Maternal Mortality, Abortion, and Health Sector reform in Four Caribbean Countries: Barbados, Jamaica, Suriname, and Trinidad and Tobago

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<td>Advocates for Safe Parenthood Improving Reproductive Equity</td>
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<td>CEDAW</td>
<td>Convention on Elimination of all Forms of Discrimination Against Women</td>
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<td>CLAD</td>
<td>Central National Accountants Agency</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSO</td>
<td>Central Statistical Office</td>
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<td>DHF</td>
<td>District Health Facilities</td>
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<td>EHC</td>
<td>Enhanced Health Centres</td>
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<td>EU</td>
<td>European Union</td>
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<td>EWMSC</td>
<td>Eric Williams Medical Services Complex</td>
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<td>FPATT</td>
<td>Family Planning Association of Trinidad and Tobago</td>
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<td>Intra-uterine Devices</td>
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<td>LGBT</td>
<td>Lesbian Gay Bisexual Transgender</td>
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<td>WHO</td>
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Introduction

It is important to place this report in an international and regional context. The year 2004, when this research was finalized, was of special significance. It was the year for celebrating the 10th anniversary of the International Conference on Population and Development (ICPD), held in Cairo, and the 20th anniversary of the launching of the DAWN Network at the NGO Forum in Nairobi, marking the final World Conference of the UN Decade for Women (1975-85). The Convenors of both NGO forums were Barbadian women – Nita Barrow convened the forum in Nairobi, while Billie Miller convened the Forum in Cairo – following in the footsteps of Gloria Scott and Lucille Mair of Jamaica, who were among those who took leadership in the activities around International Women’s Year (1975) and the ensuing UN Decade for Women.

Publishing this research at this time, allows us to draw on new insights from the continued pressure being exerted on sexual and reproductive health and rights (SRHS) worldwide, and in the Caribbean. In addition, the Caribbean is challenged by the continued erosion of budgetary allocations to health sectors, and to the strengthening of the religious right and the spread of the HIV/AIDS virus. Evidence of a backlash against women’s sexual and reproductive rights has also come from the processes of the Five-and 10-year Reviews of ICPD and the Fourth World Conference of Women (FWCW) held in Beijing (1995), and from the negotiations surrounding the Five-year Review of the Millennium Development Goals (MDGs) at the Special Session of the General Assembly held in New York in September 2005. This makes it all the more important for Caribbean women’s advocacy to formulate strategies for addressing these issues. There is a clear role for the publication and widespread use of this research in this process.

ICPD is widely acknowledged as having forged a new path with its Programme of Action that broke with its demographic moorings to define a framework that underlined the links between reproductive health and women’s rights and empowerment. DAWN’s platform document prepared for ICPD made a special contribution to the understanding of these linkages as well as to the importance of the political economic context in which health services are provided. As mentioned above, the Fourth World Conference on

1 In the event, Billie Miller, a minister in the Government of Barbados, was not able to be in Cairo due to the fact that she was in the midst of an election campaign at the time.
2 This is due to a number of factors including the loss of revenues from tariffs, and the privatization of government assets due to the spread of neo-liberalism through the WTO.
3 This conference advanced the ICPD Platform by linking reproductive health and rights to ‘sexual health and rights’.
Although this was on the agenda in Cairo, governments were not yet ready to adopt the language of sexual rights.

Since the 1980s, there has been a major restructuring of the Caribbean state, leading to the virtual abandonment of the more holistic approach to development inherent in the promise of independence. Under the leadership of the Caribbean Development Bank (CDB), the adoption of the policy framework of structural adjustment and the Washington Consensus by Caribbean governments in the ‘Nassau Agreement’ of 1984 signaled the erosion of the power of labour, the retreat of the state from its commitment to broad-based, socio-economic justice and the crumbling of a social contract based on principles of equity and social justice. Cuts in social services and benefits to the poor; rising unemployment and the expansion of the informal and ‘underground’ economy; and the privatization of public services and assets; the increase in violence and the weakening of trade unions – all came to symbolize the policy framework of structural adjustment in this region, and throughout the world.

In the 1990s these trends were consolidated by trade liberalization and the binding trade agreements of the WTO, and by the new ‘consensus’ around a variety of public sector ‘reforms’. Ironically, the weakening of and deterioration in public health services was taking place even as the ICPD Programme of Action was calling for the strengthening of health services and feminist advocacy focusing on issues of ‘quality of care’.

The consequences of these policies for women were devastating, and in particular for their health. Because of their central role in the care of people within households and in public services such as health, education and social welfare, women, especially those who were poor, were placed in triple jeopardy as a result of the cuts in social services: they were disproportionately represented among those who lost their jobs, they lost services that are essential to social reproduction, and they were expected to fill the gaps created by the cuts. UNICEF’s path-breaking study (1987) of the impact of structural adjustment policies on vulnerable groups recognized that 57% of health care takes place within the home and many governments used this to justify cuts in primary health care. The shifting of responsibility for many areas of health care from the state to the private sector and to the household (for poor families that cannot afford private health care) therefore meant that women spent increasing amounts of time taking care of family members who were sick or disabled and, consequently, lost hours of paid employment. Often, this was at the expense of their health.

Studies on health sector reform, from a gender perspective, are long overdue in the Caribbean, and this study should be invaluable for those who are concerned about how health sector reform relates to the outcomes of ICPD 10 years later.

The central place accorded to the Millennium Development Goals (MDGs) in policy dialogues and the major policy concerns surrounding the spread of the
HIV/AIDS virus provides a strategic opportunity for addressing the links between the goals of poverty reduction, gender equality, improvements in maternal health and combating HIV/AIDS, and for the adoption of an integrated approach to these problems. The Caribbean women’s movement needs to play a major role in this dialogue and in the planning and implementation of programmes. This study is part of that contribution.

However, many have noted the lack of energy and the absence of direction in the Caribbean women’s movement today, around issues that are of central concern to Caribbean people, and women in particular. At the meeting of researchers that took place in Barbados at the end of the first stage of the research, there were already signs that the findings could provide the impetus for new initiatives. There is especially need for discussions on the links between health sector reforms and the outcomes of ICPD; between sexual and reproductive rights, abortion and maternal morbidity and mortality; between gender equality and women’s empowerment and the spread of HIV/AIDS. In the context of the central place accorded to the MDGs in policy dialogues and in setting aid agendas, the study can provide data that can highlight these linkages and strengthen the work of feminist advocacy in this area.

Margaret Gill, the president of CAFRA, has addressed the question of the state of the Caribbean women’s movement today. She argues that the movement has been ‘destabilized’ by four factors: the notion of difference; the belief in the near impossibility of penetrating, what she terms, ‘amalgams of power’ (patriarchy, colonialism/neo-colonialism, capitalism and statism); the male backlash; and “late 20th century instabilities of the concept of the nation state”.

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

I believe that a necessary element in any efforts to re-energise the women’s movement in this region must be the opportunity to understand sexuality and how this relates to both the forces that empower us as individuals, and those pitted against a movement for gender equality and women’s empowerment. It is in that sense that I believe that the launching of a discussion on sexuality can serve not only to promote a better understanding of issues around the spread of HIV/AIDS and gender relations in general, but also to empower women to find renewed energy to the larger challenges facing our region today. This study can provide the impetus for starting the conversation.

5 CAFRA (the Caribbean Association for Feminist Research and Action), is the most enduring and significant regional network of feminists. From 1991-1996 CAFRA’s Coordinator served as Regional Coordinator for DAWNCaribbean. This paper was presented as the basis for an e-mail discussion.

6 WAND served as DAWN’s Secretariat from 1991-1996 during my terms as General Coordinator.
The current inertia in Caribbean women’s activism at the present time certainly stands in contrast to the leading role they played in Cairo and Beijing. In the first paragraph I made reference to the work of Caribbean women who exercise leadership at the international level in this field. However, the involvement of Caribbean women in this field goes beyond the work of the internationally-acclaimed leadership of these women. Working both as members of government delegations as well as with NGOs, in the official conferences as well as in the NGO Forums that parallel the conferences, Caribbean women have played crucial leadership roles in these processes. A few examples will indicate the level of expertise and commitment to these issues in CARICOM.

First, international regard for Billie Miller’s leadership in this field goes back to the way in which, as a minister in the Barbados government, she single-handedly and successfully gave the region its first progressive legislation on abortion. Her selection as convenor of the NGO Forum for ICPD was in recognition of her commitment to women’s reproductive rights, and her considerable political skills in this contentious area. Dame Billie’s international leadership in this field is reflected in her presidency (1991-97) of the Board of International Planned Parenthood Western Hemisphere Region (IPPF/WHP), current presidency of the Board of Directors of the Inter-American Parliamentary Group on Population and Development for the Caribbean and Latin America, and many other initiatives in this field. Most recently, the leadership of Dr Jacqueline Sharpe of Trinidad and Tobago in both Cairo and Beijing was recognized by her appointment as world president of IPPF.

The advances in women’s sexual and reproductive rights and health that occurred at ICPD and FWCW would not have been possible without the dedicated, imaginative, skilled (professional and political) and sustained work of a number of Caribbean women in the lead-up to the conferences and at the meetings themselves.

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

At this time, I was the general-coordinator of the DAWN network, and was assisted by Audrey Roberts (Jamaican resident in the Bahamas) who did most of the work around this issue, organizing regional and inter-regional meetings and supporting the DAWN team in Cairo. At the regional level, CAFRA played a major role in mobilizing women in the Caribbean around the issue, as did many of the Family Planning Associations (FPAs): Caribbean women

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7 This network of Third World women scholars—researchers was launched at the NGO Forum in Nairobi in 1985, the Forum convened by Dame Nita Barrow of Barbados.

8 The DAWN Secretariat was based at the Women and Development Unit (WAND), School of Continuing Studies, UWI.
involved in this process included Nelcia Robertson (CAFRA, St.Vincent),
Margarette May MaCauley (CAFRA Jamaica), Jacqueline Sharpe and Grace
Talma (Trinidad & Tobago FPA), Denise Nobel-Debique (Trinidad and
Tobago), Monique Essed-Fernandes (Suriname) and Chantal Monro-Knight
(Barbados)), UNFPA's youth ambassador.

In the lead up to the conference women’s organizations around the region 9
organized women’s input in national reports, participated in the preparatory
committees (Prep-coms) where the document was revised and in the ‘women’s
caucus’ where women from around the world developed strategies for
influencing their governments. At the conference, the presence of Caribbean
women on government delegations greatly facilitated NGO access. Special
mention should be made of women like Jacqueline Sharpe and Grace Talma
(Family Planning Association of Trinidad and Tobago) Carol Narcisse
(Association of Women of Jamaica, AWOJA, and one of the researchers for
this project) and Drs Beverley Miller and Yvette Delph (Barbados Ministry of
Health) on their country delegations. The engagement of health care
professionals, and representatives of FPAs and women’s organisations on
official delegations was crucial to counter the compliance of diplomats who
were more easily influenced by religious conservatives. While in the NGO
Forum groups like SISTREN (Jamaica) and CAFRA mobilized CARICOM
participants to play a crucial role in generating the political will.

In the process leading up to the Beijing conference UNIFEM 10 took the
lead in coordinating the work of the various networks – CAFRA, DAWN
Caribbean and others. Among those participating in the NGO Forum in
Beijing were also national organisations like SISTREN, AWOJA and Jamaica’s
Women’s Media Watch.

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

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

Peggy Antrobus
Barbados, January 2006

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9 Examples of these at
national level were the
Association of Women in
Jamaica (AWOJA) and the
FPA of Trinidad and Tobago.

10 By this time Audrey
Roberts worked as a
consultant to UNIFEM and
played a major role in
managing the process leading
up to the conference. Sandra
Edwards (Barbados) of the
DAWN Secretariat provided
administrative support for the
DAWN team.
Executive Summary

Development Alternative with Women for a New Era (DAWN) is an inter-regional organisation of the South that provides an analytical space for research, advocacy and discussion under the areas of the Political Economy of Globalisation and Trade, Sexual and Reproductive Health and Rights (SRHR), Sustainable Livelihoods and the Environment and Political Restructuring and Social Transformation.

In 2004 DAWN Caribbean conducted research in the area of sexual and reproductive health and rights. The policy research document, entitled “Health Sector Reform, Maternal Mortality, Morbidity and Abortion”, was completed in four Caribbean countries: Barbados, Jamaica, Suriname and Trinidad and Tobago.

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

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

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

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

**Recommendations: Steps to Reduce Maternal Mortality as it relates to Abortion**

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

**Legislation and Policy**

- In the health sector reform processes, the prioritization of women’s health issues is necessary, both in general and specifically in regard to abortion-related maternal mortality and morbidity.
- Integration of HIV/AIDS programmes into reproductive health services.
- Sensitization of hospital staff to diversity of clientele, particularly in relation to sexual diversity.
- Legislative reform pertaining to abortion in order to create an environment where safe and legal abortions can be attained.
- Initiatives to educate women about the potential harm of unsafe abortion and medical abortion and to encourage a safe and sterile provider.
- Research should be conducted to understand the impact of external factors (i.e. religion) on decision making relating to reproductive health.
- Ensure comprehensive education programmes for the school population, including information on abstinence, teen pregnancy, contraceptives, abortion, HIV/AIDS, etc, in an effort to reduce these problems.
Data

- Standardization of collection of quantitative data in hospital (private and public) settings to facilitate consistency in the presentation of data on maternal mortality and abortion in individual countries and across the region.
- Collection of qualitative and quantitative data on women’s access to abortion services, experiences with abortion providers, and experiences with abortions.
- Quantitative and qualitative research should be conducted to understand the prevalence of self-administered, medical abortion in the region.
- The impacts of violence against women, particularly as it relates to the ability and desire to access abortion services, should be better understood through further qualitative and quantitative research.
- Research to ascertain, if any, the relationships between violence against women, socio economic status, rape and incest and contraceptive delivery services, etc.
- All data should be disaggregated by age, sex, gender, socioeconomic status, race, rural/urban location and other appropriate criteria.

Focus on Gender

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

Focus on Services; Integration of programmes

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

Research of external factors that impact reproductive decision making

This research begins an important discussion on the issues that impact reproductive decision making: understanding the reproductive choices of individuals should translate into appropriate policy responses and service delivery.
The following is an initial list of topics to be explored in the context of improving health:

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

This undertaking by DAWN Caribbean is a first attempt at an individual and comparative understanding of health sector reform, maternal mortality and abortion in the region. In completing this research DAWN aims to support the work of advocates, policy makers, researchers, health professionals, activists, students and members of government to further motivate, inform, and benefit the lives of Caribbean people.
Sexual and Reproductive Health and Rights in the Caribbean: Backdrop and Methodology

Backdrop to the Research

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

The International Conference on Population and Development (ICPD) Programme of Action (1994), states:

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion.11

The Beijing Platform for Action takes the language of the ICPD and ICPD+5 further by recognizing a woman’s right to control her sexuality and sexual relations on an equal basis with men.12 The Beijing PfA is therefore seen as a key international instrument relating to women’s reproductive and sexual health rights.13

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

- Increasing women’s access throughout the life cycle to appropriate, affordable and quality health care, information and related services.
- Strengthening preventive programmes that promote women’s health
- Undertaking gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.
- Promoting research and disseminating information on women’s health
- Increasing resources and monitoring follow-up for women’s health.14

11 International Conference on Population and Development, Programme of Action, 1994
13 Ahmed, Aziza. UNIFEM Gender and Health (Beijing +10 Review)
14 Ibid.
The World Health Organization’s working definitions of sexual health and sexual rights are as follows:\textsuperscript{15}

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

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

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

The International Conference on Population and Development Programme of Action was adopted by 179 countries. The consistently strong support and advocacy of the Programme of Action by the Caribbean can be attributed largely to the mobilization and leadership of the women’s rights movement. The region reaffirmed its commitment to women’s rights in the 10-year review process. The first of three regional meetings in the 10-year review process for the ICPD PoA was held in Port of Spain, Trinidad and Tobago on November 12, 2003. At this meeting Caribbean governments came forward with the Declaration of the Caribbean Subregional meeting to assess the implementation of the Programme of Action on the International Conference on Population and Development 10 years after its adoption. The Declaration states that the governments:

1. Reaffirm our unequivocal commitment to the principles and actions contained in the Programme of Action of the International Conference on Population and Development and the document “Key Actions for Further Implementation of the Programme of Action of the International Conference on Population and Development”, in particular, with respect to ensuring reproductive rights and health, gender equality, equity, and the empowerment of women;

2. Reaffirm our commitment to the goals contained in the Millennium Declaration, and recognize that the implementation of the ICPD Programme

\textsuperscript{15} Girard, Francoise. IWGSSP Working Papers, No. 1, June 2004.
of Action and the Key Actions for further implementation of the ICDP Programme of Action is essential for the achievement of the Millennium Development Goals.

The Commitment of Caribbean countries was once again reaffirmed at the third of the three regional meetings, of the Economic Commission for Latin American and the Caribbean Thirtieth Session which took place in San Juan, Puerto Rico. The Caribbean once again “reaffirm[ed] full support to ICPD” PoA in a statement read by Trinidad and Tobago on behalf of the Caribbean region:

We have embraced the Cairo Programme of Action as our own, and are pursuing its implementation in the context of social, cultural, political and economic realities of our countries in line with universally recognised rights. We also reaffirm our endorsement of the Port-of-Spain, 2003 and Santiago, 2004 Declarations as the frameworks to guide the implementation of the ICPD Programme of Action in our countries over the next 10 years.

Research Methodology

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

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

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

- The Enabling Environment
- Sexual and reproductive health policies and programmes and the exercise of sexual and reproductive rights
- The role of NGOs; governmental and non-governmental relations; and
- Financial aspects implied in the implementation of reproductive health programmes.

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

- Basic demographic and social and economic indicators for the country, including gender-based data.
- Policies prevailing before Cairo: role of governments, role of international agencies; role of civil society organizations.
• Preparations for Cairo

• What has happened in the post-Cairo period: what governments and international agencies have done (or not) to implement ICPD.

• Identification of relevant, country-specific ICPD recommendations that are to be drawn from the ICPD Programme of Action elements listed before;

• Presence and role of reproductive health and rights advocacy community

• Presence and role of ICPD Agenda adversaries

• Health sector reform as it pertains to women’s health

• Maternal mortality policy

• Abortion law and policy

• Abortion data and statistics

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

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

• What have Caribbean women achieved in regard to sexual and reproductive health and rights in the past 20 years?

• How should the women’s movement tackle the fundamental problem of undervaluation of women’s lives?

• Given the poor state of public health globally and in the Caribbean, how can the women’s movement raise the priority of women’s health?

• How can the Caribbean move away from the current response to women’s health which addresses women’s needs primarily within a reproductive capacity?

• How can the response to women’s health needs find a space between the dominant discourses of HIV/AIDS and maternal and child health?

• How can sexual rights and sexual health be brought to the forefront of the discourse on health, particularly given the impact of the HIV/AIDS epidemic?

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

Selected Countries

The DAWN policy research is closely articulated with advocacy strategies. For that reason, the choice of countries to be studied in the region required that organic connections existed between the women’s movement of the Caribbean and the country research teams.
The four countries selected, Barbados, Jamaica, Suriname and Trinidad and Tobago, each have populations greater than 250,000 people. Specific to the research Barbados and Suriname have more liberal abortion policies than Jamaica and Trinidad and Tobago. In regard to maternal mortality, Jamaica, Suriname, and Trinidad and Tobago have higher rates of maternal mortality than many countries of similar size (with the exceptions of Belize, Guyana, and Haiti). Trinidad and Tobago was specifically chosen because of the recent activities around abortion in reaction to the group ASPIRE who have reignited the abortion debate in the public sphere.

Limitations of research

One of the greatest challenges facing research and analysis is the lack of accurate and high quality data. The Caribbean region reflects the challenges occurring globally in regards to abortion data, particularly in countries where abortion is illegal. Data around maternal mortality is also inadequate as due to weak reporting structures, and misclassification of information. (DAWN research). For example, PAHO’s recent publication Health Conditions in the Caribbean notes that there is a lack of standardization in recording mortality data: not all stillbirths are weighed, and some deaths of babies that weigh over 500 g may be registered as abortions.16

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

Report Structure

This report is a presentation of available data and concluding recommendations. The first section of the paper presents the broad country contexts allowing for an understanding of the health sector reform processes addressed in section two. The third and fourth sections of the paper present research findings on maternal mortality and abortion in the region, the final section brings the data together to draw the connections between health sector reform, maternal mortality, and abortion in the region. Finally, the report makes recommendations for the better integration and prioritization of maternal mortality and morbidity in the health sector reform process: an integral step in improving the status of women’s health in the region.
Social, Economic, and Political Context of Sexual and Reproductive Health Rights in the Caribbean
Regional Overview

The Broad Context

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Area (km²)</th>
<th>Population (1997)</th>
<th>GINI coefficient</th>
<th>HDI rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antigua &amp; Barbuda</td>
<td>442</td>
<td>69,747</td>
<td>0.525</td>
<td>37</td>
</tr>
<tr>
<td>The Bahamas</td>
<td>13,864</td>
<td>288,000</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Barbados</td>
<td>431</td>
<td>264,500</td>
<td>0.460</td>
<td>30</td>
</tr>
<tr>
<td>Belize</td>
<td>22,966</td>
<td>230,000</td>
<td>0.510</td>
<td>58</td>
</tr>
<tr>
<td>Dominica</td>
<td>750</td>
<td>76,000</td>
<td>0.488</td>
<td>51</td>
</tr>
<tr>
<td>Grenada</td>
<td>345</td>
<td>99,500</td>
<td>0.504</td>
<td>54</td>
</tr>
<tr>
<td>Guyana</td>
<td>214,970</td>
<td>770,139</td>
<td>0.423</td>
<td>96</td>
</tr>
<tr>
<td>Jamaica</td>
<td>10,991</td>
<td>2,515,500</td>
<td>0.372</td>
<td>83</td>
</tr>
<tr>
<td>Montserrat</td>
<td>103</td>
<td>5,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Kitts &amp; Nevis</td>
<td>269</td>
<td>42,600</td>
<td>0.445</td>
<td>47</td>
</tr>
<tr>
<td>St. Lucia</td>
<td>616</td>
<td>149,621</td>
<td>0.468</td>
<td>88</td>
</tr>
<tr>
<td>St. Vincent &amp; the Grenadines</td>
<td>389</td>
<td>111,000</td>
<td>0.448</td>
<td>79</td>
</tr>
<tr>
<td>Suriname</td>
<td>163,820</td>
<td>418,921</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>5,128</td>
<td>1,270,000</td>
<td>0.420</td>
<td>50</td>
</tr>
<tr>
<td>TOTAL CARICOM</td>
<td>435,084</td>
<td>6,310,528</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CARICOM (2000)

The countries of the region are characterised by similarly high domestic wealth and income disparities and high levels of social exclusion in what are historically, highly-stratified societies. Following decolonisation in the 1960s and 1970s most regional governments prioritised social development in order to right some of the serious health and educational deficits which had accrued over the past centuries of slavery and colonial rule. Most countries, with the significant exception of Haiti which has been independent for 200 years, were
generally successful at this. This is evidenced by the large middle class in most Caribbean countries. However, significant parts of the population of all Caribbean countries remained trapped in deep structural poverty, without access to adequate health, housing and sanitation facilities nor benefiting from their countries educational services. By the 1980s, ideological shifts in development strategy combined with global economic shocks arising from the 1970s oil crises led to structural adjustment programmes of various sorts across the independent Caribbean. These policies generally led to cuts in social services provision which adversely affected the poor, leaving them more deeply ensconced in poverty and deprivation. Further, large cuts in government employment, critical in small developing economies with generally low levels of private sector development, threatened to return many of the newly-created middle class to poverty while many of those who were already poor were threatened with indigence. Structural adjustment approaches to public sector management did little to improve government efficiency which, combined with increasing fiscal crises, resulted in many public sector institutions being unable to address the increasing social and economic crises that were affecting its citizenry.17

Today one sees a slight retreat from the austere economic policies recommended by the Washington institutions over the past two-plus decades. However, economic policy making has come to be dominated by concerns with fiscal management to the exclusion of long term employment and income generating strategies that might raise large sections of the region’s population permanently out of poverty. As such, the region continues to amble along depending on a few externally-driven industries such as tourism, agricultural commodities and mineral and petroleum extraction for its survival, while governments appear unimaginative in the face of pending crises including the ending of historical trade preferences and the HIV/AIDS pandemic.18

**Economic Trends**

In 1989, member states of CARICOM agreed to establish the CARICOM Single Market and Economy (CSME) with the purpose of achieving a greater level of integration than is possible under the existing treaty. Objectives of CSME include “free movement of goods, services, capital and persons, more intensive coordination of macroeconomic policies and economic relations and the harmonisation of laws governing trade and other economic activities within the common market area.” The establishment of CSME would also increase the bargaining power of CARICOM countries in arenas of international negotiations such as the World Trade Organization or Free Trade Area of the Americas. Progress towards the establishment of the CSME has been slow.19

A recent report, “Review and Appraisal of the Implementation of the Cairo Programme of Action in the Caribbean” prepared for the ten year review of the ICPD puts forward that “small domestic markets, insularity and dependence

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17 Jackson, Jason. Caribbean Development Bank. 2004
18 Ibid.
19 Ibid.
on a narrow range of goods and services characterise most Caribbean economies. The recent globalisation process poses significant challenges to small developing economies.”

While several countries have maintained economic growth, growth rates of many countries have declined. During the 1990s many Caribbean countries experienced a shift in industry from agriculture and mining to the services sector while manufacturing remained stagnant. Agriculture accounted for 13.5% of output in 1990 and 9.5% in 1999; manufacturers represented 12.7% and 11.6% while the service sector increased output from 39.1% to 46.6%.

Unemployment in the region is high, and range from approximately 12-20%. Young men and women have been most affected by high rates of unemployment, young females have been disproportionately affected.

HIV/AIDS in the Caribbean Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Adult (15-49) HIV Prevalence Rate (%)</th>
<th>Total Number of Adults Infected (15-49 years)</th>
<th>Female Infections (% of adult infections)</th>
<th>AIDS Orphans (number of children aged 0-14 who have lost one or both parents to AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>1.2</td>
<td>2,000</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Jamaica</td>
<td>1.2</td>
<td>18,000</td>
<td>40</td>
<td>5,100</td>
</tr>
<tr>
<td>Suriname</td>
<td>1.2</td>
<td>3,600</td>
<td>50</td>
<td>1,700</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>2.5</td>
<td>17,000</td>
<td>32.9</td>
<td>3,600</td>
</tr>
</tbody>
</table>

The Caribbean is second only to sub-Saharan Africa in prevalence of HIV/AIDS. In the Caribbean, and as demonstrated around the world, women often carry the burden of caretaking those members of their family living with HIV/AIDS. Special attention therefore needs to be paid to the impact of the epidemic on the lives of women as individuals, as caregivers and as the heads of their households.

The Bahamas 3.5 6,100 44.3
Barbados 1.2 2,000 —
Belize 2.0 2,200 45.5
Cuba <.1 3,200 25.9
Dominican Republic 2.5 120,000 50.8
Guyana 2.7 17,000 50.0
Haiti 6.1 240,000 50.0
Jamaica 1.2 18,000 40.0
Suriname 1.2 3,600 50.0
Trinidad and Tobago 2.5 17,000 32.9
Caribbean Countries 2.3 429,100 48.8

20 Ibid.
21 Ibid.
22 Ibid.
24 Kenneth Hall, UWI UNDP-UNAIDS DATA
Haiti currently has the highest rate of HIV/AIDS infection in the Caribbean at 5.17% of the adult population (ages 15-49). Fifty per cent of those cases are women. Along with Haiti, Jamaica, The Bahamas, Belize, the Dominican Republic, Guyana, and Suriname also have HIV+ populations where over 40-50% of the cases are represented by women. Rates are also high among the youth populations: in The Bahamas in 2001, 3% of females and 2.6% of the boys between the ages of 15-24 were found to be HIV+. In the 15-24 age group, in Belize, the Dominican Republic, Guyana, Haiti, Jamaica, Trinidad and Tobago, and Suriname, girls’ prevalence rates are higher than boys.

An analysis of the impact of the epidemic must also take into account the impact on women. In Caribbean families women are often the primary heads of households, therefore, high numbers of women living with and affected by HIV/AIDS means potentially devastating impacts on the stability of the Caribbean household.

**Financial and Implementation Strain on the Health Sector**

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

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

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

In addition, stigma and discrimination are major issues facing all people infected and affected by HIV/AIDS in the Caribbean as they not only impact an individual’s day-to-day life but also his or her ability to seek treatment in a health care system which does not respond appropriately to individuals living with HIV/AIDS. Related stigma’s associated with sexual diversity and transactional sex also impact the individual’s ability to seek out HIV/AIDS services and increases vulnerability to contracting HIV/AIDS.

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

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

There are several issues, that have been neglected or marginalized in the Caribbean. Issues of diverse sexuality have been and historically marginalized in the region particularly because historic and current stigmatization of the lesbian, gay, bisexual, and transgender (LGBT) communities. HIV/AIDS has offered the opportunity to discuss diverse sexualities, however the emphasis remains on control of rather than respect for diverse sexualities.

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

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

**Violence Against Women**

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

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

**Poverty and Education**

In 1996, the World Bank estimated that 38% of the total population in the Caribbean is poor. This ranged from 5-65% of the national populations. The poor in most countries are found among older persons, women, young males, unemployed youth and unskilled workers. Poorer families in the region tend to have more children, are less educated and often have single-parent households.
Access to education in the region is high, as demonstrated by overall literacy rates ranging for most countries between 92-99.8%. Government spending on education is high ranging, between 2.5%–9.8% of GNP. While girls often outperform boys in school, women have a greater chance of being unemployed as well as being lower paid then men.

**Regional Demographic Overview**

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

Females make up approximately 50.3% of the total population. There has been a decrease in the crude birth rate from 26/1000 in 1980–1985 to 22.4/1000 in 1990-1995. During these times the infant mortality has also dropped from 23/1000 to 21/1000. Life expectancy at birth has increased averaging approximately 68 years. Approximately 30% of the Caribbean population is below the age of 15. Less than 60% of the entire Caribbean population is between 16 and 60 years old.

**TABLE 4. BASIC INDICATORS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>53.2 (1994)</td>
<td>1.8</td>
<td>.6</td>
<td>91</td>
</tr>
<tr>
<td>Jamaica</td>
<td>62.8 (Ca. 2004)</td>
<td>2.8</td>
<td>.6</td>
<td>97.8</td>
</tr>
<tr>
<td>Suriname</td>
<td>42.1 (2000)</td>
<td>2.2</td>
<td>.9</td>
<td>85</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>52.7 (ca. 2004)</td>
<td>1.7</td>
<td>.6</td>
<td>99</td>
</tr>
</tbody>
</table>

**The Socio Political Context**

**The Caribbean Women’s Movement**

A recent paper by Margaret Gill outlines thoughts on the status of the women’s movement in the Caribbean. She states that while the Caribbean women’s movement has always been on somewhat unsteady ground, the current state of the women’s movement rests on even less stable foundations than ever before. She cites four factors contributing to this destabilization:

1. *The notion of difference* (exploring, critiquing and understanding the idea of universal sisterhood)

2. *notions of the total or absolute power of patriarchy, colonialism, neocolonialism, capitalism and statism, in other words, the belief in the near impossibility of penetrating these amalgams of power* (creating strategies, recognizing the strength of women’s organizations and presence)
3. the male backlash (the idea in popular imagination and further in academic and programmatic rhetoric that in fact men are marginalized given education indicators)
4. the 20th century instabilities of the concept of the nation state.
5. loss of funding

In the introduction to this research, Peggy Antrobus connects these ideas to sexuality and spirituality identifying a regional workshop on ‘empowerment’ sponsored by the Women and Development Unit (WAND) of UWI of the West Indies in the 1980s in which sexuality and spirituality were identified as sources of empowerment for Caribbean women. Sexuality and spirituality become a necessary and missing element in stabilizing and reenergizing the women’s movement in the Caribbean.

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

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

**Religious Fundamentalisms**

The history of religion in the Caribbean is as complex as the histories and experiences of the various groups of people that make up the population of the region: African-Caribbean, Indian, Chinese, Syrian, Lebanese, and Amer-Indian populations bring their own practice of faith and associated culture. For many, the experience of religion has been one of movement and community building, as seen within the Liberation Theology movement for many Catholics and the experiences of Indians in the Caribbean including Trinidad and Tobago and Guyana. While many of these experiences have been positive, fundamentalist practice of faith in the Caribbean, as in many other parts of the world, have often forwarded religious dogma that is most damaging and controlling towards women.

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

In regard to sexual and reproductive health and rights, religious discourse has been influential in recent debates, including those on the issues of the decriminalization of homosexuality and sex work in Barbados, abortion in St. Lucia, and discrimination on the basis of sexual orientation in Guyana. In each of these cases, various religious groups (Christian groups and individuals in general, Catholics, Muslims, and Hindus) spoke out on a particular issue. The recent rise in fundamentalism may be partly attributed to a reaction by the people of the Caribbean to increased levels of poverty, a slow down in economic growth, a loss of Caribbean culture (due to the increased presence of American media) and an increase in crime and violence in many communities. Such factors have been blamed for ‘moral decay’ and have inspired a return to faith-based communities in efforts to reclaim what is seen to be lost in regards to community. In addition to these socio-economic factors however one cannot ignore the co-optation of many churches by an evangelistic presence of church bodies from North America. This is not limited to the church, however, as many Hindu and Muslim communities have also been greatly influenced by rising levels of Hindu and Muslim fundamentalism in South Asia (countries of origin for the Indo-Caribbean community). Finally, one must look to the changing nature of monies coming in the Caribbean for HIV/AIDS (and world development community) that has been earmarked for faith based groups which, in turn, increase the influence of religious bodies in areas of HIV/AIDS, and sexual and reproductive health and rights.

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

Very little research has been done to understand the impact that religion is having on the sexual and reproductive health and rights movement in the Caribbean and in particular on the women’s movement. However, it is becoming clear that there is an important need to do so in order to tackle negative outcomes of the growing influence of religious bodies, particularly on the individual’s sexual and reproductive health and rights.
Regional Support and Dissent for ICPD from Non Governmental Actors

Regional support for ICPD and Beijing has come from various groups including women’s and feminist organizations such as ASPIRE, CAFRA and DAWN, youth groups such as the YMCA and Advocates for Youth Sexual and Reproductive Rights (AYSHR) in Trinidad and Tobago, and implementing organizations such as Family Planning Associations, such as Stiching Lobi of Suriname, and UN bodies such as UNFPA and UNIFEM through encouraging the participation of governments and activists in the ICPD +10 review process.

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

Because of the little attention dedicated to ICPD in mainstream consciousness regionally, there has been little dissent around the ICPD PoA in particular. However, specific issues that are related to women’s reproductive health and rights have come under attack in several Caribbean countries. The recent abortion debates in St. Lucia and Trinidad and Tobago, between anti-abortion Roman Catholics and other religious organisations and advocates for safe and legal reproductive services which led to the shelving of proposed legislation to liberalize abortion laws in some circumstances, serves as a good example. Public debates around homosexuality and sex work in Barbados which led to the squelching of a proposal to decriminalize these acts demonstrates the strength of a movement which seeks to legislate behaviour on moralistic and often religious grounds rather than human rights or science and behavioral science-based rationales.

The continued neglect of women’s health in the Caribbean, particularly women’s sexual and reproductive health rights, is reflected in continued valuation of women’s lives based on their reproductive capabilities, as seen through maternal and child health programs that historically focus on women of reproductive age. With increased funding dedicated to HIV/AIDS, women’s health issues are increasingly dichotomized into two streams: MCH or HIV/AIDS. Women’s health issues, in particular issues around sexual health and sexual rights, are marginalized. Specific issues within the region impacted by the neglect of reproductive and sexual health and rights include the challenge of increased tubal ligations in Trinidad and Tobago, access to contraception across sexually active populations, and a lack of focus on pleasure.
BARBADOS

Context
Barbados is the eastern most Caribbean island and extends over approximately 430 km². The 2002 UNDP Human Development Report ranks Barbados 31st among 174 countries. The population of Barbados is approximately 270,400. The country is divided into 11 parishes. Approximately 35,000 people live below the poverty line.

Barbados gained independence from the United Kingdom in November 1966 and operates as an independent state within the commonwealth. Barbados has a democratic system (two party system) of government, parliamentary elections are held every five years. The two parties are the Barbados Labour Party (BLP) and the Democratic Labour Party (DLP). The parliament, which has legislative power, consists of 21 members of Senate and 28 members of the House of Assembly (PAHO, WB BGI Country Brief). The government is a constitutional monarchy, however, and the head of state is the Queen who is represented by the Governor General. Executive power resides with the cabinet, the principal organ of policy. Judicial authority is vested in the Supreme Court which is comprised of the High Court and the Court of Appeal. The Privy Council, consists of members appointed by the Governor General. Barbados does not have a local government system and all political fiscal and administrative responsibilities are managed under the central government.

Economic Profile
Barbados is described as a small, open economy and over the past 30 years has moved from a reliance on sugar to become a services-based economy. Tourism and financial services are the main industries in the country. The unemployment rate is approximately 9.3%. Real GDP declined by 2.6% in 2001 from 3.0% in 2000. Offshore financial services and informatics are also main foreign exchange earners.

<table>
<thead>
<tr>
<th>TABLE 5 REAL GDP PER CAPITA (GENDER EQUALITY IN THE CARIBBEAN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Barbados</td>
</tr>
</tbody>
</table>

GNI PPP per Capita 2000=15,020

Demographics
The 14th Population and Housing Census in 2000 reports that the total population of Barbados is 268,792 individuals: 129,241 (48%) males and 139,551 (52%) females. Fifty-one per cent of this population is considered urban. The life expectancy at birth for women is 77.4 years and for men the life expectancy is 72.9 years. In 1998 100% of urban populations had access to potable water, and 99% of urban populations had access to basic sanitation.
(Data for rural populations not available). In 2001 the contraceptive prevalence rate was 55% for any method of contraceptive.47

In 2002, 97% of females above the age of 15 were literate; 98% of males above the age of 15 were also literate. Eighty-five per cent of Barbadians own the houses that they live in (not necessarily the land); 90% of households have running water; 90% have electricity; 80% have telephones; 85% have refrigerators and 42% have motor vehicles.48

In 2004, the life expectancy of males was approximately 71 years and for females 77.6 years. The contraceptive prevalence rate was approximately 53.2% in 1994. UNFPA Caribbean recorded the infant mortality rate to be 14.7/1000 live births. The maternal mortality ratio has been recorded as 20.49 The percentage of skilled births with a skilled attendant was 91.

### TABLE 6. DEMOGRAPHIC OVERVIEW –BARBADOS

<table>
<thead>
<tr>
<th>Year</th>
<th>Resident Population at Dec 31</th>
<th>Birth Rate (per 1000 pop)</th>
<th>Death Rate (per 1000 pop)</th>
<th>Rate of Natural Increase 1000 pop</th>
<th>Infant Mortality (per 1000 births)</th>
<th>Rate of population growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>263.9</td>
<td>14.3</td>
<td>9.1</td>
<td>5.2</td>
<td>9.8</td>
<td>.3</td>
</tr>
<tr>
<td>1994</td>
<td>264.3</td>
<td>13.4</td>
<td>8.9</td>
<td>4.5</td>
<td>8.5</td>
<td>.2</td>
</tr>
<tr>
<td>1995</td>
<td>264.4</td>
<td>13.1</td>
<td>9.4</td>
<td>3.7</td>
<td>13.2</td>
<td>.4</td>
</tr>
<tr>
<td>1996</td>
<td>264.6</td>
<td>13.3</td>
<td>9.1</td>
<td>4.2</td>
<td>14.2</td>
<td>.1</td>
</tr>
<tr>
<td>1997</td>
<td>266.1</td>
<td>14.3</td>
<td>8.7</td>
<td>5.6</td>
<td>13.2</td>
<td>.6</td>
</tr>
<tr>
<td>1998</td>
<td>266.8</td>
<td>13.6</td>
<td>9.3</td>
<td>4.3</td>
<td>7.8</td>
<td>.4</td>
</tr>
<tr>
<td>1999</td>
<td>267.4</td>
<td>14.5</td>
<td>9.0</td>
<td>5.5</td>
<td>10.0</td>
<td>.2</td>
</tr>
</tbody>
</table>

### TABLE 7. WOMEN IN DECISION MAKING POSITIONS 2000-200150

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

**Policies that Pertain to Women**

**Policies immediately relevant to women**

Since the ratification of CEDAW in 1980, Barbados has taken several steps to reform policy as it pertains to women being able to pass on citizenship to their children; rights of women in common law unions around property rights.51
The ratification of the CRC in 1990 led to the introduction of legislation around the *Family Law Act* to address the rights of the children for maintenance from non-biological fathers who are in lasting relationships with mothers. However, this law has not gained public support from men.52

In 1992, the *Domestic Violence Protection Orders Act* granted protection orders in circumstances surrounding domestic violence. The legislation provides protection for both male and female victims of domestic violence, in addition to couples in common-law unions.51

In 1992, the *Sexual Offences Act* updated older legislation addressing rape, and other sexual offences committed against girls, boys and women. Additionally, the *Sexual Offences Act* also introduces legislation around trafficking. (Husbands cannot be charged with marital rape unless there has been a breakdown in the marital relationship.)54 Homosexuality is illegal and stigmatised.55

The *Education Act* of 1991 states that the “parent of every child of compulsory school age shall ensure that the child receives full time education suitable to his age and ability.”56

The *Constitution (Amendment) Act* 2000-18 gives women equal rights with men with respect to the nationality of the children and to equal participation and freedom of assembly and association.57

Article 11, Section 2: Right to Protection of Health and Safety in working conditions include maternity leave; special protection for pregnant women; and support families?. Sec. 14: Provision of health care services, including information, counseling, and family planning services. The legal age of consent is 16, consequently young people 16 and under can be denied access to sexual health information and sex education.58

UNFPA Caribbean notes that the rights of Barbadian women are still to be fully realized. This is exemplified by the inability of wives to charge their husband with rape unless they are able to demonstrate that there has been a breakdown in the marital relationship.59

**Poverty Reduction Strategy**60

Barbados established a Poverty Alleviation Bureau in October 1998 to examine and report on the living conditions of persons and organizations making applications to the Poverty Eradication Fund for assistance.

The main objectives of the bureau are to:

- Assist in the alleviation and eradication of poverty through the empowerment of individuals and groups by the provision of economic and financial opportunities as well as education and vocational training.
- Establish a cordial and effective working relationship with government agencies, NGOs, CBOs, individuals and community groups in an effort to reduce inefficiencies, duplication of efforts and wastage of resources.

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57 Ibid.
58 Ibid.
59 Ibid.
• Ensure a faster and more meaningful delivery of services.
• Create the climate for young people to gravitate towards the growth and development of small/micro business enterprises.
• Pioneer the development of a new entrepreneurial class.

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

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

**Relief 2000**

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

**JAMAICA**

**Context**

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

**Demographics**

Information given in the *Economic and Social Survey 2004*

62 indicates that the population of Jamaica at the end of 2004 was estimated at approximately 2,650,900 million with a roughly 1:1 male- female ratio, 49.3% males and 50.7% females (the proportions remain unchanged since 2002). The rate of natural increase was 1.4 per cent, while the actual population growth rate was 0.5 per cent reflecting the net effect of the pattern of birth deaths and the effects of external migration (0.9 per cent).

Jamaica’s population is highly urbanized. The urban population in 2001 comprised 52.0 per cent of the total population. The trend seems to be the
growing urbanization of parishes other than the capital which recorded the greatest growth in previous years. The parishes recording the highest urban growth rates were St. Elizabeth (3.7 per cent); St. Catherine (2.9 per cent); St. Ann (2.0 per cent) and St. Thomas (1.7 per cent). Urban St. Andrew grew marginally at 0.4 per cent reflecting its lowest rate ever recorded and Kingston registered negative growth at 0.12 per cent.

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

Jamaica's population is predominantly young and of working and child bearing ages. Children under five and those 5-9 years old were 10.4 (271,736) and 10.7 (279,323) per cent of the population respectively in 2001. Adolescents aged 10-19 (244,470 males, 253,439 females) accounted for 19 per cent and persons aged 20-49 were 43.8 per cent of the population.

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

There has been a decrease in the number of women in the Houses of Parliament from 15% to 12%, but still maintaining 3 women as Ministers out of a total of 18. There has been a drop in women's presence in local government from 24% to 15%.

**Economic Profile**

The growth rate has been consistently below 1.0 per cent since 1997. The report makes special note of the fact that the current growth rate is below the projected rate of 0.8 per cent, and hence Jamaica is on target for achieving its National Population Policy growth target of below 3.0 million by the year 2020.

In 2004, the number of persons in the labour force increased by 0.4% per cent to 1, 194 800. The overall labour force participation rate was 64.3 per cent. The male labour force participation rate was 73.3 per cent, while the female rate was 55.8 per cent.
The number of employed persons increased to 1,055,200 up from 954,300 in 2002. Female employment increased by 1,900 to 444,300 largely in the Wholesale and Retail Trades, Hotels and Restaurant Service. There were 139,600 unemployed persons with female unemployment being 16.4% while the male was 7.9%. Female youth unemployment was 40.6% compared to 23.4% of male youth. In 2004, females accounted for 62.3% of the unemployed labour force compared to 61.9% in 2003.

The 2004 Economic and Social Survey says the ‘economy recorded its sixth consecutive year of real GDP growth’ of an estimated 1.2% in 2004. The point-to-point inflation rate for 2004 was 13.7% per cent, down from 14.4% recorded for 2003.

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

**SURINAME**

**Context**

The total land area of the Republic of Suriname is 163,820 square kilometers, excluding disputed territories with the neighboring Guyana, and is divided into 10 administrative districts. These can be divided in the coastal area northern lowlands and savannah), which is well inhabited; and the hinterland (southern highlands covered by tropical rainforest) which is sparsely inhabited. The urban districts, Paramaribo and Wanica cover only 0.4% of the land area, but are inhabited by approximately 68% of the population, with an estimated population density of 470.1 per square km. The district of Sipaliwini, which covers 79.7% of the land area is inhabited by approximately 5.5% of the population with an estimated population density of 0.9 per square km. (Estimates for the year 2000).

Statistics for 2003 show that the population density of the urban areas has increased to 1,338.3 for Paramaribo, and to 193.1 for Wanica. In Sipaliwini, density has further decreased to a mere 0.2 per square km. It is important to note that for Sipaliwini the sex ratio is the lowest of all districts, 91 compared to a national 101. This can be explained by the fact that the men leave the villages to search for economic possibilities, the women stay behind.

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66 Economic and Social Survey, 2004 Overview, Planning Institute Of Jamaica
67 Ibid
68 Chief Medical Officer’s Report 2000
69 GBS, Suriname Population Census 2003, Preliminary Report, table 5 and 7
** Demographics**

### TABLE 8. DEVELOPMENT OF POPULATION 1994-2000

<table>
<thead>
<tr>
<th>Year</th>
<th>Start Population</th>
<th>Birth Growth</th>
<th>Death</th>
<th>Natural Growth</th>
<th>Migration Saldo</th>
<th>End Population</th>
<th>Crude Birth Rate#</th>
<th>Crude Death Rate#</th>
<th>Crude Growth in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>413,591</td>
<td>8,418</td>
<td>2,842</td>
<td>5,576</td>
<td>-1,443</td>
<td>417,724</td>
<td>20.3</td>
<td>6.8</td>
<td>1.0</td>
</tr>
<tr>
<td>1995</td>
<td>417,724</td>
<td>8,717</td>
<td>2,696</td>
<td>6,021</td>
<td>-400</td>
<td>423,345</td>
<td>20.7</td>
<td>6.4</td>
<td>1.3</td>
</tr>
<tr>
<td>1996</td>
<td>423,345</td>
<td>9,393</td>
<td>2,894</td>
<td>6,499</td>
<td>-2,022</td>
<td>427,822</td>
<td>22.1</td>
<td>6.8</td>
<td>1.1</td>
</tr>
<tr>
<td>1997</td>
<td>427,822</td>
<td>10,794</td>
<td>2,678</td>
<td>7,916</td>
<td>-1,407</td>
<td>434,331</td>
<td>25.0</td>
<td>6.7</td>
<td>1.5</td>
</tr>
<tr>
<td>1998</td>
<td>434,331</td>
<td>10,221</td>
<td>2,814</td>
<td>7,407</td>
<td>-2,577</td>
<td>439,161</td>
<td>23.4</td>
<td>6.4</td>
<td>1.1</td>
</tr>
<tr>
<td>1999</td>
<td>439,161</td>
<td>10,144</td>
<td>2,992</td>
<td>7,152</td>
<td>-640</td>
<td>445,673</td>
<td>22.9</td>
<td>6.8</td>
<td>1.5</td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>445,673</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*CBB, Demographic Data Suriname 1998-1999*

### TABLE 9. DEMOGRAPHIC INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated mid-interval population</td>
<td>424,590</td>
<td>430,261</td>
<td>435,797</td>
</tr>
<tr>
<td>Still births</td>
<td>228</td>
<td>223</td>
<td>260</td>
</tr>
<tr>
<td>Live births</td>
<td>10,221</td>
<td>10,144</td>
<td>9,804</td>
</tr>
<tr>
<td>Total births</td>
<td>10,449</td>
<td>10,367</td>
<td>10,064</td>
</tr>
<tr>
<td>Women in 15-44 age group</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Live births for females 15-44</td>
<td>10,148</td>
<td>9,794</td>
<td>9,279</td>
</tr>
<tr>
<td>Fertility rate (live births per 1000 females 15-44)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Infant Deaths</td>
<td>163</td>
<td>227</td>
<td>175</td>
</tr>
<tr>
<td>Maternal Deaths</td>
<td>9</td>
<td>11</td>
<td>15</td>
</tr>
</tbody>
</table>

*Chief Medical Officer’s Report, 2000*

### TABLE 10. TOTAL POPULATION BY AGE AND GENDER MID-YEAR ESTIMATES BY AGE GROUP AND SEX, 1995

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

*GBS, May 1999*

Data collected for the year 2000 suggest the same structure as the GBS 1995 estimates. Suriname has a pyramid-shaped population structure with 52% of its population younger than 25 years. 70
TABLE 11. POPULATION AT CENSUS YEARS BY SEX, SEX RATIO AND GROWTH PER ANNUM

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

Fertility

TABLE 12. FERTILITY RATES

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>3.6</td>
</tr>
<tr>
<td>1985</td>
<td>3.4</td>
</tr>
<tr>
<td>1990</td>
<td>2.6</td>
</tr>
<tr>
<td>1995</td>
<td>2.4</td>
</tr>
</tbody>
</table>

The steady decline is most likely due to increased education in family planning and contraceptive use. Unfortunately, fertility rates for 2000 seem to be unreliable. For MICS data the Brass P/F procedure was used, with a TFR of 3.3 as a result. This seems very unlikely with regard to the declining trend, and so further investigation was warranted.\(^1\) PAHO predicted that the fertility rate would drop to 2.1 for the period 1999-2003.

Life Expectancy

The Chief Medical Officer’s Report 2000 estimates life expectancy at birth to be around 70 years of age for 1990-1995, with women living approximately five years longer. This is supported by findings of the PAHO, which state that life expectancy at birth was 69.1 years for men and 74.1 years for women in 1998. According to other figures however, life expectancy for men was 68 years and 70 years for women in 1998\(^2\).

Infant mortality and Maternal Mortality

TABLE 13. VITAL STATISTICS RATES 1995-2000***

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Still birth rate</td>
<td>17.6</td>
<td>21</td>
<td>21.4</td>
<td>22.3</td>
<td>22</td>
<td>25.8</td>
</tr>
<tr>
<td>Neonatal Death Rate</td>
<td>9.0</td>
<td>10.7</td>
<td>9.8</td>
<td>9.0</td>
<td>10.8</td>
<td>14.9</td>
</tr>
<tr>
<td>Perinatal Death Rate</td>
<td>27.3</td>
<td>31.5</td>
<td>32.5</td>
<td>32.7</td>
<td>32.6</td>
<td>38.4</td>
</tr>
<tr>
<td>Infant Death Rate</td>
<td>24.7</td>
<td>52.5</td>
<td>22.0</td>
<td>15.9</td>
<td>22.4</td>
<td>17.8</td>
</tr>
<tr>
<td>Maternal Death Rate</td>
<td>0.46</td>
<td>0.43</td>
<td>0.74</td>
<td>0.88</td>
<td>1.08</td>
<td>1.53</td>
</tr>
<tr>
<td>Estimated Birth Rate</td>
<td>21.3</td>
<td>22.7</td>
<td>25.8</td>
<td>24.1</td>
<td>23.6</td>
<td>22.5</td>
</tr>
<tr>
<td>Estimated Death Rate</td>
<td>6.6</td>
<td>7.0</td>
<td>6.9</td>
<td>6.6</td>
<td>7.0</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Chief Medical Officer’s Report 2000

Infant death rate per 1,000 live births\(^*\)
Maternal death rate per 1,000 live births\(^*\)

\(^1\) Suriname Multiple Indicator Cluster Survey, GOS, March 2001

\(^2\) Summary of Situation Analysis and Response Analysis HIV/AIDS, 2001

*** Still birth: Fetal deaths of 22 weeks or more gestation
Neonatal death rate per 1,000 total births
Perinatal death rate: still birth + early neonatal death per 1,000 total births
Birth rate per 1,000 of population
Death rate per 1,000 of population
Assume infant death counts from 28 days after birth until 1 year of age.
Since 2001 the Bureau of Public Health has made efforts to improve data collection and monitoring systems. Due to underreporting the registered MMR were 38 per 100,000 for 1990, 45.9 for 1995 and 31.9 for 1996. Based on active hospital surveillance, the MMR was corrected to 153 per 100,000 for the year 2000.73

All death rates remained steady between 1996 and 1998, then increased in 1999 and 2000. The increase can be contributed to better reporting and case identification of deaths, and deaths due to causes exacerbated by the economic hardships during these years. The two-fold increase in infant mortality based on registered deaths in the year 1996 could not be explained, and was not supported by the data retrieved from the death certificates. The increase could possibly be due to a data collection or entry error, according to the CMOR.

**Contraceptive prevalence**

In the 2000 Suriname Multiple Indicator Cluster Survey, 42.1% of women married or living in union reported current use of contraception. An earlier Contraceptive Prevalence Survey, conducted in 1992 showed that 49% of women aged 15-44 used a contraceptive method. However, wide discrepancies were found between women of different ethnic and age groups.74

**TABLE 14. CONTRACEPTIVE PREVALENCE AMONG IN-UNION WOMEN BY AGE GROUP (15-44 YEARS)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>User</th>
<th>Non user</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>29.6</td>
<td>70.4</td>
</tr>
<tr>
<td>20-24</td>
<td>50.3</td>
<td>49.7</td>
</tr>
<tr>
<td>25-29</td>
<td>52.4</td>
<td>47.6</td>
</tr>
<tr>
<td>30-34</td>
<td>60.1</td>
<td>39.9</td>
</tr>
<tr>
<td>35-39</td>
<td>58.7</td>
<td>41.3</td>
</tr>
<tr>
<td>40-44</td>
<td>47.9</td>
<td>52.1</td>
</tr>
</tbody>
</table>

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

It is noted that contraceptive knowledge appears to be high among young people but this is not necessarily reflected in contraceptive use. In a 2000 study in 2 high-risk pilot areas almost all respondents age 15-24 knew about the pill and condom. Around 30% of these respondents found access to contraceptives easy. All the same, among the respondents age 15-19 only 22.8% used contraceptives.75

**Female education**

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

The output of the education system at all levels is low, both quantitatively and qualitatively speaking. Each year, 23% of all pupils, at all levels, have to repeat a class, while 23 - 40% do not pass their exams. The percentage of dropouts is alarming, 7% in primary school and 25% in secondary school.  

There is no indication that girls enroll less than boys. It must be remarked however that for children in the interior, education is not always accessible and is of considerably lower quality.

While the percentage of women in higher education has gradually increased over the past years and is now higher than men, this is not reflected in the proportion of women in leadership positions in the country. Women comprise 9% of university lecturers, 17% of the National Assembly, 19% of Council of Ministers, 14% of councils of political parties, and 5% of medical specialists.

**Political and Economic Profile**

Since the late 1950s the mining and processing of bauxite became the core of the economy. It also provided successive governments with the means to distribute wealth, without stimulating or developing other sectors of production.

The strong and centralised government control that still reigns today is built on a political patronage system, where political factions, followers and friends can be rewarded with civil service jobs, houses, and other (artificially made) scarce commodities.

Of a total population of 481,146, and with an employment figure varying between 11% and 14%, the total of 36,151 civil servants make up 37% of the labour force. More remarkable, almost 25% of the total labour force is comprised of desk civil servants (23,987). This army of pencil pushers is more than 10 times the military army (2,042), more than 20 times the police force (1,142) and almost 20 times the total of nurses (1,235)!

**Race / ethnic Composition**

Suriname has a multi-ethnic population with 16 distinct ethno-linguistic groups. The largest groups are the Creole (35%), East Indian (34%), and Javanese (16%), followed by the Maroons (10%), the native Amerindians (2%), Chinese (2%). The other 1% is formed by Lebanese, Europeans and others.

Female Participation in Labour Force

In 1996 and 1997, the unemployment rate for women was twice that of men. Although there was a general increase of six per cent in employment from 1995 to 1997, job losses occurred in sectors that employ the most
women. Women still work mainly in the traditional “caring” sectors, which pay the least. The government is the main employer of women, the majority in the lowest echelons (71% of low-level civil servants is female). With globalization and the economic crisis, female entrepreneurs have disappeared from the formal sector and moved to the informal sectors.\textsuperscript{84} In the private sector, the rights of women workers are not well regulated and credit is hardly accessible. The estimated share of females in the economically active population is 32%.

**Most Relevant Gender Gaps**

The almost equal gender distribution in the population is not reflected in the authority relations in the various societal sectors. The current gender distributions indicate significant discrepancies in access to power and resources, in favor of males.

**Gender Related Policies**

In the draft report of the CEDAW consideration of reports of States parties, the Committee on the Elimination of Discrimination Against Women commended Suriname for the appointment of a Commission on Gender Legislation that was given the task of producing gender-sensitive legislation and reviewing draft laws related to the international conventions on gender equality and to present recommendations on new legislation. In addition, the Committee noted that there was the implementation of the Gender Action Plan (2000-2005), which takes into account the Beijing Platform for Action, the Caribbean Community Post-Beijing Plan of Action and Suriname’s national priorities.\textsuperscript{85}

**Poverty Reduction Policy**

Suriname is in 17\textsuperscript{th} place on the World Bank’s list of countries with the richest natural resources. At the same time Suriname is the third poorest country in the Caribbean sub-region, preceded by Haiti and Guyana. Economic inequality almost doubled in a dramatic way over the last 30 years, leaving the lower 50% of the population with 20.2% of national expenditures and the top 20% of population with 50.5% of national expenditures.\textsuperscript{86}

The decline in prices of bauxite and aluminum, years of internal unrest and war, and suspension of Dutch development aid in 1983 contributed to two decades of social, political and economic instability in Suriname, resulting in soaring inflation and deterioration of infrastructure and social services. In 1994 inflation peaked at 368.5, after which the situation gradually stabilized. According to the General Bureau for Statistics, the 2001 inflation was 38.6. An estimated 60-70% of the population lives below the poverty line. Based on income poverty ratio 91% of persons in the interior live below the poverty line\textsuperscript{87}. The years of war, with the interior as primary battleground, forced migration, poor infrastructure and high levels of disease have contributed to a disproportionately poor quality of life for the population in the interior.

\textsuperscript{84} Unifem. Fact sheet, Situation analysis of women, Paramaribo, 2000
\textsuperscript{87} MICS 2000
In 2000, three different estimates confirmed that poverty is a major and complex problem in Suriname. The UNDP-supported study on poverty estimated that general (food and non-food) poverty could be higher than 72%. The Bureau of Statistics estimated that “the percentage of poor persons in Suriname most probably lies between 49% and 74%” with 20% living in extreme poverty and 31% receiving some form of social assistance. Estimates obtained from the UNICEF-supported Multiple Indicators Cluster Survey (MICS 2000) suggest a regionally weighted average of about 73.2% poverty. The poverty studies identified female heads of household, youth (0-24 yrs.), the interior population and senior citizens as high-risk groups for poverty.

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

TRINIDAD AND TOBAGO

Context

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

Demographic Data

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>606,388</td>
<td>607,345</td>
<td>1,212,733</td>
</tr>
<tr>
<td>2000</td>
<td>633,051</td>
<td>629,315</td>
<td>1,262,366</td>
</tr>
</tbody>
</table>

Republic of Trinidad & Tobago, Central Statistical Office, 2000 Population and Housing Census Community Register

In the ten years between 1990 and 2000, the population increased by 48,633. The sex ratio was 100.59.
TABLE 16. AGE STRUCTURE

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population in Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 years</td>
<td>377,035</td>
</tr>
<tr>
<td>15-30 years</td>
<td>305,539</td>
</tr>
<tr>
<td>30-45 years</td>
<td>224,695</td>
</tr>
<tr>
<td>45-65 years</td>
<td>148,776</td>
</tr>
<tr>
<td>65 years and over</td>
<td>70,385</td>
</tr>
</tbody>
</table>

Republic of Trinidad & Tobago, Central Statistical Office, 1990 Demographic Report

Fertility

In T&T there has been a decline in general fertility rates from 1992 until 1996 with a slight increase in the general fertility rate occurring in 1997. According to WHO, there is an age specific fertility rate of 45.9. The total fertility rate for the period 1995-2000 was 1.7 children per woman.

Below are the general fertility rates for T&T from 1991–1997.

TABLE 17. GENERAL FERTILITY RATES, TRINIDAD & TOBAGO
1995–1997

<table>
<thead>
<tr>
<th>Year</th>
<th>Fertility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>73.49</td>
</tr>
<tr>
<td>1992</td>
<td>74.00</td>
</tr>
<tr>
<td>1993</td>
<td>64.10</td>
</tr>
<tr>
<td>1994</td>
<td>59.30</td>
</tr>
<tr>
<td>1995</td>
<td>56.30</td>
</tr>
<tr>
<td>1996</td>
<td>52.00</td>
</tr>
<tr>
<td>1997</td>
<td>52.20</td>
</tr>
</tbody>
</table>

Adapted from CEDAW Report, p.91

Life Expectancy

According to the Central Statistical Office, in the in 1990, life expectancy at birth for females was 73.21 years, and for males 68.41 years. (Source: CSO Annual Statistical Digest of 2000).

Infant Mortality

According to the 1999 Population and Vital Statistics Report of the Central Statistical Office, the infant mortality rates were as follows:

TABLE 18. INFANT MORTALITY RATES, TRINIDAD & TOBAGO
1991-1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Infant Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>11.0</td>
</tr>
<tr>
<td>1992</td>
<td>10.5</td>
</tr>
<tr>
<td>1993</td>
<td>12.2</td>
</tr>
<tr>
<td>1994</td>
<td>13.8</td>
</tr>
<tr>
<td>1997</td>
<td>17.1</td>
</tr>
<tr>
<td>1998</td>
<td>18.5</td>
</tr>
<tr>
<td>1999</td>
<td>17.1</td>
</tr>
</tbody>
</table>

Adapted from Republic of Trinidad & Tobago, Central Statistical Office, Population and Vital Statistics Report, 1999 and CEDAW Report, p. 91
TABLE 19. LIVE/STILL BIRTHS 1999

| Total live births | 18,321 |
| Total still births | 228 |


Maternal Mortality

TABLE 20. MATERNAL MORTALITY RATES, TRINIDAD & TOBAGO 1991-1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Maternal Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>49.18</td>
</tr>
<tr>
<td>1992</td>
<td>60.70</td>
</tr>
<tr>
<td>1993</td>
<td>66.40</td>
</tr>
<tr>
<td>1994</td>
<td>76.20</td>
</tr>
<tr>
<td>1995</td>
<td>67.5</td>
</tr>
<tr>
<td>1996</td>
<td>38.9</td>
</tr>
<tr>
<td>1997</td>
<td>70.4</td>
</tr>
<tr>
<td>1998</td>
<td>44.7</td>
</tr>
<tr>
<td>1999</td>
<td>38.2</td>
</tr>
<tr>
<td>2001</td>
<td>70.4</td>
</tr>
</tbody>
</table>

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

Ethnic Groups

Trinidad and Tobago is a heterogeneous society. Its ethnic composition, as quoted in the last census, follows:

TABLE 21. ETHNICITY TRINIDAD & TOBAGO

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>39.6</td>
</tr>
<tr>
<td>Indian</td>
<td>40.3</td>
</tr>
<tr>
<td>Mixed</td>
<td>18.4</td>
</tr>
<tr>
<td>White/ Caucasian</td>
<td>0.6</td>
</tr>
<tr>
<td>Chinese/Syrian/ Lebanese</td>
<td>0.5</td>
</tr>
<tr>
<td>Other ethnic group/ Not stated</td>
<td>0.6</td>
</tr>
</tbody>
</table>


Contraceptive Prevalence

Contraceptives are widely available in Trinidad and Tobago. There are over 100 government health centres which provide a free family planning service to the general public. A variety of contraceptives are available at the health centers.

The Family Planning Association of Trinidad & Tobago (FPATT) operates three (3) clinics in San Fernando, Port of Spain and Tobago as well as a mobile clinic which generally covers rural and marginalised areas. In addition to providing contraceptive delivery service (including emergency contraception), FPATT also offers other sexual and reproductive health care services. For
example in 2001, FPATT opened its one of a kind ‘Living Room’, a multipurpose youth centre in Port of Spain that focuses specifically on young person’s reproductive and sexual health care needs. In addition, in 1996 FPATT launched its “For Men Only Clinics” in Port of Spain and San Fernando. Other services provided by FPATT include pregnancy tests, pap smears, urine tests for diabetes, breast examinations, general gynaecological services, counselling, as well as prostate screening and family life education programmes.

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

The 1987 Demographic and Health Survey conducted by FPATT noted that knowledge of modern methods of contraception was nearly universal, with 83% of women in a union having used a method at some time while 44% practised modern contraception. There are a variety of contraceptive methods available for use in Trinidad & Tobago. FPATT lists its inventory of contraceptives which includes: intra-uterine devices or IUDs, diaphragms, spermicidal, injectables, oral contraceptives, female sterilisation (tubal ligation) and male sterilisation (vasectomy). Oral contraceptives, injectables and condoms are, however, the most widely used methods of contraception among couples in Trinidad and Tobago. See table below

**User Patterns**

**TABLE 22. CONTRACEPTIVE ACCEPTORS BY METHOD 2000-2002**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Contraceptives</td>
<td>49.5</td>
<td>55.0</td>
<td>45.0</td>
</tr>
<tr>
<td>IUDs</td>
<td>12.7</td>
<td>8.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Condom</td>
<td>14.6</td>
<td>11.0</td>
<td>13.0</td>
</tr>
<tr>
<td>Condoms, Spermicides +</td>
<td>1.2</td>
<td>0.9</td>
<td>11.0</td>
</tr>
<tr>
<td>Foam</td>
<td>8.0</td>
<td>6.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Injection</td>
<td>11.0</td>
<td>10.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>0.4</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Permanent</td>
<td>2.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal Tablet</td>
<td>-</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Female Sterilisation</td>
<td>-</td>
<td>7.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Male Sterilisation</td>
<td>-</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Creams &amp; Jellies</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
</tr>
</tbody>
</table>

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

**Female Education**

**Background**

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

In 1997, 71.5% of the population was recorded as enrolled at the secondary level, and in 2000, 99.9% recorded as enrolled at primary school level. At both primary and secondary levels, female enrollment as a percentage of male enrollment was substantially higher; at primary school 112% and 120% and at secondary 100% and 102%.

**Attainment**

Though variation between the sexes is minimal, the majority of those who attended schools were females and education attainment levels are relatively similar for the sexes with only slight differences. It is felt that females are outperforming males at schools and much concern surrounds this perception of male under-achievement in education.

**TABLE 23. HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT 1990**

<table>
<thead>
<tr>
<th>Education</th>
<th>Male</th>
<th>Female</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>10.5%</td>
<td>11.5%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Nursery/Kindergarten</td>
<td>3.0%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Primary</td>
<td>48.8%</td>
<td>46.9%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Secondary</td>
<td>33.4%</td>
<td>34.9%</td>
<td>34.2%</td>
</tr>
<tr>
<td>University</td>
<td>2.2%</td>
<td>1.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other</td>
<td>0.8%</td>
<td>1.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>1.3%</td>
<td>1.1%</td>
<td>1.1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>560,934</td>
<td>564,194</td>
<td>1,125,128</td>
</tr>
</tbody>
</table>

TABLE 24. ENROLLMENT IN GOVERNMENT AND ASSISTED PRIMARY SCHOOLS
1999/2000

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83,051 or 50.9%</td>
<td>80,155 or 49.1%</td>
<td>163,206</td>
</tr>
</tbody>
</table>

TABLE 25. ENROLLMENT IN PUBLIC SECONDARY EDUCATION
1999/2000

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51,471 or 48.8%</td>
<td>54,071 or 51.2%</td>
<td>105,542</td>
</tr>
</tbody>
</table>

Republic of Trinidad & Tobago, Central Statistical Office, Annual Statistical Digest, 2000, p. 57

In 1990, more males exceeded females in the university-educated population (2.2% and 1.6% respectively), overall an extremely small proportion of the population (See Table 1), and which came to change in later years. Since that time a larger number of females have registered and graduated from the University of the West Indies (UWI) - exceeding the male population there.

Table: 26. Females as a Percentage of Matriculation in Programmes
1996/1997

<table>
<thead>
<tr>
<th>Programme</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Degree</td>
<td>68.8</td>
</tr>
<tr>
<td>Diploma</td>
<td>73.3</td>
</tr>
<tr>
<td>Certificate</td>
<td>66.8</td>
</tr>
<tr>
<td>Advanced (post-graduate)</td>
<td>65</td>
</tr>
<tr>
<td>Higher Degree</td>
<td>45.6</td>
</tr>
</tbody>
</table>


In 1996-7, females overall comprised 56.8% of the total UWI St. Augustine population. In previously male-dominated disciplines like the physical and natural sciences females are now equal to or exceeding males, with the exception of engineering.

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

According to UNDP statistics however, in tertiary education, the ratio of female to male students was 72%. 95

UNDP, 2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>B.Sc. Agriculture</td>
<td>28</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>B.A. Humanities</td>
<td>34</td>
<td>100</td>
<td>53</td>
</tr>
<tr>
<td>B.Sc. Engineering</td>
<td>67</td>
<td>10</td>
<td>126</td>
</tr>
<tr>
<td>B.Sc. Natural Science</td>
<td>71</td>
<td>96</td>
<td>80</td>
</tr>
<tr>
<td>B.Sc. Social Science</td>
<td>66</td>
<td>111</td>
<td>141</td>
</tr>
<tr>
<td>MBBS Medical Sci.</td>
<td>28</td>
<td>6</td>
<td>49</td>
</tr>
<tr>
<td>Education</td>
<td>-</td>
<td>-</td>
<td>43</td>
</tr>
</tbody>
</table>

Republic of Trinidad & Tobago, Central Statistical Office, Annual Statistical Digest, 2000, p.65

Literacy

In spite of the high rates of school enrollment and attendance, it is estimated that 12.6% of persons 15 years and over and 16.2% persons currently working are illiterate.\(^{96}\)

Women have higher rates of literacy than men in the 15-24 and 25-39 year age groups, though among older persons, aged 40-54/55+ year age groups, women have higher levels of illiteracy than men. Trinidad and Tobago's literacy rate is 97% for the female population over 15 years old, and 99% for the male population over 15 years of age.\(^{97}\)

Female Participation in Labour

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

The challenges faced by women in Trinidad and Tobago are not at all dissimilar to those faced by women in other parts of the developing world. Generally men are predominant in the labour force, and women are underpaid in every sector of employment, except when employed by the state. Throughout the world, as in Trinidad and Tobago, women have a greater opportunity for career advancement in the public sector. A significant development in the history of labour took place in 1998 with the passage of a Minimum Wage Act, in part because of the agitation of the local branch of the International Wages for Housework Campaign. In 1996 the Counting Unremunerated Work Act was enacted, in which housework and child care would be recorded as unremunerated work, with the use of surveys. Trinidad and Tobago was one of the first countries in the world to ratify this legislation, which required its statistical office to pick up the data. In 2000, women’s participation rate in the labour force stood at 38.6% and men at 61.4%.\(^{98}\)

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

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96 Adult Literacy Tutors Association (ALTA), Port of Spain, National Literacy Survey 1994.
97 Draft National Gender Policy & Action Plan-T&T.
98 Final Draft National Gender Policy & Action Plan-T & T.
tend to have higher rates of unemployment, and unemployment persists for females until the ages of 31-40, whereas for men it persists until the age of 30.

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

Women, then, continue to fall at the lower end of the socio-economic ladder and face real labour rights issues, especially in wage discrimination. As no equal pay legislation exists, women are subjected to wages disparate from their male counterparts, engaged in similar work. In all occupational groups, women still earn as much as 50% less than men do. Wage differentials are especially sharp in the private sector.99

Women's participation in agriculture and the agricultural sector is swiftly diminishing, while the importance of self-employment and entrepreneurship is increasing for women, especially in the informal sector involving sales of crafts and other nondescript items. Official statistics however record women as only 31% of own account workers in 2000.

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

**Sexual Harassment**

It should also be noted that despite fervent discussions about sexual harassment no national legislation exists, although some companies have sexual harassment policies in place. A draft policy on sexual harassment prepared over ten years ago remains untouched and unapproved by the national government.100

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

**Maternity Protection Act**

In 1998, a *Maternity Protection Act* was passed which entitles all women, except female members of parliament, to 13 weeks of paid leave every two years, and is considered a watershed in female labour rights struggles. Payments are the responsibility of the employer and the National Insurance Scheme, thereby ensuring no loss of earnings for pregnant women and recent mothers. Though termination because of pregnancy is illegal, there are recorded instances of dismissal of pregnant women, especially of temporary and casual workers, proof of the law’s difficulty in uniform application and implementation.¹⁰¹

Statistics do not reveal the impact of economic status, religion, ethnicity, differences of age and geographic location i.e. urban-rural on the quality and outcome of life for men, women and children in Trinidad & Tobago.

**Gender-related policies**

There have been several legislative achievements in the promotion of gender equality and women’s empowerment, which may be considered forerunners to the Government of Trinidad and Tobago Draft National Gender Policy and Action Plan to be presented for review on June 30, 2004. Trinidad and Tobago has followed the lead of the Cayman Islands regionally, and India and Canada internationally, in the creation of an official gender policy. This does not represent a lack of concern for gender issues however, as prior to the policy itself, several legislative items were passed.

- *The Domestic Violence Act No.27* of 1999: this Act repealed the 1991 *Domestic Violence Act* and widened the definition of domestic violence to include financial, sexual, psychological, and physical abuse. It also makes provision for the compensation of victims, and enlarges the ambit of the protection order.
- *The Maternity Protection Act No.4* of 1998: This was implemented to prevent discrimination against women by employers on the grounds of their pregnancy. By this act, fathers are also permitted three days leave of absence from work at the birth of their children. It was enacted in recognition of women’s unique role as child bearers, and enhances equality for women as a result of the challenges posed by intrinsic physical and biological differences. Section 7 of the Act ensures that women’s terms and conditions of employment are not affected by pregnancy. Section 12 ensures that women who are pregnant or on maternity leave are not subject to dismissal where dismissal on the grounds of pregnancy is regarded as a contravention of the principles and practices of good industrial relations.
• **The Sexual Offences (Amendment) Act No.30 of 1994**: This Act was amended to cover all forms of sexual violations and to increase the penalties for violations such as rape, sexual assault, incest, and sexual indecency.

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

• **The Legal Aid and Advice (Amendment) Act No. 18 of 1999**: This Act was amended to make provisions for the granting of legal aid to applications made under the Domestic Violence Act #27 of 1999.

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

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

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

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

**Poverty Reduction Policies**

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

The World Summit on Social Development, which was held in Copenhagen in 1995, promoted a global strategy to address poverty and inequity. This was addressed on a national level by the Government of Trinidad and Tobago and in 1996 a structure, including a Ministerial Council on Social Development, was set up specifically to eradicate poverty. Emerging out of the overall aim of poverty reduction was a Civil Council on Social Equity which strove to bring about better coordination of the activities of the sector and the affiliated NGOs. These agencies are serviced by the Change Management Unit (CMU) for Poverty Eradication and Equity Building, which has devised three major initiatives for poverty eradication. These include:

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

The present government of Trinidad and Tobago in its commitment to reducing poverty levels has contracted Kiari Consultants to design a decentralized integrated system for the delivery of social services. The objective is to ensure that social services are able to effectively reach citizens in the most remote parts of the country.

The objective is to deliver services in an integrated manner (family support, training, income support, and health services), so that the multifaceted needs of any individual or family could be addressed in a holistic manner.

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

The government has also acquired $6 million Euro funding from the European Union to assist in improving the structure for poverty reduction. A unit has been subsequently established to implement what is called the EU-Sponsored Poverty Reduction Programme (EU-PRP), which provides support to the government in three broad areas. (see below: Poverty Reduction Programmes – Trinidad & Tobago European Union Sponsored Poverty Reduction Programme)

**Structure**

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

The EU-sponsored Poverty Reduction Programme (EU-PRP) will also attempt to procure up-to-date data on poverty by engaging a national as well as a regional survey of living conditions. In addition, EU-PRP will provide grant funding to be managed by the RSHDCs to support civil society interventions at the regional level.

**Poverty Reduction Programmes**

The following programmes have been adapted from Social Sector Investment Programme 2004. These run concurrently with the wider poverty reduction approaches adopted by the government of the Republic of Trinidad & Tobago:

*Women in Harmony*: (D) A 1997 survey on living conditions gave rise to this programme hosted by the Ministry of Community Development and Gender Affairs. It provides training in agriculture and elderly care for single women between 26-45 years, and single female heads of households, and unemployed women.

*Non-Traditional Skills Training for Women*: (D) This is a programme designed to provide technical and vocational training to low-income women. It is hosted by the Ministry of Community Development, Culture and Gender Affairs, and targets women between 19-25 years, because government was of the view that since women’s work (domestic work etc) earned the lowest incomes they should be given the opportunity to earn more via non-traditional gender occupations. The programme has three components: training, job placement, and programme promotion. The overall objective is to increase the level of skilled labour available in the country. In 2003, 348 women
participated in the programme, and the anticipated intake for 2004 is 350 persons.

**YTEPP**: (D) Hosted by the Ministry of Science, Technology, and Tertiary Education this programme offers training in literacy, numeracy, vocational skills, entrepreneurial development and support services to young people, especially young girls.

**Unemployment Relief Programme (URP)**: (D) This ongoing relief programme is hosted by the Ministry of Local Government, and provides short-term employment relief for all unemployed persons while enhancing the skills of individuals in the community, and developing, maintaining and improving the physical and social infrastructure. It is comprised of infrastructure projects, environmental enhancement, and a Women’s Programme. The Women’s Programme was established in 2001 and targets females 17-65 years of age, single parents and female heads of households, as it is of the view that these are the women most vulnerable to poverty. It provides employment to 3,050 women every two weeks. In 2003, its projects included sanitation and construction, populated by 6003 persons, and 28,300 women benefited from the Women’s Programme.

**Community-Based Micro Enterprise Programme (Micro Enterprise (MEL) Loan Facility)**: (D) Under the Office of the Prime Minister-Social Services.

**National Social Development Programme (NSDP)**: (D) Ministry of Public Utilities and the Environment supervises the operation of this project. It targets low-income communities, and its objective is to bring relief to deprived communities with the provision of basic upgrades and amenities and multi-purpose social and recreational facilities. The overarching objective is to improve the standard of living and socio-economic welfare of citizens.

**National Enterprise Development Company (NEDCO)**: (D) Ministry of Labour and Small and Micro Enterprise Development hosts this programme that targets youth and young single mothers who cannot access capital or support for entrepreneurial activity. In 2003, 1,400 new businesses were started, 4,000 jobs created, and 10% of its clients were women.

**Export Centres Programme**: (D) The Ministry of Community Development and Gender Affairs hosts this programme that targets unemployed women between the ages of 25-50 years. It encourages handicraft and attempts to enhance the skills of community based artisans via cottage industry business encouragement. In 2003, 250 persons benefited from training, and 250 trainees graduated from the programme in 2004.

**Reach Programme**: (D) This programme includes youth and single mothers without access to capital and support for their entrepreneurial activity. The Department of Social Services and Gender Affairs of THA is responsible for this project.

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

**Adolescent Mothers Programme** (R) The Ministry of Social Development, in collaboration with the Child Welfare League of Trinidad and Tobago, hosts a community-based project that targets pregnant adolescents, teenage mothers and their children. It provides counseling, remedial/continuing education, day care services for their children, and training in pre and post-natal childcare at established centres. The Programme is intended to decrease the number of repeat pregnancies among young women and to break the cycle of inter-generational poverty which may emerge among the target groups due to early pregnancy. The Centres are located at Port-of-Spain, La Horquetta, and Sangre Grande. The Department of Social Services and Gender Affairs is the body responsible for the Adolescent Mother Programme in Tobago.

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

**European Union Sponsored Poverty Reduction Programme**: Office of the Prime Minister, Social Services Delivery. This programme supports the Government of Trinidad and Tobago in the formulation and implementation of a ‘National Poverty Reduction Strategy’ that is more responsive to the needs of the most vulnerable groups in the population. Its target: poor, single, female-headed households, children and youth from disadvantaged communities. The three support areas mentioned earlier are:-

Improving the delivery of poverty reduction services through the decentralization of poverty intervention (micro credit and micro project support).

Strengthening of institutional framework for poverty reduction programmes through the establishment of Regional, Social and Human Development Councils.

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

Overview

The Government of Barbados views health as a fundamental right of all Barbadians. In this regard, the Government of Barbados provides comprehensive health care to all citizens at an affordable cost and ensures that environmental concerns are considered in all aspects of national development.102

Barbados National Strategic Plan for Health has stated the following ‘vision’:

The vision for a healthy people is to empower individuals, communities, and organizations in the pursuit of health and wellness in a health system that guarantees the equitable provision of quality health care, thus contributing fully to the continued economic, cultural, social and environmental development of Barbados.

The Strategic Plan for Health for Barbados for the years 2002-2012 is based on the Caribbean Charter for Health Promotion which was developed in Port of Spain in 1993 at the first conference of Health Promotion.103

Primary health care is an integral part of the country’s health care delivery system.104

Cultural Norms in Barbados which Govern Health

The notion of the male as the head of the household, despite the large number of female-headed households continues to be a dominant idea. There is acceptance of women in the labour force, however gender norms dictate that women earn less money and stay in positions that are not high profile. Women are often economically dependent on men which impacts their decision making ability, particularly as it pertains to sexual relationships. While a changing dynamic, women are expected to do unpaid work in the household. Women are perceived to be caretakers, and in this light are often faced with caring for sick individuals, particularly those with HIV/AIDS.105

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

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

There are also cultural barriers around accepting young people as sexual agents. Currently, age of consent for sexual activity is 16 years of age. The age of consent law, while perhaps useful in protecting young children from assault by older members of the community, works against young people who attempt to access sexual health and family planning services. Currently, young people in Barbados have no access to family planning without the consent of their parents.

Financing the Health Care System

The budget for the health sector for the fiscal year 2000/2001 was $280 million, or 14% of total government expenditure for the year. The Ministry of Finance allocates the budget within the health sector. The government has independent control over health professionals with regard to legislation around health services; physicians and nurses often stay involved in policy dialogue through trade unions.

Expenditure on health services is increasing in both the public and the private sector. Within the last 15 years, an increasing number of health services have been provided by the private sector. Fifty per cent of primary health services are provided by the private sector and 20% of the population has private health insurance.

Private sector expenditure in 1995 was $105.4m which was about 30% of total expenditure for health by the population. In the fiscal year 2000-2001 government allocation for health was $280m, approximately 14% of total government expenditure (Barbados Strategy). The percentage of GDP spent on health in 1999 was 6.6% (PAHO Gender sheet). Hospital services consumed the largest share of expenditure, accounting for 53.9% or $151 million of the budget; primary pharmaceutical programme was allocated 9.4% or $26.3m while 8% or $2.1m was allocated to the care of the disabled. Expenditure on direction and policy formulation services was 4.3% or $12 million of total expenditure.

Hospital services consume the largest share of government expenditure. Overall, QEH and the Psychiatric Hospital, the Medical Aid Scheme and the Emergency Ambulatory Service account for 53.9% or $141m of the budget (Barbados Strategy)
### TABLE 27. RECURRENT EXPENDITURE ON HEALTH WITH THE PERCENTAGE OF TOTAL RECURRENT GOVERNMENT EXPENDITURE, 1997-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Govt Expenditure</th>
<th>Total Health Care Expenditure</th>
<th>% Total Health Care Expenditure</th>
<th>% Total Clinical Health Care Expenditure</th>
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</thead>
<tbody>
<tr>
<td>2000-2001</td>
<td>2,042,799,832</td>
<td>280,000,000</td>
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<td>198,196,962</td>
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<tr>
<td>1999-2000</td>
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<td>284,570,078</td>
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<tr>
<td>1998-1999</td>
<td>1,818,805,721</td>
<td>178,892,254</td>
<td>10</td>
<td>133,790,864</td>
</tr>
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<td>1997-1998</td>
<td>1,704,476,193</td>
<td>226,418,256</td>
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<td>166,991,050</td>
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<td>1996-1997</td>
<td>1,533,599,255</td>
<td>232,959,918</td>
<td>15</td>
<td>162,056,564</td>
</tr>
</tbody>
</table>

**Cost to the individual**

Total Health Expenditure Per Capita (USD) in 1999 was 506 as a percentage of GDP. Services at government facilities are free of cost at the point of delivery. Private health services are also offered and are mainly used by those who can afford to pay. The government provides drugs and related items to clients free of cost at the point of service. Under the Special Benefit Service, drugs listed in the Barbados Drug Formulary also are free at the point of service to persons 65 years of age and over; children under 16 years of age; and persons being treated for hypertension, diabetes, cancer, asthma, and epilepsy (PAHO HIA). HIV/AIDS drugs are given to all individuals who request them.

**Insurance**

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

**Organization of the Health Sector**

The Government operates and runs Queen Elizabeth Hospital (QEH), a 600-bed secondary and tertiary care facility, four district hospitals for geriatric care, a main geriatric institution, a mental health hospital and a half way house, two rehabilitation institutions for the physically and mentally handicapped, an AIDS hostel, a development centre for disabled children and adolescents and a nutrition centre. QEH provides care 24 hours a day.

Challenges faced by the QEH include the influence of crime and violence in society, the effect of an aging physical plant and equipment, nursing shortage and equipment.

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

Each polyclinic serves a catchment area which varies in size from 17,000-50,000 persons (Barbados Strategy).
Private Sector

There are approximately 100 general practitioners. There is one small private hospital—Bayview Hospital—which has 30 beds and represents less than 4% of the country’s acute bed capacity.

Health Services Delivery

There are six major areas of health service delivery:

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

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

Primary health care challenges include shortage of staff resources, especially at the clinic level.¹¹⁵

At the secondary level of health care government operates the QEH which has 547 beds and 24 hour acute, secondary, tertiary and emergency care. The hospital houses 90% of country’s acute care beds and clinical services.¹¹⁶

Health Sector Reform

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

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

¹¹⁵ PAHO HIA
¹¹⁶ PAHO HIA
The strategic directions provide the overarching framework for organizing health care in the country and for all partners in the health system to link their policy decisions and investments to health outcomes.

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

**Family Health**

Overall Goal: improved health and quality of life of the population.

The family health strategy looks at several major components: reproductive health, women’s health, men’s health, health of adolescents, and the elderly, oral health, and rehabilitation.

The National Strategy on HIV/AIDS for Barbados defines reproductive health as a function of population growth, total fertility rate, and maternal mortality.

Women’s health was defined through breast and cervical cancers as well as obesity.

Men’s health is defined through prostate cancer, percentage of men at the psychiatric hospital, obesity and men’s lacking visitation.

Adolescent health is defined by cancer and a listing of reasons of death among young people.

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

**Reproductive Health**

Priority health issues:

- Inadequate ante/intra/post natal and neonatal services
- Inadequate breastfeeding programme
- Inadequate family planning services

Strategic goal

- Improved quality of life for men, women and children.

Key health indicators

- Reduce infant mortality rate below 10 per 1000 live births
- Maintain present 0% maternal mortality rate
- Decreased incidence of low birth weight and babies
- Morbidity and Mortality associated with cancers and STIs in men and women reduced by 20%.
Women’s Health
Priority Issues
- Inadequate screening services for women
- Violence against women

Strategic Goal
- Improved quality of life for women
- Key Health indicator
- Current mortality and morbidity associated with cancers and STIs in women reduced.

Men’s Health
Priority Issues
- Inadequate men’s health programmes
- Limited utilization of services
- Inadequate screening programmes for men’s health

Strategic goal
- Improved quality of life for men
- Key Health Indicator
- Reduce current mortality and morbidity associated with cancers and STIs in men

Adolescent Health
Priority Issue
- Lack of a comprehensive adolescent health programme

Strategic Goal
- Improved adolescent well being

Key Health Indicators
- Between 2003–2012, 80% of adolescents participating in community and school health programmes.
- Between 2003–2007 increase health-seeking behaviour among adolescents by 10%
- By 2012 reduce levels of adolescent obesity by 30% of Adolescent Health and Fitness Study (1999) Survey.
- By 2012, reduce 10% of reported numbers of adolescents expressing feelings of depression and wanting to harm others, as expressed in the 1999 Adolescent Health Survey.
- Injuries due to accidents and violence reduced by 2% per annum
- By 2012, reduce substance abuse among adolescents by 30%

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

HIV/AIDS

Overall goal
• Reduction in the incidence and impact of HIV infection.

Priority issues
• Inadequate management and care of persons infected and affected with HIV/AIDS
• Increasing incidence and prevalence of persons living with HIV/AIDS (PLWHA)
• Inadequate information, education and communication programmes

Strategic Goal
• A national multi sectoral programme that reduces the incidence and impact of HIV/AIDS
• Key Health Indicator
• Between 2002-2012, 50% reduction in the morbidity and mortality rate and a 50% reduction in the HIV incidence rate.

Notes and challenges of Barbados Strategic Plan for Health

Gender dimensions

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

Challenges

There is recognition of gender as an influential factor in the determinants of health: “Gender norms influence the health system’s practices and priorities. Many health issues are a function of gender-based social status or roles.” Although this is mentioned early on, there is very little recognition of this throughout the document.

Outside of women’s health, there is no further discussion of gender, women or men in any other strategic direction on HIV/AIDS.
While violence against women (VAW) is raised as a priority issue, no strategic goal has been defined which will assist in lowering rates of VAW.

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

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

**Quality management**

In 2000 a Continuous Quality Improvement Programme was started in Barbados with feasibility and sensitization studies conducted in five MOH institutions including the Winston Schott Polyclinic, the Mental Hospital, the St. Michael District Hospital, and the St. Andrew’s Children Centre.  

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

**JAMAICA**

**Overview**

In 2000, the World Health Organization rated Jamaica as having the eighth best performing health system out of 191 developed and developing countries. Over the last three decades Jamaica has implemented a number of far-reaching policies, projects and programmes aimed at reforming its health systems. So, although a formally designated Health Sector Reform Programme did not come into being until 1997, there have been other reform initiatives prior to that time. The Ministry of Health has conducted reviews of the policy initiatives over the years. Internal reports of the Ministry outline these initiatives, the details of which follow. The information on efforts to reform Jamaica’s health system shows that family planning and maternal and child health have been central features. However, except for the period 1987–94 in which there was specific reference to achieving the goals of the Population Policy of the time; there has not been another such explicitly-stated objective of national health reform programmes/projects.

**The 1970s**

Faced with widespread health inequalities and an expensive hospital-based health system, the government, guided by ‘democratic socialist’ principles, set
about a major restructuring effort in 1974, focusing on the primary health care (PHC) approach. Thus Jamaica had conceived and begun implementation of the PHC approach before its adoption, internationally, in 1978 as the preferred strategy to achieve “health for all”.

Among the main reform programmes and measures implemented were:

- Expansion of the network of primary health care facilities by almost 100%
- Training and deployment of new categories of health ‘auxiliary’ workers such as community health aides, pharmacy technicians, dental nurses and nurse practitioners
- Establishment of PHC regions and districts with the Ministry of Local Government playing a major role in their management
- Establishment of community councils with health as one of their main concerns
- Abolition of user fees for public health services
- Social marketing of “health for all”
- Construction of new regional hospital

The 1980s

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

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

The 1990s (to 2001)

Continuing macroeconomic problems as well as epidemiological, technological and social concerns led to an intensification of health reform and the implementation of a Health Sector Reform Programme beginning in 1997. The reforms have emphasized the ‘new public management’ approach with a steering and stewardship role for the state while delegating and divesting management and delivery of health services. The main reform measures and activities in this period have been:
• Decentralization of the management and delivery of health services with the establishment of four regional health authorities
• Restructuring of the Ministry of Health Head Office to focus on planning, policy and legal and regulatory functions
• Implementation of revised user fees (again in 1999)
• Continuing divestment of non-technical and some technical services
• Increased attention to quality assurance and client-oriented services
• Proposals for a National Health Insurance Plan beginning with a National Health Fund\textsuperscript{120}
• Attention to efficiency improvements in the management of facilities and delivery of services
• Development, deployment and management of human resources
• Establishment of an Emergency Medical System

\textsuperscript{120} The National Health Fund was introduced in 2003
<table>
<thead>
<tr>
<th>PROJECT/PROGRAMME</th>
<th>EXTERNAL SUPPORT</th>
<th>KEY OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Jamaica Population Project (c. 1970s)</td>
<td>World Bank</td>
<td>• Improve maternal and child health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop primary care infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enhance capacity in family planning activities</td>
</tr>
<tr>
<td>Health Improvement for Young Children (1977 - 81)</td>
<td>USAID</td>
<td>• Train and deploy Community Health Aides especially in Cornwall County</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve maternal and child care services</td>
</tr>
<tr>
<td>Five-Year Development Plan for Health (1978 - 82)</td>
<td>PAHO</td>
<td>• Provide primary health care to all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop an integrated and comprehensive national health system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop human resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Decentralise management of health services</td>
</tr>
<tr>
<td>Health Management Improvement Project (1981 - 85 ex. 90)</td>
<td>USAID</td>
<td>• Upgrade management/ efficiency of health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve health infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop alternative financing methods</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support decentralization of services</td>
</tr>
<tr>
<td>Jamaica Population and Health Project (1987 - 94 ex 95)</td>
<td>World Bank UNFPA</td>
<td>• Strengthen institutional capacity of MOH and National Family Planning Board</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop Infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Achieve goals of National Population Policy (1983)</td>
</tr>
<tr>
<td>Health Sector Initiatives Project (1989 - 96 ex. 98)</td>
<td>USAID</td>
<td>• Enhance cost recovery efforts (Share-care)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Upgrade planning and management capability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support decentralization and integration of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support private sector role in health</td>
</tr>
<tr>
<td>Social Sectors Development Project (1989 - 94 ex. 96)</td>
<td>World Bank UNDP</td>
<td>• Improve management and efficiency in health and education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop health infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop human resources</td>
</tr>
<tr>
<td>Health Services Rationalization Programme (1990 - 95, ex. 2002)</td>
<td>IADB</td>
<td>• Strengthen health policy and programme management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve quality and availability of secondary care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop human resources</td>
</tr>
<tr>
<td>Support to Local Health Systems (1991 - 93, ex. 2001)</td>
<td>Government of Italy</td>
<td>• Promote local health system development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop human resources</td>
</tr>
<tr>
<td>Health Sector Reform Programme (1997-01, ex. 02)</td>
<td>IADB</td>
<td>• Improve ability of the sector to cope with new epidemiological challenges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enhance financial sustainability, efficiency and quality of health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengthen policy making role and decentralization initiatives of Ministry of Health</td>
</tr>
</tbody>
</table>
TRINIDAD AND TOBAGO

Overview

After the structural adjustment policies of the 1980s where state spending on health and social service delivery was substantially reduced, and food subsidies were removed or reduced, the health system deteriorated.

Trinidad and Tobago experienced four general elections in 10 years. Changes in government administrations prevented the development of and continuity in the public sectors of health and gender. These changes in administration have generated many structural changes, and changes in policies affecting every sector in much the same way as it has health, gender, and reproductive rights. The sometimes dialectic visions of the administrations have led to the termination or cessation of programmes that fall under the umbrella policies of the government, and the loss of momentum for projects and concepts, in keeping with the administration’s goals for the country. This has affected gender issues more adversely than it has poverty issues where the political approaches of the two major parties have not been radically opposed to each other. While the formulation of a National Gender Policy and Action Plan is the initiative of the current People’s National Movement (PNM) administration, in 1987 the first Women’s Bureau in the Ministry of Social Development was created. This was during the National Alliance for Reconstruction (NAR) administration, devised according to the WID (Women in Development) framework. In the same year the Policy Statement on the Advancement of Women was crafted by the same administration, the most nascent form of a gender related policy for the country.

The Centre for Gender and Development Studies at the University of the West Indies St. Augustine was the body commissioned by the Ministry of Community Development, Culture and Gender Affairs, to draft a National Gender Policy. The initial draft was completed in 2004 and was submitted to Cabinet in December 2004 for approval.

The Reform Process

Actors involved

The Health Sector Reform Programme (HSRP) was started in Trinidad and Tobago in 1993 as an attempt by the state to resuscitate a failing health care system. It has been financed primarily by the Inter-American Development Bank (IADB) with the help of several other international funding agencies and organisations that have assisted and continue to assist in the formidable task of rearranging health care services. The Pan American Health Organisation (PAHO) and the European Union (EU) have also provided assistance. PAHO has been primarily involved in capacity building, while the EU’s involvement has been specifically focused on improving HIV/AIDS-related care and
reducing the number of new infections. The World Health Organisation (WHO) has also contributed to the health care reform movement in T&T.

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

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

All programme activities executed under the Health Sector Reform Programme fall under the Project Execution Team or PET, which is comprised of representatives of the Ministry of Health management executive team, the director Project Administration Unit, chief executive officers of the Regional Health Authorities, and the director- Health Policy and Planning of the Division of Health and Social Services of the Tobago House of Assembly.

Regional Health Authorities Act

According to the Regional Health Authorities Act’s website

Under the HSRP, administrative and structural changes are being made to facilitate the shift of responsibility and authority for the management of health care services from central government control to the region where services are delivered. In 1994 the Regional Health Authorities Act (RHAA) Act, No. 5 was enacted. This legislation aims to (a) improve the efficiency in health care delivery; (b) educate and train persons in medical research, nursing, dentistry, pharmacy and other health related fields; (c) collaborate with municipalities on matters related to the construction, operation, and maintenance of property; and (d) establish and develop relationships with national, regional, and/or international bodies engaged in similar pursuits.

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

To ensure coherence and standardisation among the Regional Health Authorities, the Ministry of Health has adopted a series of policy and administrative measures. In the context of decentralisation, the Ministry has assumed the role of “purchaser” of defined services from the RHAs, annually on behalf of the population. These “purchases” relate to service-related needs as identified through analysis of routinely collected health services information and as revealed in the results of a national survey carried out in 1995. In response to the Ministry’s Purchasing Intentions, the RHAs develop their service and administrative responses. Documents providing estimated costs form the basis for discussion and negotiation with the Ministry, before submission for government funding.

Once funding has been allocated for the RHAs, annual service agreements (ASAs) are finalised and then signed by the minister of health and the chairman of each RHA Board. These documents support monitoring and performance evaluation. Apart from ASAs, the minister also has authority under the RHA Act to give directions to the boards on matters deemed to be important and necessary.

**Division of Labour**

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

The parallel systems have led to the establishment of parallel administrative systems to deal with the two classes of staff. A duplication, in many cases, of administrative staff now exists. The RHAs went overboard in setting up their administrative structure. Managerial posts were created everywhere and anywhere. Managers with little or no experience in Health care systems were hired on an ad-hoc basis. The resultant top-heavy RHA administration has resulted in the RHA budget being skewed to the tune of
78% of its annual Budget for funding personnel and 10% for goods and services. Thus while the IADB has been pushing for a Primary Health Care slant to Health reform the RHAs have been left with little to channel to the community. At the same time the per capita expenditure on health has declined yearly (TT$667 in 1982 to TT$279 in 1992)

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

Coverage

T&T's HRSP has also adopted the World Health Organisation's primary health care approach. Consequently, all Regional Health Authorities have primary health care at the core of its strategic and budgetary priorities.

The Regional Health Authorities have been geographically defined as Eastern, North-Western, South-Western, Central, and Tobago (see Table 13).

<table>
<thead>
<tr>
<th>Regional Health Authority</th>
<th>N. of Dependent Municipalities</th>
<th>N. of Health Centres</th>
<th>N. of Hospitals</th>
<th>N. of Extended Care Units</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.W.</td>
<td>3</td>
<td>18</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>4</td>
<td>20</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>S. W.</td>
<td>5</td>
<td>31</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Eastern</td>
<td>2</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Tobago</td>
<td>16</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from CEDAW Report, p. 88

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

<table>
<thead>
<tr>
<th>AREA TYPE</th>
<th># of HOSPITALS</th>
<th># DISTRICT HEALTH FACILITIES</th>
<th># HEALTH CENTRES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>5</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Rural</td>
<td>4</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>5</td>
<td>104</td>
</tr>
</tbody>
</table>

Adapted from CEDAW Report, p. 88
At the level of primary care, four different types of primary health care centres operate: District Health Facilities (DHF), Enhanced Health Centres (EHC) offering specialized health services such as radiology, ophthalmology and dentistry, health centres (HC) for populations of 24,000 or less, and Outreach Centres (OC) for the least populated areas, which would provide limited services by visiting health professionals.

Integration Between Levels of Care

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

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

User’s Fees

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

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

Financing

The health sector is financed in part by international sponsors whose funds are matched by those of the Government of Trinidad and Tobago. This practice of matching funds is one that is done relative to the resources of the country. A budgetary current expenditure vote is also taken by Parliament in which the financing for the health sector is determined. The public health sector has, in the past, been financed from the nation’s tax revenues. The current system of financing the health care sector from general taxation is neither sustainable nor equitable.
The Health Sector Reform Programme looks at alternative models of funding for the sector, prime among which is the introduction of a National Health Insurance Scheme (NHIS). The extent of the HSRP demands a structure of supporting and corollary policies and activities. To this end the NHIS would be funded through contributions from employers, employees and with the government paying on behalf of the indigent. The local government will develop the NHIS, albeit initially on a pilot basis. Another fundamental supporting/corollary service for the reform programme as part of the NHIS is the articulation and agreement on a package of basic health care services in which user fees for some services will be charged. Agreed protocols and standards of care, peer review, systems to capture costs and outcomes in a manner supportive of decision-taking, the provision of a unique identifier to each citizen; and user fees for some services are all elements which are germane to the successful implementation of an NHIS.

The Public Debate

The process of health reform has not generated great public debate. The intended changes have been publicised in the media, and through public service announcements, and with meetings in town/village councils, but most of the changes have taken effect as a result of commission/inquiry recommendations, and the obvious shortcomings of the system. As far as public involvement is concerned, one example is the way in which one of the Regional Health Authorities transacts its business. The board, which heads the North-West Regional Health Authority (NWRHA), holds a town meeting prior to the end of its term. At these meetings, a report of the previous year is delivered, and there is a provision for questions from the public. The public audience is usually very diverse, comprising citizens who receive its services, and the Authorities’ employers and employees. The last town meeting was held in March 2004, and the NWRHA is expecting the installation of a new board. This is perhaps the most official form of public debate that exists within the ambit of the health sector.

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

Although the government did not implement all of the recommendations made at that consultation, and the few other meetings that were held in its wake, it represented a level of interest in national opinion, by the local administration. According to the T&TMA, “...eight years on, while some restructuring has taken place very little reformation has occurred”.\(^\text{124}\)
Reproductive Health

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

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

The Population Unit has been reorganized as the means of improving the health status of the national population by promoting and enhancing access, equity, quality, efficiency and sustainability in the delivery of reproductive health care services. The Population Programme Unit was established in 1969 to facilitate fertility management in Trinidad and Tobago. As its focus rested upon maternal services and the provision of contraceptive options especially for women, the population has reaped commensurate benefits with declining fertility rates (see Table 3 page ——).

In 1989, the government reconstituted its National Population Council, and after the 1994 ICPD in Cairo, Trinidad and Tobago adopted a National Population Policy in 1997 as part of the HSRP. Under this policy, the Policy for the Reorganization of The Population Programme Unit to Establish Sexual and Reproductive Health Services In Primary Health Care, the government is mandated to provide gynaecological care and screening for breast and cervical cancers for women, and prostate cancer for men, as well as HIV/AIDS-related services (screening, diagnosis, treatment).

The Population Programme Unit of the Ministry of Health has also recently completed a nation-wide training programme for nurses to improve the quality of reproductive health care.

In addition, with the decentralization of the national health system in T&T over 100 government health centres now offer family planning as a part of their maternal and child health care programme.

In September 2005, the government teamed with PAHO to develop a five-year strategic plan for the implementation of its Sexual and Reproductive Health (SRH) policy.

The local group, ASPIRE issued a press statement asking the government to address the issue of maternal morbidity and mortality as it relates to unsafe abortions and in keeping with achieving the Millennium Development Goal (MDG) of improving maternal health.
Legislation and Norms

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

Accountability Mechanisms

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

SURINAME

Overview

An estimated 89% of households in Suriname have a polyclinic or healthcare center within a radius of 5 kilometers. The Regional Health Service (RHS, 50 clinics/stations) is a parastatal foundation responsible for providing primary health care to the poor in the coastal area (peri-urban and rural), and provides services to an estimated 120,000 Free Medical Cardholders and an estimated 25,000 persons covered by the State Health Insurance Fund. The RHS is supposed to offer free preventive services in cooperation with the national Family Planning Agency and Youth Dental Care. Figures for 2003 suggest that the Regional Health Services (RGD) provides primary health care through 62 health posts in eight districts. The largest population served consists of those qualifying for free health care benefits, around 80,000 persons.

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

Noting that over the last years, the share of total government expenditure (TGE) going to health care was only 3%, it comes as no surprise that this medical infrastructure has been severely hollowed out. Polyclinics are in a bad state; they are understaffed, and continually in need of medicine and materials. The RGD Management Information System, 2003 states that the RGD provides primary health care through 62 health posts in eight districts. The largest population served consists of those qualifying for free health care benefits, around 80,000 persons.

126 the Family Planning Agency, Stichting Lobi, is an autonomous NGO, and therefore not dependent on government subsidies.
127 Bakker, W. Health Conditions in Suriname, 1996
128 RGD Management Information System, 2003
equipment. Furthermore, doctors serving in rural areas refer more and more pregnant women to a hospital in the capital, since they are not equipped to deal with possible complications at delivery. They have no anaesthetics and no blood for transfusion.\textsuperscript{131} To make things worse this poor service comes at a high price. Even where services are supposed to be provided for free, in reality patients have to pay.\textsuperscript{132} The whole medical infrastructure is suffering greatly from the fact that the government fails to fulfill their financial obligations. In the capital, out of four hospitals, two are private and church-affiliated, one is a state enterprise, and one is a parastatal foundation. In the private hospitals, tariffs for patients are higher and wages for nurses are lower. In recent years, the foundation’s Lands Hospital has made headlines due to financial problems and the story of “kidnapping” babies. The hospital resorted to keeping babies hostage until the mothers paid their bills as it often experienced problems in collecting payments for deliveries.

Although policy efforts have been made to reorganize the health sector and to expand the system of public health insurance, reality moved the other way. Health institutions and the state’s health insurance fund were time and again faced with the government defaulting in payments. As a consequence, patients are often confronted with the “no pay, no cure” treatment. More and more individuals and companies who could afford it made the shift to private health insurance, therewith further eroding the basis for general health insurance, and widening the gap between those who have access to quality health care and those who have not.\textsuperscript{133}

Sex disaggregated statistics for indigent and insolvent households who are issued a free medical card (from 29,335 in 1990 to 60,200 in 1998)\textsuperscript{134} indicate that roughly twice as many women (heads of household) as men are registered.##

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

### Legislation and Norms

Both multi-annual development plans and policy papers from the Ministry of Health underline the ambition to realize good health care and accessibility to good health care for everyone. The Constitution of the Republic declares that everyone has the right to health, and acknowledges the duty of the state to promote health care in general by improving living and working conditions, and by providing health information.\textsuperscript{135}

Suriname is also party to the Convention on the Rights of the Child (CRC) and to the Convention on Elimination of all forms of Discrimination Against women (CEDAW), both ratified in 1993. Suriname also ratified the Convention of Belem do Para in 2002. Marital rape does not exist in penal law.
In the Multi-annual Development Plan 1999-2003 a structural reform of the health sector was announced with the following priorities:

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

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

In the meantime, bilateral assistance from the Netherlands underwent a structural change. Instead of broad development cooperation, the Netherlands now opts for a sector approach, where they support only selected sectors. Since the health sector is selected, they have also invested in several studies called Quick Scans. These have resulted in a Health Sector Plan, that is to be officially announced this month. Since it is not really clear how these two initiatives will be combined by the Ministry of Health, it is hard to guess what implementation will follow when.

Decentralization Aspects

As stated before, some responsibilities are delegated to NGOs (Stichting Lobi, Medical Mission, youth dental care, the Regional Health Service). Since the government is highly centralized, there is no decision-making on health matters on district level.

Accountability Mechanisms

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

Over the decade 1990–2000, parastatal utilities did not once submit an annual report. The Central National Accountants Agency (CLAD) is supposed to control these utilities, but is equipped with only one qualified accountant. Women’s organisations can only hold government accountable through international conventions and through media, petitions, etcetera.

\[136\] Eichler, R. Suriname Health Sector Assessment 1999, IADB

\[137\] Apart from regular bilateral development cooperation with the Netherlands, Suriname is also entitled to an amount of money that was agreed upon when gaining Independence, the so-called Treaty Funds. The Netherlands expressed their anxiousness to have these funds invested in the sectors that they selected, of which health is one.


Maternal Mortality

TABLE 31. ESTIMATED MATERNAL MORTALITY IN BARBADOS, JAMAICA, SURINAME, AND TRINIDAD AND TOBAGO FOR MDG REVIEW (OUT OF 100,000)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>275,330</td>
<td>33</td>
<td>81</td>
<td>95</td>
<td>100</td>
<td>91</td>
</tr>
<tr>
<td>Jamaica</td>
<td>2,665,636</td>
<td>120</td>
<td>106</td>
<td>87</td>
<td>79</td>
<td>95</td>
</tr>
<tr>
<td>Suriname</td>
<td>417,000</td>
<td>230</td>
<td>153</td>
<td>110</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>1,274,799</td>
<td>68</td>
<td>70</td>
<td>160</td>
<td>98</td>
<td>99</td>
</tr>
</tbody>
</table>

The challenges in collecting maternal mortality data is demonstrated by the conflicting data available. The above data was from UWI data compiled for a review of the Millennium Development Goals. Below is a table recorded by UNFPA demonstrating the changes in maternal mortality post-ICPD.

TABLE 32. ESTIMATED MATERNAL MORTALITY IN BARBADOS, JAMAICA, SURINAME, AND TRINIDAD AND TOBAGO FOR ICPD REVIEW

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>70</td>
<td>20</td>
</tr>
<tr>
<td>Jamaica</td>
<td>120</td>
<td>106.2</td>
</tr>
<tr>
<td>Suriname</td>
<td>88 (1998)</td>
<td>153</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>NA</td>
<td>70.4</td>
</tr>
</tbody>
</table>

Experiences during the research process also illustrates problems associated with maternal mortality data. In doing the research in Barbados, interviewees who were administrators at the Ministry of Health stated that in fact that maternal mortality rate in Barbados was zero in 2003. Further research is necessary to understand at which point data discrepancies are occurring.
**BARBADOS**

Antenatal clinics: provide care for pregnant patients; monitor progress; initiate early interventions where the risks of complications are evident. The specific aim of the programme is at promoting early registration of antenatal patients by the 12th week of gestation and regularly thereafter for monitoring maternal health and foetal growth as well as to prevent medical complications of the mother and the foetus. Approximately 49.9% of antenatal clients registered in the first 16 weeks of clinics and teenage pregnancies are 24% of total pregnancies.\(^{141}\)

All pregnant women seen in polyclinics are referred to QEH between 30–36 weeks for continued care and delivery. \(^{142}\)

**JAMAICA**

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

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

**SURINAME**

Between 1986 and 1994, maternal mortality was the fifth leading cause of death in women. Please note that the Bureau of Public Health which collects data expresses difficulties with extrapolating to the per 100,000 ratio. Also, until this year they worked with the census figures from 1980, and tried to correct these with estimated prognoses. It is not yet clear how much information of the census held in 2003 has been saved from the fire. Recently, the General Bureau of Statistics announced that funds were being mobilized

to re-collect the most crucial data. There is no policy yet on maternal mortality, although the corrected rates are alarming.

A study conducted in 1991–1992 stated that most incidents of maternal mortality were due to post-delivery hemorrhaging and pregnancy-induced hypertension, accounting for respectively 29 and 19% of these cases. It is furthermore stated that these deaths could have been avoided if there had been timely transportation and blood transfusion available.\textsuperscript{143}

It is important to note that health workers in the interior report malnutrition and chronic anaemia suffered by women and children. The anaemia gets worse when the woman gets pregnant. Women themselves do not regard it as a problem, but are in acute danger when the slightest thing goes wrong when they have to deliver. There are also reports that there is high pressure from the Maroon community to have children early, and to have a lot of them. This causes women in bad economic conditions to exhaust their bodies by having a baby every two or three years. The extra risks of teenage pregnancies have caused some doctors in the interior and rural areas to refer all teenagers to the capital for their first delivery.\textsuperscript{144}

TRINIDAD AND TOBAGO

\begin{table}[h]
\centering
\begin{tabular}{|l|c|}
\hline
Year & Maternal Mortality \\
\hline
1991 & 49.18 \\
1992 & 60.70 \\
1993 & 66.40 \\
1994 & 76.20 \\
1995 & 67.5 \\
1996 & 38.9 \\
1997 & 70.4 \\
1998 & 44.7 \\
1999 & 38.2 \\
2001 & 70.4 \\
\hline
\end{tabular}
\caption{Maternal Mortality Rates, Trinidad & Tobago 1991-1999}
\end{table}

Quantitative data on this issue, however, is rare.

\textbf{Abortion and Maternal Mortality}

A 1999 PAHO/WHO report identified Trinidad & Tobago as among the countries of the region where abortion and its complications were the leading cause of maternal morbidity. Maternal mortality rates, on the other hand do not appear to be significantly affected by abortion. Advocates for Safe Parenthood Improving Reproductive Equity (ASPIRE), a non-governmental organization has publicized the death certificate of at least one woman who died from an unsafe abortion in 2000. There are other anecdotal stories about women dying from unsafe abortions but no records on this matter are maintained by the national government because abortion is illegal.
This is not a new problem. Even the most cursory glance at the Ministry’s records (Ministry of Health Annual Reports) shows that the problem has been carefully documented for more than 50 years. Unsafe abortion has been a major cause of maternal mortality.

Unsafe Abortion and Maternal Mortality: An Age-old Problem

<table>
<thead>
<tr>
<th>TABLE 34. MATERNAL MORTALITY RATES TRINIDAD &amp; TOBAGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>1944</td>
</tr>
<tr>
<td>1947</td>
</tr>
<tr>
<td>1951</td>
</tr>
<tr>
<td>1955</td>
</tr>
<tr>
<td>1960</td>
</tr>
</tbody>
</table>

General rates of maternal mortality have declined in the 1990s, falling from 76.2% in 1994 to 70.4% in 2001. (see Table 34 Maternal Mortality Rates, Trinidad & Tobago).

Policies on Maternal Mortality

The ‘Policy For The Reorganization of the Population Programme Unit To Establish Sexual And Reproductive Health Services in Primary Health Care’ aims to improve the quality, availability, accessibility, and use of sexual and reproductive health services in T&T, of which maternal health is a part. As one of its broad objectives, this policy proposes to reduce levels of maternal mortality.

The Maternity Protection Act of 1998 and the Occupational Safety & Health (No. 2) Bill of 1999’ are legislative initiatives that were enacted to ensure to some extent the protection of the woman and the unborn child.

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

(6) An employer shall, after being notified by a female employee that she is pregnant and upon production of a medical certificate to that effect, adapt the working conditions of the female employee to ensure that she is not –

a) Involved in the use of, or exposed to, chemicals, substances or anything dangerous to the health of the unborn child; or
b) Subjected to working conditions dangerous to the health of the unborn child

Declining maternal mortality rates are evidence of improvements being made to female sexual and reproductive health since the post-1969 independence period, and the efficiency in the delivery of primary health care services now specifically targeting female reproductive issues. (see Table 33-Maternal Mortality Rates, Trinidad & Tobago). Outside of research conducted by ASPIRE, there is no research around the link between abortion and maternal mortality.

CAFRA (the Caribbean Association for Feminist Research and Action), is the most enduring and significant regional network of feminists. From 1991-1996 CAFRA’s Coordinator served as Regional Coordinator for DAWNCaribbean. This paper was presented as the basis for an e-mail discussion.

WAND served as DAWN’s Secretariat from 1991-1996 during my terms as General-Coodinator.
BARBADOS

Available data on abortion comes from the Chief Medical Officer’s Report for the years 2000-2001.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TEENAGE TOP</th>
<th>TOTAL TOP</th>
<th>TEENAGE TOP AS A % OF TOTAL Abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>163</td>
<td>709</td>
<td>23</td>
</tr>
<tr>
<td>1992</td>
<td>168</td>
<td>723</td>
<td>23.2</td>
</tr>
<tr>
<td>1993</td>
<td>122</td>
<td>593</td>
<td>20.6</td>
</tr>
<tr>
<td>1994</td>
<td>118</td>
<td>588</td>
<td>20.1</td>
</tr>
<tr>
<td>1995</td>
<td>86</td>
<td>484</td>
<td>17.8</td>
</tr>
<tr>
<td>1996</td>
<td>109</td>
<td>533</td>
<td>20.5</td>
</tr>
<tr>
<td>1997</td>
<td>105</td>
<td>583</td>
<td>18.0</td>
</tr>
<tr>
<td>1998</td>
<td>104</td>
<td>644</td>
<td>16.0</td>
</tr>
<tr>
<td>1999</td>
<td>123</td>
<td>526</td>
<td>23.4</td>
</tr>
<tr>
<td>2000</td>
<td>89</td>
<td>528</td>
<td>16.9</td>
</tr>
<tr>
<td>2001</td>
<td>104</td>
<td>645</td>
<td>16.1</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>AGE GROUP IN YEARS</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15</td>
<td>11</td>
<td>7</td>
<td>12</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>15-19</td>
<td>94</td>
<td>97</td>
<td>111</td>
<td>84</td>
<td>96</td>
</tr>
<tr>
<td>20-24</td>
<td>151</td>
<td>136</td>
<td>112</td>
<td>112</td>
<td>150</td>
</tr>
<tr>
<td>25-29</td>
<td>131</td>
<td>173</td>
<td>113</td>
<td>138</td>
<td>128</td>
</tr>
<tr>
<td>30-34</td>
<td>81</td>
<td>108</td>
<td>93</td>
<td>86</td>
<td>110</td>
</tr>
<tr>
<td>35-39</td>
<td>72</td>
<td>90</td>
<td>64</td>
<td>81</td>
<td>117</td>
</tr>
<tr>
<td>40+</td>
<td>42</td>
<td>33</td>
<td>21</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>TOTAL</td>
<td>583</td>
<td>644</td>
<td>526</td>
<td>529</td>
<td>645</td>
</tr>
</tbody>
</table>

Legal abortions represented 2.8% of the leading causes for hospitalization in 1995, compared with 3.9% in 1992 (PAHO HIA).
Abortion Legislation in Barbados

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

1. Treatment for the termination of a pregnancy of not more than 12 weeks duration may be administered by a medical practitioner if he is of the opinion, formed in good faith—
   a) that the continuance of pregnancy would involve risk to the life of the pregnant woman or give injury to her physical or mental health; or
   b) that there is substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped.

2. The written statement of a pregnant woman that she reasonably believes that her pregnancy was caused by an act of rape or incest is sufficient to constitute the element of grave injury to mental health required by subsection 1a.

For pregnancies between 12–20 weeks duration, two practitioners are required; and for pregnancies of over 20 weeks, three practitioners are required. Written consent of a parent or guardian must be given for treatment for the termination of pregnancy for a patient under the age of 16 years or of a period of unsound mind of any age.

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

There are currently no statistics available on the number of deaths or illnesses attributable to abortions. Private sector doctors are supposed to report data regarding abortions, however, this is not respected and there is underreporting (Barbados ICPD review UNFPA).

Situation of Abortion

While abortion is legal in Barbados, anecdotal evidence suggests that many women continue to undergo unsafe abortions, evidenced through the admittance of women needing post-abortion care after seeking services in the private sector. Such cases are often recorded under miscarriage or complications of pregnancy and are therefore data is not available as to the frequency of such problems.\textsuperscript{146}

In addition, the use of Misoprostol (Cytotec), a well-known abortifacient, has been documented in Barbados. The specifics of use, including how widespread it is and why women choose to use Misoprostol, is not known.\textsuperscript{147}

\textsuperscript{146} Interview with staff member of QEH
\textsuperscript{147} Arilha, Margareth and Barbosa, Regina Maria. *Cytotec in Brazil: At Least it Doesn’t Kill*. www.hsph.harvard.edu/organizations/healthnet/reprorights/docs/arilha.html. Downloaded 8/7/2004.
JAMAICA

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

There is no law or regulation restricting information about abortion. The Medical Association of Jamaica supports the legalization of abortion and has lobbied for Jamaica's adoption of an abortion law modeled on Barbados's Medical Termination of Pregnancy Act, which allows for abortion before the twentieth week of pregnancy in cases of rape or incest. It is felt that the absence of such legislation will further marginalize the promotion,

CASE STUDY

Understanding abortion law reform: Case Study: Barbados:
A 'Quiet' Advocacy Campaign

The liberalisation of abortion laws in Barbados came through the quiet advocacy of Billie Miller, currently acting as the Minister of Foreign Affairs. Her own interest in abortion law reform came from her work within the family planning sector, where she interacted with many women of diverse age who sought out abortion services. Miller has also spoken about the need to address the consequences of violence faced by young girls and women in the case of incest and rape.

From 1976-1981 Miller was the Minister of Health and Social Security. During this time she struggled to find the right time to introduce legislation that would change the state of a abortion laws. Fearing political backlash, Miller's political party dissuaded her from tabling abortion legislation around times of election. Miller decided that she would begin a campaign of 'silent' advocacy, canvassing the terrain of stakeholders in abortion laws and policy. She met with members of various churches, community leaders, and fellow Ministers in government offices to convince them that liberalizing abortion policy was a key element in protecting women's lives and health. Miller admittedly feels that she benefited from the fact that Barbados has a small Catholic Community, a strong voice of opposition throughout the region and in the world against women's health rights.

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

When the bill was drafted, Miller once again was told that it was too close to elections to put forward legislation on abortion. In 1981, Miller was appointed the Minister of Education and Culture. Despite the fact that she no longer held her post in the Ministry of Health, she brought the bill to cabinet and it was passed with no objection. Miller's work through her quiet campaign of advocacy and activism paid off in the end with legislation that continues to save women's lives today.
preservation and maintenance of the highest standards of the sexual and reproductive health of Jamaican women.

The report, Women of the World: Laws and Policies Affecting Their Reproductive Lives; Latin America and the Caribbean (1997)\textsuperscript{148} notes that “because abortion is illegal in most circumstances in Jamaica, it is difficult to obtain information on its prevalence”.\textit{[Is this a quote?]}

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

According to Pate (1997),\textsuperscript{149} complications brought on by illegal abortions were among the leading causes of maternal deaths in Jamaica. Anecdotal accounts indicate that abortions are carried out by doctors in private practice, and while it no longer carries out the procedure, the public Glen Vincent Clinic in Kingston reportedly refers persons for abortions in certain circumstances.

**Abortion Legislation in Jamaica**

The situation outlined in the report Women of the World (1997) remains the same today. The report indicates that;

\begin{quote}
In Jamaica, abortion is prima facie illegal. It is a felony for anyone to perform an abortion or for a pregnant woman to attempt to abort her fetus by using any instrument, poison or other means...Where the abortion is performed by another person, the woman’s consent to the abortion is no defense...Although the penal code provides no exceptions to its proscriptions against abortion, the common law has developed principles permitting specific exceptions.
\end{quote}

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

Despite the official status under the law, the Women of the World report (1997) points out that Jamaican common law follows the precedent set by the ruling in the English case Rex vs Bourne which allowed that an abortion would not be unlawful when the operation was performed in good faith for the purpose of preserving the life of the mother.

In 1975, then Minister of Health and Environmental Control, Dr. Kenneth McNeil, issued a Statement of Policy on abortion. The Women of the World report states that

\begin{quote}
\textsuperscript{148} Women of The World: Laws and Policies Affecting Their Reproductive Lives; Latin America and the Caribbean; Centre for reproductive Law and Policy, New York, 1997
\textsuperscript{149} Ernest Pate, Maternal and Child Health in Pan American Health Organization Health Conditions in the Caribbean 171, 179 (1997)
\end{quote}
The statement of Policy called for the amendment of the offences Against the Person Act of 1864...so as to make clear when abortion would be lawful in Jamaica...and to take steps to make rape, carnal abuse and incest a lawful ground for abortion.

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

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

The fact that abortions are illegal creates an environment of secrecy, the fact that they are nonetheless available in the public services but limited to certain circumstances means that many women who do not fit the criteria must either pay for the privately done procedure, resort to ‘back street’ arrangements or carry the child to full term. Management of the complications of unsafe abortions is part of routine obstetric care in hospitals. In early 2005, the Medical Council of Jamaica said it would present a policy statement to the Ministry of Health to facilitate the review of the abortion legislation. The impetus for this statement was to better understand the maternal deaths associated with unsafe abortion. The Medical Council is calling for a new law modelled after the law in Barbados.150

SURINAME

Figures on abortion cannot be obtained from the hospitals since abortions are registered under curettage. Findings of the CPS 1992 suggest that 88.7% of all women aged 15-44 never had an abortion.151

Stichting Lobi however estimates that between 8,000 and 10,000 abortions take place annually, with a strong representation of women under the age of 24.152 This implies almost a 1:1 ratio with live births annually. A sample survey of clients of the Lobi clinic revealed that 34% of the women had at least one abortion.153 In 1999, a study done in the interior suggests that young girls are very well informed about both modern and traditional ways of abortion.154

Understanding traditional abortion has been difficult based on various practices dependent on various ethnic and cultural groups and little research conducted on the topic. For example, the Javanese use massage techniques for all their reproductive problems, while Maroons mostly use herbs. Since

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151 Leckie, G. Reproductive health and rights of adolescents in Suriname, Stichting Lobi 1997
152 Stichting Lobi, Sample Survey Clients 1988-1989
153 Terborg, J. en Boven, K. Sexual Behavior and sexually transmitted diseases among Maroon and Indigenous populations in the hinterland of Suriname, Medical Mission, 1999
154 Terborg, J., Granberg, A. and Eiloof, D. Report on the quality of reproductive health services for adolescents on 2 poli clinics of the Regional Health Service in Latour and Pontbuiten. PAHO/Prohealth, January 2004
women in general are reluctant to talk about abortion, there are no scientific
data on whether it works and whether it is safe. Anecdotal evidence tells the
story of one family (partly Maroon, partly Creole) in which women tell each
other to drink the water of a very young coconut. It is said to loosen the foetus
and “rinse” it out of the womb. There has been no “scientific” effort to
determine how effective such methods may be.

Stichting Lobi initiated discussions on abortion several times, through live
debates and television talk shows. Though it is silently tolerated, abortion as a
right is not advocated. It is interesting to note that even among women
activists and health workers the attitude is ambivalent. Recent research in a
peri-urban neighborhood shows that 45% of health workers consider abortion
murder, and think it should be forbidden. \(^{155}\)

**Abortion Legislation in Suriname**

Abortion in Suriname is illegal. According to the law, a woman who
intentionally induces abortion is subject to three years imprisonment. The
person who conducts the abortion is subject to four years and six months
imprisonment and up to 12 years if she did not consent. If the woman dies,
the penalty is increased to up to six years imprisonment, and in the second to
up to 15 years imprisonment. If the person performing the abortion is a
medical practitioner, midwife, or pharmacist, the above-mentioned penalties
may be increased by one-third and the person can be barred from practicing
his or her profession.

The code prohibits a person from treating a women or providing treatment
to her knowing that thereby her pregnancy may be destroyed.

An abortion can be done to save the life of the woman.\(^{156}\) The law, which was
modeled after old Dutch law, was never modified. In reality however, it is not
enforced. Even stronger, during the research it turned out that most key persons
were convinced that abortion was legal in Suriname! The only barrier to having a
safe abortion by a real doctor in a real hospital is the money, or the distance. Like
all prices, the price for abortion has gone up: from SRD 300= in 2002, to SRD
600= in 2004 (equals USD 222, more than an average monthly salary).

**Post abortion care**

There is no care after the abortion. The abortion takes place as a policlinic
consult and the patient is supposed to leave immediately after surgery.
Anecdotal evidence suggests that surgeons tend to be more concerned about
money rather than consultation services. When questions were asked, they
were purely medical and comments tended to be denigrating. This means an
opportunity is missed every time to find out how the unwanted pregnancy
came about, and how the client thinks to prevent this from happening in the
future. Since abortion that is not on medical indication is illegal no policy or
protocol exists, there is no training, and it definitely has no place in the health
sector reform debate.

\(^{155}\) UN population
information.

\(^{156}\) Brief Notes of Abortion Research, ASPIRE, 2000
TABLE 37. NUMBER OF ABORTIONS AT PUBLIC HEALTH SECTOR FACILITIES 1994

<table>
<thead>
<tr>
<th>Types of Abortion</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous Abortion</td>
<td>23</td>
</tr>
<tr>
<td>Legally Induced Abortion</td>
<td>4</td>
</tr>
<tr>
<td>Illegally Induced Abortion</td>
<td>12</td>
</tr>
<tr>
<td>Other Abortions*</td>
<td>4,226</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4,265</strong></td>
</tr>
</tbody>
</table>

*unspecified incomplete abortions, including induced abortions

**NOTE:** Data does not reflect abortions in the private sector, which remains unavailable

Cedaw Report

TABLE 38. EXCERPTS OF TYPES OF ABORTION AS REPORTED IN THE MINISTRY OF HEALTH’S ANNUAL REPORT, 1991-1993

<table>
<thead>
<tr>
<th>Types of Abortion</th>
<th>ICD. 9</th>
<th>1991 Cases</th>
<th>LOS*</th>
<th>1992 Cases</th>
<th>LOS*</th>
<th>1993 Cases</th>
<th>LOS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td>634</td>
<td>19</td>
<td>59</td>
<td>34</td>
<td>204</td>
<td>22</td>
<td>70</td>
</tr>
<tr>
<td>Legally induced</td>
<td>635</td>
<td>3</td>
<td>25</td>
<td>4</td>
<td>38</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Illegally induced</td>
<td>636</td>
<td>22</td>
<td>58</td>
<td>29</td>
<td>79</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>Other</td>
<td>630-33</td>
<td>2,778</td>
<td>8,398</td>
<td>3,465</td>
<td>11,112</td>
<td>3,259</td>
<td>9,025</td>
</tr>
<tr>
<td></td>
<td>637-39</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,822</strong></td>
<td><strong>8,540</strong></td>
<td></td>
<td><strong>3,532</strong></td>
<td><strong>11,433</strong></td>
<td><strong>3,294</strong></td>
<td><strong>9,126</strong></td>
</tr>
</tbody>
</table>

1991, Table 49, p. 75; 1992, Table 50, p. 93; 1993, Table 51, p. 111

*LOS: Length of Stay (days).

Even more alarming than maternal mortality, is the less sensational but far more pervasive problem of maternal morbidity. This has been a huge burden form as early as the 1950s.

TABLE 39. ADMISSIONS FOR COMPLICATIONS OF ABORTION IN PORT OF SPAIN GENERAL HOSPITAL AND SAN FERNANDO GENERAL HOSPITAL

<table>
<thead>
<tr>
<th>Year</th>
<th>Port of Spain Hospital</th>
<th>San Fernando Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1953</td>
<td>954</td>
<td>633</td>
</tr>
<tr>
<td>1954</td>
<td>1,090</td>
<td>619</td>
</tr>
<tr>
<td>1956</td>
<td>1,379</td>
<td>927</td>
</tr>
</tbody>
</table>

As we show in the table below, 40 years later, unsafe abortion remains the leading cause of maternal morbidity.

TABLE 40. OTHER ABORTIONS 1992-1997

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Port of Spain</td>
<td>703</td>
<td>563</td>
<td>1,059</td>
<td>1,179</td>
<td>940</td>
<td>631</td>
</tr>
<tr>
<td>Mount Hope Women’s</td>
<td>1,238</td>
<td>1,074</td>
<td>1,300</td>
<td>1,429</td>
<td>1,304</td>
<td>1,329</td>
</tr>
<tr>
<td>San Fernando</td>
<td>1,288</td>
<td>1,251</td>
<td>1,452</td>
<td>1,300</td>
<td>1,492</td>
<td>1,329</td>
</tr>
<tr>
<td>Sangre Grande</td>
<td>138</td>
<td>133</td>
<td>183</td>
<td>161</td>
<td>218</td>
<td>158</td>
</tr>
<tr>
<td>Pt. Fortin</td>
<td>83</td>
<td>72</td>
<td>32</td>
<td>93</td>
<td>28</td>
<td>65</td>
</tr>
<tr>
<td>Scarborough</td>
<td>259</td>
<td>196</td>
<td>188</td>
<td>179</td>
<td>182</td>
<td>188</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,465</strong></td>
<td><strong>3,259</strong></td>
<td><strong>4,152</strong></td>
<td><strong>3,986</strong></td>
<td><strong>4,035</strong></td>
<td><strong>3,675</strong></td>
</tr>
</tbody>
</table>

Hospital admission and discharge records.
This widespread practice of abortion is clearly a major public health problem. Every year admissions for unsafe abortion were among the top ten leading causes of admission, competing with intestinal infections, other injuries, and skin infections. In at least two years, 1991 and 1992, complications of abortion was the No. 1 cause of hospital admission.

Women are admitted to the public hospitals as a result of complications from unsafe abortions such as haemorrhage, fistula, pelvic infection disease, sepsis, sub incomplete abortion excessive. ASPIRE purports that these complications would be avoided if the government would decriminalize abortion so that safe services can be provided to all women.

On average, each of these women, will spend approximately 4 days in the hospital, and will require blood tests, blood transfusions, medication and IV treatments. It is estimated that as a result of these needs, the government spends approximately $9 million per year in treating women who are suffering from the complications of unsafe abortion.

It is estimated that more than a third of gynaecological beds are occupied by abortion complications, and according to ASPIRE records 90% of medical practitioners interviewed believed that a civil law would reduce the number of complications. 65% agree that a civil law would save the government money. While they were divided on the extent to which a civil law would improve maternal health, more than half (56%) felt that it would. Only 36% felt that it would not. None of the medical practitioners interviewed thought that the law was either effective or fairly effective. Despite this fact, the law remains unchanged. 157

In a 1999 PAHO/WHO Report, Trinidad and Tobago was identified as one of the countries in the region where abortion and its complications were the leading causes of maternal morbidity. 158

**Estimate of Numbers of Abortions (illegal or legal)**

The incidence of abortions is unknown. Crude estimates exist but they in no way truly reflect the number of operations that are performed every year. According to one hospital, in 1999 D&C (dilation and curettage procedures) was performed 1,177 times, and 615 times over the period of June-September 2000. 159

While data regarding abortions is available for public health institutions, it only represents a small percentage of women – i.e., those who experience related complications. Thus, all of the abortions that do not result in complications remain unrecorded. In addition, those performed at private centres are not accounted for even though it is estimated that 60% of private gynecological practitioners offer these services.

ASPIRE, however, based on its' research has estimated that there are as many abortions as births, about 19,000 per year. 160

**Abortion Legislation in Trinidad and Tobago**

Under Trinidad & Tobago’s *Offences Against the Person Act*, Sections 5 and 6, Chap. 11:08, of 03 April 1925, abortion is a criminal offense. This law states

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157 WHO/PAHO, 1999:24
158 CEDAW Report
that any woman who *unlawfully* procures a miscarriage or any person who
unlawfully causes a woman to miscarry is subject to imprisonment for four
years. In addition, any individual who *unlawfully* supplies a woman with an
instrument to procure a miscarriage is subject to imprisonment for a period of
two years.

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

Research conducted by a non-governmental organization called Advocates
for Safe Parenthood Improving Reproductive Equity (ASPIRE) indicates that
over 51% of all T&T women will have at least one abortion by age 44.\(^{161}\)
Consequently, the criminalization of abortion affects most women of
reproductive age in T&T.

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

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

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\(^{161}\) PAHO. Health
*Conditions in the Caribbean.* 2002. Pate, Ernest. Maternal
and Child Health. P. 171-
188.

* Based on research
conducted in the completion
of this report.

\(^{2}\) Ernest Pate, maternal and
Child Health in Pan
American Health
Organization Health
*Conditions in the Caribbean*
171, 179 (1997)
THE ABORTION DEBATE: A CASE STUDY OF TRINIDAD AND TOBAGO

In 2000, ASPIRE publicly announced that it was calling on the T&T government to reform the criminal abortion law and enact a civil law that would allow abortion upon request in the first trimester. And, until May 2004, ASPIRE was the only vocal pro-choice organization calling for the decriminalization of abortion. On May 28, 2004, however, in recognition of the International Day of Action for Women's Health, CAFRA T&T, and a newly formed group of lawyers called the Lawyers for Reproductive Rights (LRR) joined ASPIRE in a press conference calling for abortion law reform. The groups received press coverage in two of the three major daily newspapers and the local cable television news.

ASPIRE's mission is to achieve reproductive equity for all citizens of T&T. The campaign for abortion law reform, however, is its major initiative.

This group has attempted to generate public discussion and dialogue on the issue of abortion. The dialogue involves the Church (all denominations but its most strident opponent is said to be the Roman Catholic Church), lawyers, doctors, youth groups, social workers, human rights activist, and grassroots community persons.

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

ASPIRE's abortion law reform campaign has been strategically devised to include not only public debate through letters to the editor but meetings with interest groups, parliamentary representatives, and ministry officials. In addition, ASPIRE has a website, www.ttaspire.org, that includes information for the public.

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

The public perception of ASPIRE's work and function as the 'abortion group' that promotes abortions freely, precludes widespread open support from many individuals and groups, who although they secretly support the cause, shy away from supporting ASPIRE due to fear of being typecast. However there are individuals so devoted, that concerns over negative stereotypes are sidestepped to further the cause. For example, prominent businessman Emile Elias donated $7,500 to ASPIRE in December 2003. In spite of the obstacles, ASPIRE is in the process of developing a wider base of local support.

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

Abortion is not broadly legal and is permitted to preserve the mental and physical health of the woman and to save the life of a woman. It is therefore not available on request, or circumstances of rape and incest, foetal impairment, contraceptive failure or for economic or social reasons.

As the group with abortion issues highest on its agenda, ASPIRE is not aware of any policy initiatives on post-abortion care. It is the group’s belief and experience that no significant progress can be made concerning post-abortion care until the law is changed.

We have relied very heavily on official data to establish the widespread public health problem. But this is by no means the full scope of the problem. Not every back-street abortion ends up in a hospital. Many, perhaps many more than the ones admitted, are fortunate enough to escape the need for hospitalization.

What of clandestine, safe abortions provided by medical practitioners? There is, of course, no hard data on the total number of abortions for the society as a whole. No one has these data. ASPIRE conservatively estimate that the total number of abortions is proximate to the total number of births, about 17,000 every year.
Abortion and Maternal Mortality

Abortion as it relates to Maternal Mortality is underreported and could account for 30% of maternal deaths most of which are caused by haemorrhage or sepsis. In some hospitals in the Caribbean, 50% of gynecology beds are occupied by patients with incomplete abortions and some patients have been repeatedly admitted for incomplete abortions.\(^{162}\)

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

### TABLE 41. HEALTH SECTOR REFORM, MATERNAL MORTALITY, AND ABORTION

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

\(^{162}\) UN population information.
While the in-depth health systems overview demonstrates that countries have identified women’s health as an issue this tends to fall within two broad categories: basic maternal health or HIV/AIDS/STIs. The latter is normally is packaged within the context of PMTCT programs. Table – illustrates the absence of conversation and discussion regarding maternal mortality and morbidity in the health sector reform process that leads to a failure to meet women’s health needs.

The lack of prioritization of abortion related maternal morbidity and mortality issues has historically occurred in countries regardless of legal status of abortion changing only in 2005 with the recent interest of the Jamaica Medical Council prioritizing abortion related maternal mortality as a priority policy area. Unfortunately, such a trend has not been noted in other countries in the region where abortion is currently illegal. Most startling and unique to the Caribbean region, however, is the number of women who do access safe abortions despite the criminalization of the medical procedure. Research suggests that women who can afford to pay for such services, access them under appropriate physician care. Women who do not have the means to pay for abortion, however, continue to turn to unsafe methods.

The following chart presents the legislation, the practice and the reality of women’s access to abortions. Reproductive rights activists from within the region have offered perspectives on where, why, and how this gap between theory and practice exists. The reliance on activists to fill in the details is symbolic of the lack of qualitative and quantitative data on abortion in the region. The alignment of appropriate legislation, policy, and service delivery depends on the prioritization of abortion related mortality issues in the context of health sector reform.
**Abortion Policy in Barbados, Jamaica, Suriname, and Trinidad and Tobago**

**TABLE 42. ABORTION POLICY AND PRACTICE IN SELECTED COUNTRIES**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>ABORTION: THE POLICY/LAW</th>
<th>ABORTION: THE PRACTICE*</th>
<th>REASON FOR THE DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jamaica</td>
<td>Abortion is illegal and falls under the Offences Against the Persons Act. Jamaican common law follows the precedent set by the ruling in the English case R v Bourne which allows that an abortion should not be unlawful when the operation is performed in good faith for preserving the life of the mother.</td>
<td>The practice in the public health sector is to provide for abortion services when: Two doctors recommend it on the basis that the pregnant woman is physically or mentally at risk. A woman has been a victim of rape or incest provided she is able to show documentary evidence that the pregnancy resulted from the crime committed against her.</td>
<td>There has been little disagreement with abortion to protect the life and/ or health of the mother. Indeed the church in Jamaica has indicated its agreement with this. It is abortion on demand and set within the framework of a reproductive right that Church leaders and a significant and vocal sector of the society strongly oppose as a “sin”. The right to terminate a pregnancy is viewed as going against traditional norms of the role and “place” of women and as a challenge to one of the definitions of masculinity which is male ‘headship” i.e. having decision-making power that supersedes that of women. It is also considered to be undermining the aspect of the definition of masculinity that is based on sexual prowess and virility as manifested in having children. The law may not have been formally changed to date due to the expected backlash or outcry by the Church - in particular the Roman Catholics and other fundamentalists, as well as. elements within the dominant male culture in JA some entertainers and some religious leaders in particular denounce abortion as criminal - this stigmatizes women, practitioners &amp; potential activists; The lack of a general rights perspective in public policy and programming, in particular where women are concerned undervalues the importance of this issue as a key policy and programme priority.</td>
</tr>
</tbody>
</table>

| Trinidad and Tobago | Offences Against the Person ct Chap. 11:08 56. Every woman, being with child, who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, and any person who, with intent to procure the miscarriage of any woman, whether she is or is not with child, unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, is liable to imprisonment for four years. | Many private doctors and private facilities provide abortions. This widespread practice of abortion is clearly a major public health problem. This practice of admission for unsafe abortion is so routine that in some of our larger hospitals special arrangements have been made to manage these patients. In spite of the law, women with money have easy access to safe abortions from private practitioners. They live above the law. Poor women with similar needs are forced to take risks with unsafe practices. Unsafe abortion has been a leading cause of hospital admission. (Ministry of Health’s Annual Reports - 1991-93) Medical abortions are very prevalent - the use of drugs (such as misoprostol or Cytofets) to have an abortion. The criminal law does not lend itself to regulations and so there are no standards of care and protocols. The indiscriminate use of this drug without proper follow care etc. often results in grave harm to women. | The current law is obsolete. The law was established when abortion was a risky procedure and the death rate associated with the procedure was high. Today, abortion is probably the most commonly performed surgical procedure in our country and there are virtually no complications when trained medical practitioners provide treatment. In spite of recording several ‘illegal’ abortions and thousands of ‘other’ abortions every year, no legal action is taken against anyone. The truth is that no society has ever effectively enforced this law. That is impossible. Women with unwanted pregnancies will take risks. The law is irrelevant only to those who can afford to pay. This is precisely why it persists. It is not a nuisance to persons of influence and stature. Persons who possess the political influence to change the law have the economic means to escape its grasp. Those with voice have no need. And those with the need have no voice. Women would do what they have to do to terminate a pregnancy. |

* Based on research conducted in the completion of this report. 163 Ernest Pate, maternal and Child Health in Pan American Health Organization Health Conditions in the Caribbean 171, 179 (1997)
Suriname

Abortion is therefore legal under restrictive circumstances.

Abortion in Suriname is illegal. A woman who intentionally induces abortion is subject to three years imprisonment. The person who conducts the abortion is subject to four years and six months imprisonment and in the second to up to 15 years imprisonment. If the person performing the abortion is a medical practitioner, midwife, or pharmacist, the above-mentioned penalties may be increased by one-third and the person can be barred from practicing his or her profession.

The code prohibits a person from treating a woman or providing treatment to her knowing that thereby her pregnancy may be destroyed. An abortion can be done to save the life of the woman.37

Safe abortion is accessible to any woman who can afford one. Recent research (2004) shows that 45% of health workers in one peri-urban area considered abortion murder and feel that it should be forbidden.

In 1999, a study conducted in the interior of Suriname suggested that young girls are well informed about modern and traditional means of abortion.

A sample survey of visitors to the Stichting Lobi clinic revealed that 34% of the women had at least one abortion.

Post-abortion care is not provided. Abortion is done as a polyclinic operation and the patient is supposed to leave as soon as she is physically able to.

An abortion can be done to save the life of the woman.38 The law, which was modeled after old Dutch law, was never modified. In practice however, it is not used. The only barrier to having a safe abortion by a real doctor in a real hospital is the money. Like all prices, the price for abortion has gone up: from SRD 300.= in 2002, to SRD 600.= in 2004 (equals USD 222.=, more than an average monthly salary).

Figures cannot be obtained from the hospitals since abortions are registered under curettage. Findings of the CPS 1992 suggest that 88.7% of all women aged 15-44 never had an abortion.165

Stichting Lobi however estimates that between 8,000 and 10,000 abortions take place annually, with a strong representation of women under the age of 24.46 This implies almost a 1:1 ratio with live births annually. A sample survey of clients of the Lobi clinic revealed that 34% of the women had at least one abortion.166 In 1999, a study done in the interior suggests that young girls are very well informed about both modern and traditional ways of abortion.167

Barbados

The Medical Termination of Pregnancy Act of 1983-4 provides for the lawful termination of pregnancies.

The termination of a pregnancy of not more than 12 weeks duration may be administered by a medical practitioner if he is of the opinion formed in good faith:
A) that the continuance of the pregnancy would involve risk to the life of the pregnant woman or gave injury to her physical or mental health; or
B) that there is substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped.

The written statement of a pregnant woman that she reasonably believes that her pregnancy was caused by an act of rape or incest is sufficient to constitute the element of grave injury to mental health required by subsection 1a.

For pregnancies between 12-20 weeks duration, two practitioners are required; and for pregnancies of over 20 weeks, three practitioners are required. Written consent of a parent or guardian must be given for treatment for the termination of pregnancy for a patient under the age of 16 years or if a period of unsound mind of any age.

Women are able to access abortions free of charge in the public health system.

Abortions are also provided under particular conditions (those stipulated by the legislation) at the Barbados Family Planning Association. Abortions are available in the private sector.

Despite the existence of free and safe anecdotal evidence suggests that some women take abortifacients. In addition, anecdotal evidence also suggests that woman appear in public sector hospitals with incomplete or ‘botched’ abortions from the private sector.

The continued use of unsafe methods of abortion could be due to fear of stigmatization by abortion providers. Additionally, given the population size and presence of one public hospital, issues of confidentiality may keep women from accessing abortion services in the health care system. These challenges could potentially be remedied through provider sensitization through training. Further qualitative and quantitative research is needed in order to better understand the nuanced dynamics associated with access to abortion services.

164 UN population information.
165 UN population information.
166 Jagdeo, T. CPS, 1993
167 Leckie, G. Reproductive health and rights of adolescents in Suriname, Stichting Lobi 1997
168 Stichting Lobi, Sample Survey Clients 1988-1989
169 Terborg, J. en Boven, K. Sexual Behavior and sexually transmitted diseases among Maroon and Indigenous populations in the hinterland of Suriname, Medical Mission, 1999
The international community has committed itself in a series of political and legal agreements to promoting and fulfilling sexual and reproductive health and rights. Governments at the International Conference on Population and Development (ICPD) in 1994 agreed to a holistic definition of reproductive health and at the Fourth World Conference on Women, held in Beijing in 1995, sexual rights were acknowledged as integral to human rights and women’s empowerment. These commitments have been renewed in the five and ten year reviews of Cairo and Beijing and acknowledged as a key means of implementing agreements such as the Millennium Development Goals which prioritizes the reduction of maternal mortality.

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

The following are recommendations as derived from the above presentation of data and information as to moving the region closer to the full respect, protection and fulfillment of women’s human rights as it pertains to individual and maternal health. In particular, several steps have been identified which would reduce the incidence of incomplete and unsafe abortion. These recommendations should be examined closely in the context of health sector reform and health systems planning processes. Each recommendation should be understood in the context of a rights-based approach.170

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

Data

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

• In-country and regional standardization of quantitative data collection in medical institutions which would include private and public hospitals

170 "A rights-based approach to development is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. Essentially, a rights-based approach integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development. The norms and standards are those contained in the wealth of international treaties and declarations. The principles include equality and equity, accountability, empowerment and participation." (UNHCR. http://www.unhchr.ch/development/approaches-04.html Downloaded October 12, 2004.)
as well as settings to standardize data as it pertains to maternal mortality and abortion.

- Collection of qualitative and quantitative data on women’s access to abortion services, experience with abortion providers, and experiences with abortions. *(I don’t understand what this means)*

Quantitative and qualitative research should be conducted to understand the prevalence of self-administered medical abortion in the region.

- The impacts of violence against women, particularly as it relates to the ability and desire to access abortion services should be better understood through further qualitative and quantitative research.

- Research to ascertain if there is any relationship between violence against women, socioeconomic status, rape and incest and contraceptive delivery services etc.

- All data should be disaggregated by age, sex, gender, socioeconomic status, race, rural/urban and other criteria.

### Focus on Gender

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

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

- Training of health care providers to prevent stigmatization and discrimination of individuals seeking abortion related services.

### Appropriate and Integrated Services

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

- Integrate prevention of mother to child transmission programs (pMTCT) into maternal and child health programmes, assessing clearly the impact of pMTCT on mother’s as well as children’s lives.

- Broadening the scope of reproductive health services to include sexual and reproductive health with a focus on rights.
• Increased focus on adolescent sexual and reproductive health services including legislative and policy reform to reify current laws that act as barriers to accessing services for young people.
• Where abortion is legal, service providers should receive training on abortion counseling and support to better serve the needs of the patient.
• Develop and implement sexual education programs for young people.

**Legislation and Policy**

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

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

**Research of external factors that impact reproductive decision making**

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

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

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