the municipal level, which is paid on a capitation basis and hence does not cover the financial cost for cancer treatment; (4) risk of the central level establishing new programmatic areas without providing commensurate resources, effectively resulting in an unfunded mandate; (5) a generally low level of community participation, including limited involvement of women's groups.

packages will imply a move away from free-standing or vertical programs toward integrated health-care delivery.

This will involve setting up new support systems and management structures, providing staff training, and overcoming resistance to change. The Brazilian experience in making the transition from providing a basic reproductive health package in a vertical program to delivering it in a decentralized context suggests that these problems are not insurmountable.³³ Governments have also found that often they cannot sustain the required level of financing, with reproductive health programs competing more explicitly for scarce public and donor resources in an environment of growing needs. Colombia presents one of the single most interesting reform scenarios, because the introduction of the essential health package was accompanied by mutually reinforcing changes in the way the package was delivered and financed (see box 4).

Financing Options and Payment Modes. Another key feature of health reform programs is broadening financing options (such as user fees, co-payments, and insurance) to mobilize resources, control unnecessary demand, and promote risk-pooling. The justifications for user charges are well known. Worldwide evidence has shown that individuals in most developing countries spend substantial amounts on private health care and are willing to pay for quality services. They recognize that free care may in fact involve hidden charges and implicit rationing. Critics of reforms argue that the introduction of user charges has impaired access to health care for poor women (Langer and others 2000).

The empirical evidence on the demand for medical care in developing countries is mixed.

Some researchers have found that prices are not important determinants of utilization of medical care (Birdsall and Chuhan 1986; and World Bank 1987). Others have documented that prices are important, and that the poor are more sensitive to price changes (for example, price elasticity of demand falls with income). Gertler and van der Gaag (1990) cite empirical evidence from Peru and Côte d'Ivoire, illustrating that the demand for medical care is very price-sensitive for individuals in the lowest-income groups, and quite inelastic for those in the highest-income groups. The data also found that user fees seem to have a greater negative effect on children's utilization than on adults'. Gertler (1999) argues that there is also some evidence substantiating that women's demand for medical care is more price-elastic than men's, implying that increases in user fees will reduce access to care for females more than males. Other evidence also substantiates these findings. One survey carried out in 70 countries found that fees were mentioned as the most serious obstacle to reproductive health services (WEDO 1999). In the sample of countries cited above, Henderson and others found that up to 35 percent of respondents mentioned cost of services and transport problems.³⁴ Controlling for age and health need, women in the lowest-income quintile use fewer services than their need would suggest, implying some access problems.

These findings suggest that while user fees are a potential source of substantial revenue for the health sector (particularly as willingness to pay increases with income), care must be taken in their design to ensure that the poor are not denied access. Particular attention will need to be given to poor women (and children), who use services more often than men, and who sometimes use a larger share of household expenditures on

BOX 4**Colombia**

Law 100—the cornerstone of the reform—provided for *universal access* and introduced the concept of *demand-side subsidies* with money following the patient. The goal was to promote competition, efficiency, and solidarity. Competition was promoted on both the insurer and provider sides, with beneficiaries free to select their organization of choice. Insurers are reimbursed for the provision of a basic package of services based on a risk-adjusted premium (that is, age and sex) that follows the enrollee to her chosen plan.

Basic health-care packages were designed, differentiating between those in the contributing scheme and those in the subsidized scheme. A solidarity fund provided for cross subsidization of the two schemes. The essential package was initially defined using standard burden of disease and cost-effectiveness criteria (Plaza 1999). Following a broad-based consultative process, this “basic” package was substantially expanded with the final version covering most health interventions, including a wide range of women’s health services (such as reproductive health, complications from pregnancy, Caesarean sections, and cancer). Complementary public health interventions involving large externalities were targeted to women and children and delivered and financed by the ministry of health. To reduce unnecessary demand and mobilize additional resources, user fees and co-payments were introduced, taking into account the ability to pay.

Since the introduction of the reform there has been a large rise in health spending and a dramatic improvement in access and equity. Nationwide, the proportion of insured increased from roughly 20 percent in 1993 to nearly 60 percent in 1998. The subsidized scheme now covers some 8 million Colombians who previously did not have access to insurance. This expansion has benefited vulnerable groups, such as women, who are less healthy on average than their counterparts in the contributing scheme, and who have greater perceived needs. The proportion of insured households in the two lowest income quintiles rose from less than 12 percent in 1993 to roughly 53 percent in 1998. Improved access to insurance is reflected in increases across the board in utilization rates during 1993–97. The introduction of demand-side subsidies has been the lynchpin in improving targeting and raising equity in health spending. These subsidies have had an important redistributive effect. Subsidies as a percent of GDP rose from .4 to 1.3 percent for those in quintile 1, while they dropped from .4 to –.2 percent for those in quintile 5.

These positive developments are tempered by evidence that highlights difficulties facing the poor in taking advantage of the new benefit package. First, information asymmetries have prevented consumers from making good choices about insurers, and practices such as hoarding of funds or partial commissioning of the basic package have precluded access to quality services and resulted in relatively lower rates of utilization for those in the lowest income quintiles. Regulatory capacities have not been developed at a sufficiently rapid pace to offset these problems. Second, while the capitated premium should create incentives to provide promotional and preventive care, which are an essential part of women’s health services, high turnover of beneficiaries has created disincentives to some providers. Third, fragmentation of reproductive health services amongst a large number of providers has been cited as an additional concern. Fourth, evasion of payments and underreporting of salaries have resulted in financial shortfalls for the contributing scheme. This raises concerns about the financial sustainability of the system and the government’s ability to expand both the range of services in the subsidized package to coincide with the contributing one as well as to provide access to the 17 million Colombians who remain uninsured. Perhaps one of the key lessons emerging from the Colombian reform is the need to design an affordable package of services which can be provided to a large number of beneficiaries rather than a generous package which remains within the reach of a few. Related to this point, the process used in the Colombian reform highlights the importance of managing the sociopolitical dimensions of a process that is otherwise technical, by bringing key stakeholders to the table at an early stage.

health (Henderson and others 1999). Gertler and van der Gaag (1990) stress that clinics in poor areas cannot survive unless they are heavily subsidized.³⁵ They argue for *gradation* and *differentiation* (for example, by level of care) in the application of user fees, and continuous monitoring to assess impact and compliance with guidelines and regulations. In Ecuador, for example, despite a law mandating that maternity care be provided at no cost, facilities offering obstetrical services continue to levy fees to maintain and improve service quality (Langer and others 2000). The implications of introducing user fees for women's health services need to be assessed in different reform settings to ensure that user fees will not have an adverse impact on poor women's ability to utilize services, and to offset these effects through the introduction of appropriate exemption policies and cross subsidies.

The introduction of insurance can improve access to women's health services and redress inequities. Countries have often introduced insurance as a way to pool risks for events that have a relatively low occurrence but that result in a substantial burden to households (such as treatment of complications from pregnancy and some obstetric care; treatment of cancers of the reproductive system; and treatment of chronic conditions such as hypertension and osteoporosis). Empirical evidence has shown that insurance can substantially improve access to care. Henderson and others (1999) found that, in the Dominican Republic, insured women were 60 percent more likely to seek care than uninsured ones. Bolivia's Mother and Child Health Insurance Program also illustrates how access can be improved to the poorest women as part of a health reform effort to decentralize decisions, maintain national priorities, and have money follow patients.

In situations where private insurance markets have been developed, it is critical to ensure appropriate regulation. The risk of unregulated or poorly regulated for-profit private insurance markets can be serious. For example, the ISAPREs in Chile charge women higher contributions because of the additional risks associated with reproductive health and the higher expected utilization rates. Langer and others (2000) emphasize the importance of determining whether the regulatory role of the public system is effective in ensuring that reproductive and women's health issues are adequately addressed by private insurance companies, whether these are included in packages, and how much they cost.

Many programs have also supported modifications to *provider payment mechanisms* in an effort to improve efficiency and raise accountability. There is little empirical evidence on the effects of provider payment mechanisms on the provision of women's health care. A notable exception is the impact of alternative provider payment mechanisms on the rate of Caesarean sections. Data from a sample of hospital records in Brazil revealed that physicians were more likely to perform C-sections on women who could pay for the service, illustrating how financial incentives can adversely affect decisions that should be based on medical need (Janowitz and others 1983).³⁶ In principle, a move away from traditional payment mechanisms (such as salaries or fee-for-service), as has occurred in numerous reform programs, has the potential to benefit women's health programs. For example, the increased emphasis on capitated formulas should produce incentives to provide preventive and promotional health services that are essential to women's health, assuming that it does not result in undertreatment. When the capitated payment is in the form of a

demand side subsidy, such as in Colombia, this can empower women to select their provider or insurer of choice, or both.

The move away from salary payments for physicians (which tend to encourage absenteeism and poor productivity) toward capitation tied to performance improvements may also improve quality of women's health services and increase accountability of personnel. For example, an innovative program in São Paulo, Brazil, relying on health-care workers organized under cooperative-type arrangements and using capitated reimbursement mechanisms, has produced impressive reductions in waiting times, hospital stays, and overall costs, while generating a substantial increase in patient satisfaction (Harmeling 1999).

The introduction of case-based payments (for example, DRG type), which cover all service tests and treatments for a specified diagnosis, provides incentives to standardize care and disincentives to perform unnecessary procedures and could be used effectively in some situations. For example, to curb the frequency of Caesarean sections, which have reached epidemic proportions in the region, case-based payments, in combination with second opinions, could be used to discourage unnecessary use of this procedure. As discussed above, one of the key issues that will need to be addressed is the coherence in provider payment mechanisms across levels of care, which is particularly important in the provision of an integrated package of women's health services.

Reorienting Public and Private Roles Through Contracting and Private Sector Collaboration.

The Latin America region has seen a large expansion in contracting, both within public health systems and among public financing agencies and private sector providers. Contracting is being in-

creasingly used to improve efficiency and quality, to provide highly specialized services that require costly equipment, and to expand coverage. Within publicly funded systems, service agreements have been introduced in some countries (such as Costa Rica, Colombia, and Chile) in an effort to enhance transparency, improve decisionmaking, and transfer risks to providers.

The expansion in contracting of private sector providers can have potential benefits for the provision of women's health services. In many developing countries women often prefer private practitioners because of the convenient and flexible hours of service and perceived high quality of care, including the strong emphasis on privacy and respect. The private sector is a heterogeneous group, consisting of both nongovernmental organizations and for-profit organizations.

The main focus of this section is on the potential role of nongovernmental organizations in expanding access to quality services for poor women—either through explicit contracts or more general collaborative arrangements with the public system. While NGOs have a longstanding involvement in catering to the needs of poorer households and women, in particular, they have received a major boost following the Cairo conference and are now playing a critical role in partnering with the public sector. To date, there has been relatively little public-to-NGO contracting for health services in Latin America, and even less systematic analysis of the impact of using NGOs on access to and utilization of women's health services. However, given the positive potential of this mechanism—particularly for women's health services—this section attempts to highlight some positive features of this collaboration, identifying examples of good practice where poor women appear to be well served by

BOX 5**Contracting: The key ingredients for success**

- ✦ Putting in place an appropriate legal and regulatory framework and a conducive political environment.
- ✦ Minimizing transaction costs and getting the incentives right.
- ✦ Ensuring continuity in service provision and minimizing delays in payments.
- ✦ Strengthening management information systems, monitoring results, learning from mistakes, and making required adjustments.

the NGO sector. It also highlights the types of issues that are emerging in promoting public-private partnerships and in using contractual arrangements (box 5).

The nature and scope of this collaboration have varied tremendously across countries, depending on the political will of governments to use the capacity of NGOs. The arrangements between the public and private sectors range from informal collaboration (such as in Bolivia and Haiti) to formal contracts (such as in Colombia and Costa Rica). The PROSALUD model, which is based on the principle of promoting sustainability through cost recovery, appears to represent a promising approach to catering to some low-income segments of the health-care market (box 6). This model has been replicated in other low-income settings, such as Haiti, with positive initial results (Baer 1999). City March is a large Haitian NGO that participates in mixed management of health facilities with the government, providing curative care with a strong cost recovery component. The organization owns and operates

a hospital and a number of dispensaries, catering to lower- and lower-middle-income families. Successful features include use of a strong management information system; reliance on bonus payments to motivate personnel; and creative use of income-generating activities to stimulate nutrition interventions. Notable results include a drop in the infant mortality rate from 150 to 66 per 1,000 during 1980–95, and an increase in the contraceptive prevalence rate from 15 percent in 1993 to 38 percent in 1998.

In some countries, introduction of competition between public and private providers has opened up new opportunities for NGOs and offered women a greater range of choice among providers. A notable example is Colombia's PROFAMILIA, a world-renowned NGO, which has an impressive record of achievements in providing reproductive health services. PROFAMILIA has been taking advantage of the opportunities offered by the new legal framework by contracting its services to both public and private sector institutions. This has allowed the organization to diversify its risks and lessen its dependence on donor funding, which declined from 30 percent of the organization's total budget in 1993 to only 5 percent in 1999. Abramson (1999) found that the increased competition provided incentives to PROFAMILIA to modernize its technology and improve the efficiency and quality of its services and to fill important service delivery gaps.

Some of the key issues that have emerged in contracting are similar to those found in other countries: payment delays by purchasers, difficulties in complying with information requirements of various players, greater risks assumed by the organization as a result of the payment modalities used, and high transaction costs of administering to patients who belong to different

BOX 6**PROSALUD**

PROSALUD has made impressive progress in providing an integrated package of primary health services to low-income populations in urban and periurban areas of Bolivia, operating a network of facilities with a high degree of autonomy. The package includes access to free preventive services (such as prenatal and postpartum care; and health education) as well as to a wide range of curative services on a fee for service basis (such as obstetric and gynecological care, deliveries, and family planning; and ambulance service and emergency care). PROSALUD uses an effective *one-stop shop-ping* approach, whereby most services are available on a 24-hour basis, and laboratory exams and prescriptions are handled at the same facility. The overriding principle of the PROSALUD model is to promote *sustainability through cost recovery*, by using revenues generated from curative care to fund operating costs. The goal is to provide quality services at high volumes, thereby keeping unit costs low. Fees are set according to costs and ability to pay, with indigenous groups being exempt from payments. To discourage unnecessary use, women who self-refer to the reference hospital pay a significantly higher fee than those who are referred. Other important features of the PROSALUD model include its strong emphasis on: privacy and respect, particularly during childbirth (such as *partos humanizados*); community participation and outreach; demedicalization of service delivery; and monitoring and evaluation.

With the launching of the decentralization process and the introduction of the Popular Participation Law in 1994, PROSALUD aimed to work closely with the government by expanding its network nationally through agreements with municipalities, whereby the government agreed to contribute infrastructure and supplies for priority programs while the NGO was delegated responsibility for service provision. By contrast, PROSALUD and other NGOs have not elected to participate in the government's maternal and child health insurance scheme, because the reimbursement rates for most procedures are set considerably below cost. Moreover, lengthy processing delays for reimbursements have created further disincentives. In some PROSALUD health centers births attended by professionals have declined, but the overall number appears to have remained fairly steady. This situation highlights the importance of *getting the incentives right* in building effective partnerships between the public and private sectors.

insurance schemes. While PROFAMILIA's strong financial situation and its diversification strategy have enabled it to cope with payment delays, NGOs in other countries have found themselves vulnerable to the unpredictability of donor funding, which has seriously impeded service provision.³⁷ This highlights one of the key lessons for NGOs—the need to reduce dependence on donor funding and to adopt sustainable strategies such as cost recovery and revenue generating activities.

Conclusion. In each of the areas of reform—decentralization, public sector priority setting, reori-

enting financial arrangements, and modification of the public-private roles—both positive and negative aspects of the reforms for women's health have been pointed out. It is important not to dwell on the negative, because for the most part the goals of the reforms can and should be consistent with higher quality and more effective health efforts. Many, but not all, of the negative aspects can be corrected by being aware of the problems and tweaking the reforms to be friendlier to women's health needs. As the reform agenda moves forward, it is time to become more precise about these issues and actions.

Conclusion

Inescapably, health sector reform efforts, as is true for health programs and policies, will be more effective if the well-known biological and socioeconomic differences between men and women are taken into account in their design and implementation. Empirical information on women's health status and access to services, as well as analyses of patterns of spending on women's health can inform good policymaking.

Despite the vast diversity across the countries and populations of Latin America and the Caribbean, the information compiled for this study points toward several conclusions:

- ✦ Most women in poor countries, and the poorest women in rich countries, are suffering unnecessarily from inattention to the fundamental services that would make pregnancy and childbearing safe. The inattention is unnecessary because it can be fixed either within existing resource constraints or with feasible changes in resource allocation.

- ✦ As the population ages, as some communicable diseases decline in importance, and as tobacco use, obesity, and other "lifestyle" factors take an increasing toll, a growing share of women in the region are at risk for diseases that erode quality and length of life, including cardiovascular disease, diabetes, and cancer. For the most part, the women most negatively affected are those with the fewest resources.

- ✦ Both governments and households devote a considerable share of financial resources

to health services directed to women, but obvious coverage gaps remain. For example, while in absolute terms many countries of the region spend "enough" on reproductive health care to ensure full population access to a core package of services, in those same countries the poorest 20 percent of the population is only able to obtain services that are limited in coverage and quality. In the poorest countries of the region, a large-scale mobilization of financial resources is required to support basic care for most women.

- ✦ Strategies commonly associated with health sector reform—including decentralization, public sector priority-setting, financing changes, and adjustments in the roles of public and private sectors—can be harnessed to improve women's health outcomes. At the same time, they carry risks for women if done without the active participation of individuals who are aware of gender-related differences in biological and social vulnerabilities.

Ten policy guidelines fall logically from this study, which will, of course, need to be adapted to specific country situations.

Expansion of Reproductive Health Services

- ✦ To improve the health status of women, given tight budget constraints, countries now falling into the low status and medium-low status categories should focus resources on improving basic reproductive health conditions. The interventions required are relatively low-cost, in

general, and yet have major pay-offs in health conditions and human welfare. Providing appropriate family planning methods to women who want to control their fertility, providing early and reliable prenatal and essential obstetric care, fostering good nutrition, and developing specially targeted services for women at high risk for sexually transmitted diseases should all be very high on the public priority list.

- ✦ In the seven to ten countries in the region that underspend on reproductive health (and probably other women's health) services, close analysis is required to determine the feasibility of, and mechanisms to achieve, a significant expansion of total resources for the health sector, or a shift of existing resources toward the most cost-effective and needed reproductive health services. External donors can play a valuable role both in the mobilization of resources and in providing information for better priority setting.

- ✦ In the countries of the region where spending on women's health services and service utilization is relatively high, poorer women will only benefit from the relative abundance of resources with better targeting mechanisms on the supply side, and a concerted effort to address important demand-side constraints.

- ✦ In medium-high and high status countries, governments should ensure that the same basic reproductive health services reach the poorest 20 to 40 percent of women. This initiative would be a cost-effective way to reduce the large gap in women's health conditions between the poor and the better-off segments of the population.

Addressing Noncommunicable Diseases

- ✦ Particularly in better-off countries, governments have an important role in promoting cost-

effective screening and preventive interventions, such as cervical cancer screening directed at women who are at high risk of the disease, and supporting cardiovascular disease prevention programs, particularly for low-income populations that are at disproportionate risk and have few resources.

Tweaking Health Reform

- ✦ Women's health advocates and health sector reform advocates have common interests—one group cannot achieve its goals without the other—yet the absence of a common vocabulary and mechanisms for participation and communication impedes dialogue. Both national policymaking bodies and international agencies can play a role in bringing women's health advocates into the dialogue on health policy.

- ✦ Decentralization can have positive effects on women's health services when (1) women's health advocates (and women patients themselves) have a voice in the local decision-making process; (2) coherent national policies and "rules of the game" are in place that favor the delivery of women's health services of acceptable quality; (3) formula-based transfers are used to ensure sufficient funding based on need and to redress historic inequities; and (4) support is provided to bolster technical and managerial capacity at the local level.

- ✦ Strategies for public sector priority setting that employ analysis of cost-effectiveness often favor core reproductive health services. The challenge, as seen in several countries, is to obtain reliable and up-to-date information about both costs and efficacy, and to minimize the impact of interest groups seeking to use political influence to capture budgetary resources for specific programs.

✦ Broadening financing options to mobilize resources, control unnecessary demand, and promote risk-pooling has better outcomes for women's health if the design takes into account the possibility that women have less access to and control over household income than do men. In particular, a variety of studies have confirmed that core maternal and child health services are best funded by means other than user fees.

✦ Contracting with nongovernmental organizations and public-private collaboration have

tremendous potential to increase access to and the quality of women's health services in the region, although experience to date is limited. The key ingredients for success include (1) putting in place a legal and regulatory framework that protects service providers, financiers, and, above all, consumers; (2) minimizing transaction costs and incorporating incentives for productivity and quality; (3) ensuring continuity in service provision and minimizing delays in payments; and (4) strengthening management information systems, monitoring results, and making required adjustments.

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Notes

1. Mortality due to chronic and degenerative disease is estimated to be 10 times higher than deaths from infectious and parasitic disease.

2. For example, 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, receive less health care and education as they mature.

3. World Bank 1993 documented the cost-effectiveness of these interventions, including prenatal and delivery care, childhood illnesses, family planning, and STI (sexually transmitted infections) treatment, in the minimum package. Financing this package could reduce the burden of disease by more than 30 percent in low-income countries and by about 15 percent in middle-income countries.

4. For example, researchers have identified important differences such as height and weight, fat ratios, and metabolism that can alter the effectiveness of drugs. To the extent that most clinical trial testing of new drugs or treatments has excluded women, this exclusion can have a potentially negative impact on women.

5. This section draws primarily from the background paper by Gertler 1999. Some text is taken from that paper.

6. This framework is fully consistent with the conceptualization articulated in World Bank 2000.

7. It is important to note that the word "choice" does not mean that all options are open, or that the choice is unconstrained by limited resources (money, time, information, and others). For poor families, and for women who may have little access to financial resources, the set of options may be very limited indeed.

8. Defined as having a body mass index (BMI) of less than 18.5. The BMI is an indicator that combines information about both height and weight.

9. Information for this part of the chapter was derived from four sources: Carr 1999; Loganathan 1999;

and Pande and Gwatkin 1999. Some text in this chapter is taken from Dara Carr's report, which was prepared as background for this study.

10. Out of the full range of possible variables, these were shown to have the greatest ability to discriminate among country groups. For more information on data and methods, please see Loganathan (1999).

11. Modern contraception excludes periodic abstinence and other traditional methods. It includes hormonal and barrier methods, as well as sterilization.

12. It is important to note that, while the IARC provides the most comprehensive data on cervical cancer incidence, the data are far from complete or fully reliable. They are based on population-based cancer registries, which are usually incomplete and restricted to urban populations. Readers are encouraged to keep in mind shortcomings in the quality of information when interpreting the data presented.

13. Cardiovascular diseases include a group of conditions affecting the circulatory system, including ischaemic heart disease, cerebrovascular disease, and hypertensive disease.

14. Obesity typically is defined as having weight for gender, age, and height at +2 standard deviations from a reference population. Overweight is between +1 and +2 standard deviations.

15. This chapter is based on the following background reports: Hernández, Glassman, and Poullier 2000; and Henderson, Montes, and Glassman 2000.

16. Brazil's household survey is subnational. Additional details on the surveys are available in the background reports.

17. Guatemala was not included in the household spending analysis, as a nationally representative household survey that included expenditure and utilization questions was not available at the time of the study.

18. Included in the category of “public” services are situations where universal access is mandated and the use of private facilities is paid for by the government.

19. According to this view, women perceive morbidity and use more services than men because they have been socialized to acknowledge and articulate bodily signs and symptoms, and to seek the help of others, including health-care providers and informal sources of care, more readily than do men (Hibbard and Pope 1986).

20. Care during pregnancy and delivery in public hospitals accounts for a large proportion of health-care utilization in the public sector. For example, obstetric care represents 44 percent of inpatient stays in the Dominican Republic and 40 percent in Brazil.

21. It should be noted that the analysis of the equity of need-based utilization only provides insight into the distribution of utilization and says nothing about the absolute levels of service available in each country.

22. Wagstaff and van Doorslaer 1998.

23. A study conducted in Mexico found no evidence of gender bias unfavorable to girls (see Langer and Lozano 1998).

24. A study of the equity of public expenditure on health in Egypt (Berman and others 1998), for example, showed that males received three times the amount of major program subsidies as compared to females, yet exhibited lower service-utilization rates. Women were found more likely to use services, although they were perhaps less expensive services, and to spend out-of-pocket more frequently.

25. There are obvious shortcomings to this approach. (1) The package of reproductive health services does not constitute all of women’s health services, although it does include many of them—and certainly most that are likely to be financed by the public sector, for at least some populations. (2) There is an implicit assumption that funds could be reallocated without significant transition costs, and that countries could deliver services efficiently enough to achieve the unit costs upon which the cost of the package of reproductive health services is based.

26. The package recommended at the International Conference on Population and Development includes family planning, prevention of sexually transmitted infections (including HIV/AIDS), research, and other basic

reproductive health services) and is estimated to cost approximately US\$135 per woman in the Latin America and Caribbean region.

27. The Paraguayan figure is likely to be somewhat inflated because information on hospital expenditure is not available for Paraguay. However, even after accounting for this omission, the figure is still large.

28. Using the typology established for this purpose, these countries are: Bolivia, Ecuador, Guatemala, Honduras, Nicaragua, Peru, and Haiti.

29. Most transfer formulas in the region have a large population-based weighting. In Colombia the transfer mechanisms are adjusted for unmet need and local fiscal effort. In Chile transfers to municipalities, which are responsible for primary health care, are based primarily on a per capita allocation, which is complemented with an allocation for the provision of public goods.

30. In Brazil, BEMFAM provides a good example of collaboration, with the municipality providing facilities and staff, while the NGO provides training, contraceptives, and technical support.

31. Hanson and McPake (1993) found a notable absence of women on local health committees despite the emphasis on promoting the health of women and children.

32. For example, costs of drugs, contraceptives, and medical equipment—which are essential to women’s health services—can be kept lower if the government takes advantage of its purchasing power. Therefore, the procurement of these items should probably remain centralized in most settings, although the government may wish to contract out the procurement function to the private sector.

33. The government’s *Programa Assistencia Integral a Saude de Mulher* (PAISM) was set up in 1984 to provide for a comprehensive range of women’s health services (prenatal care, delivery, and postpartum care; breast and cervical cancer screening; STI care; infertility services; and family planning education and services). By 1995 implementation remained patchy, and it became increasingly evident that this vertical program needed to be integrated into municipal-level primary health care. As a result, basic interventions such as prenatal and maternity care, family planning, and cancer screening have improved dramatically. For example, prenatal consulta-

tions increased by over 50 percent and cervical and breast cancer screening increased from 14 percent to 44 percent during 1995–97 (Harmeling 1999).

34. This figure varied widely across countries: Brazil 6.6 percent; Peru 34.5 percent; Paraguay 5.3 percent; Mexico 29.5 percent; and the Dominican Republic 11.6 percent. In this study the impact of cost, transport, availability, and quality of care on likelihood of use appeared to affect women and men equally.

35. They point out that user fees at levels of half and full marginal cost recovery would price most poor residents out of the market. They find that fees can be charged without a significant drop in utilization if the

cost of medical care takes no more than 2 to 3 percent of a household's nonfood budget.

36. Study findings indicated that the rate of Caesarean sections increased with payment status of women, with 75 percent of private patients, 40 to 50 percent of insured patients, and only 15 to 30 percent of indigent patients having had a Caesarean section delivery. Researchers found that differences in medical conditions were too small to explain these rates.

37. For example, as a result of an abrupt loss of donor funding, PROFAMIL in Haiti suffered a major blow to its operations and was forced to rationalize its services (Baer 1999).

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