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Canada's Spotlight on the Americas

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UNAIDS reports progress mixed for Caribbean

HIV affects the Caribbean more deeply than any region outside of Sub-Saharan Africa, states the 2009 AIDS Epidemic Update released on Nov. 24 by UNAIDS, the joint United Nations Program on HIV-AIDS.

The document highlights that the Caribbean has the second highest level of adults infected with HIV in the world, amounting to one per cent of the population. In the region, 0.7 per cent of the population has HIV and 0.8 per cent of the population's new infections were detected in 2008.

However, the region as a whole has taken great measures to boost access to HIV treatment. As of December 2008, the region achieved treatment coverage for 51 per cent of the population, compared with 10 per cent in July 2004.

FOCUS ON GENDER

Americas Need Canadian Commitment to Sexual and Reproductive Health

Carmen Barroso

The Minister of International Cooperation, Beverley Oda, unveiled the new Canadian International Development Agency (CIDA) Children and Youth Strategy on Nov. 20, 2009. It aims to increase child survival—including maternal health—to improve the quality of education and ensure the safety and security of children and youth. In the Americas where maternal mortality rates are stagnating and teenage pregnancy is on the rise, this goal cannot be accomplished without renewed attention to sexual and reproductive health.

“(O)ur government will help the children living in poverty today become resourceful, engaged and productive adults,” said Oda. “(W)e can make a difference in the lives of the world's most vulnerable, particularly young girls.”

Canada's re-engagement strategy for the Americas would benefit immeasurably from substantial investments in sexual and reproductive health programs, which are cost-effective and have important multiplier effects but have not yet attracted enough donor support.

The Latin America and Caribbean (LAC) region has made significant advances on reproductive health in past decades. The United Nations Population Fund noted that LAC has the highest level of contraceptive prevalence of any major area in the developing world. For instance in Cuba, Costa Rica and Brazil, rates of modern contraceptive use have risen above 70 per cent and in Puerto Rico and Paraguay, above 60 per cent, while fertility rates dropped significantly. With fewer children, women have increased their economic participation and contributed to regional prosperity.

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Note from the Editors - Living Up to Reproductive Health Commitments

Fifteen years ago, tens of thousands of government and civil society representatives met in Beijing, China for the Fourth World Conference on Women. They agreed to a comprehensive plan for securing human rights for women and girls worldwide. In March 2010, they will meet again at United Nations headquarters to reaffirm commitments and assess progress; one of the most contentious issues on the agenda relates to sexual and reproductive rights.

These rights refer to the ability to make free, informed, responsible and safe decisions in relation to sexual relations, fertility, pregnancy and childbirth among others. If women are in a position to exercise these rights, then their sexual and reproductive health condition can be significantly improved.

In the Americas, political leaders have acknowledged the need to address sexual and reproductive health concerns, especially by tackling high maternal and infant mortality rates, a rise in unwanted teenage pregnancies and the spread of HIV-AIDS. In launching the Health Agenda for the Americas at the June 2007 Organization of American States General Assembly, health ministers from across the region made sexual and reproductive health one of the priority issues for the area in the following decade. They also pledged to focus on the poorest, marginalized and vulnerable groups, notably Indigenous Peoples.


To make sustainable advances in sexual and reproductive health, Latin American and Caribbean (LAC) countries will need to ensure that the progress is rights-based and that women are empowered to take control of their

reproductive lives; it is also crucial that men be active participants in this process. Approaching this issue through a rights framework is crucial as individuals' health conditions are inextricably linked to socioeconomic inequalities — including gender, ethnicity, poverty or lack of access to education, healthcare or legal services— that can limit choices.

The situation with regard to reproductive health varies widely across the Americas. The latest World Health Organization statistics on maternal mortality — deaths of women giving birth— show that the LAC average rate of 135 per 100,000 live births is more than 12 times that of North America. There are also important variances within LAC; while many countries fare relatively well in terms of maternal mortality, Bolivia's and Guatemala's rates are more than double the regional average. These are the highest rates in the hemisphere following the much worse case of Haiti.

It is also notable that the adolescent fertility rate has risen in LAC, now roughly one in five pregnancies. These pregnancies are often unwanted, suggesting inadequate sexuality education and low contraceptive use. Adolescents living in conditions of poverty are significantly more affected by this reality.

Unwanted pregnancies also contribute to the high numbers of illegal abortions. This is an important public health problem for the region, calling into question the rigidity of legislations penalizing abortion. U.S. President Barack Obama's recent decision to lift the "Global Gag Rule," also known as the Mexico City Policy, which withheld U.S. funds to any organization supporting abortion, could reignite the debate amongst American states.

This *FOCALPoint* edition discusses sexual and reproductive health and rights issues in countries where these problems are most pressing: Bolivia, Guatemala and Haiti. It also highlights the important societal debates taking place in countries such as Brazil, Chile, Mexico and Nicaragua. Finally, it shows how Canada can take a leadership role in the region by investing in sexual and reproductive health programs that can be powerful catalysts for poverty alleviation and sustainable development. 

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Americas Need Canadian Commitment to Sexual and Reproductive Health

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Important policies have been adopted at the national and regional levels on reproductive health and rights. Most recently, the new constitution of Ecuador included universal access to sexual and reproductive health while that of Bolivia broke new ground by enshrining sexual rights. Regional leaders are reaching consensus on these key issues, especially with regard to the importance of comprehensive sexuality education.

Yet, there is still much to accomplish. According to a 2001 bulletin by the World Health Organization (WHO), in most of LAC, maternal mortality rates declined prior to 1990, but “only Argentina, Chile, and Costa Rica were able to demonstrate sustained reductions in maternal mortality over the 1990s. Elsewhere, there appears to have been a relative stagnation in maternal mortality ratios since 1990.”

An average maternal mortality rate of 135 per 100,000 live births in LAC, as reported by WHO, is scandalous for such a prosperous region. The Pan American Health Organization also reports that mothers in the LAC region are 14 times more likely to die in childbirth than in Canada. The risk of death from pregnancy complications and childbirth is one in 130 women in the region whereas in Canada the risk is one in 7,750. Although maternal mortality rates vary greatly from country to country, it is alarming that in some cases they surpass those of less economically developed countries in Africa. According to the U.S. NGO EngenderHealth, in 2005 Bolivia’s maternal mortality rate was more than 220

and Peru’s was roughly 200 as compared to Botswana’s rate of 100, as cited by the World Bank.

If commitments to providing reproductive healthcare and education are not increased, it is unlikely that the Millennium Development Goal (MDG) to reduce maternal mortality will be met by 2015. Maternal mortality is preventable; not only is its occurrence an indicator of poor attention to women’s health, but it also demonstrates low commitment to the basic human right to life.

Looking at another key indicator, in many LAC countries, teenage pregnancy is increasing among the poorest populations. Statistics show a high unmet need for contraception, and fertility rates among poor adolescents in the region are higher than for Asia or North Africa. The wealthier young women demonstrate low contraceptive use resulting in high fertility rates, but youth in lower economic standing have rates from three to five times those of wealthier adolescents. Too often, early motherhood for them results in a life sentence to poverty since adolescent parents are more likely to drop out of school, limiting their economic prospects and perpetuating the poverty cycle. In Colombia, where there are reliable statistics about the desirability of motherhood, half of teenage pregnancy is undesired. This suggests a need for greater educational and occupational opportunities for young women in order to offer alternatives.

In general, making reproductive health and rights a national priority brings clear results. The case of Honduras, for instance, illustrates that effective

state-led efforts can have a lasting impact. There, the development of national health infrastructure in conjunction with a focus on safe motherhood and family planning contributed to decreasing maternal mortality rates by 40 per cent between 1990 and 1997 according to the World Bank, an exception in LAC where these rates generally stagnated during this period.

Emphasis was placed on the quality and provision of prenatal, delivery and post-partum health services. Increased access to antenatal care, training of birth attendants, emergency obstetrics and hospital referrals for pregnant women at risk of complication all contributed to reducing maternal mortality rates. In fact, a recent study by the Global Health Council found that since the 1990 launch of the national family planning program in Honduras, maternal mortality dropped by 69 per cent. However, recent opposition to sexual and reproductive health efforts in the country suggests that support for these successful policies by international donors could greatly contribute to securing gains in maternal health and promotion of youth rights.

At the regional level, the 2008 Mexico City Ministerial Declaration on “Preventing Through Education,” endorsed by 30 LAC health ministers and 26 education ministers, signals a shift in the political landscape in favour of universal sexual rights. The regional consensus on the need for comprehensive sexuality education sets the stage for improved efforts to curb high teenage pregnancy and maternal mortality rates. Their commitment to updating

the contents and didactic methods of curricula by 2010 to include comprehensive sexuality education for the promotion of sexual health based on human rights and democratic values is a move in the right direction. Furthermore they have committed to a 75 per cent reduction in the number of youth who do not receive comprehensive sexuality education as part of the curriculum in schools run by the Education Ministries.

Investments in sexual and reproductive health prove to be powerful, cost-effective interventions that save millions of lives and spur economic development. There is an urgent need for greater overseas development assistance (ODA) for sexual and reproductive health in the Americas and the Canadian government has a unique opportunity to play a leadership role. International aid can and should focus on scaling up such lifesaving interventions because they are a powerful catalyst for breaking the cycle of poverty. The Canadian government's shift in focus toward Latin America and the Caribbean comes precisely at a moment when the region's current landscape is favourable to, and has already committed to, an emphasis on reproductive health and rights and comprehensive sexuality education. Through targeted support for reproductive health and rights in the region, Canadian ODA can build upon this consensus to participate in enhancing prosperity. This will result in the stronger positioning of Canada as a regional collaborator and will ensure its aid yields the greatest results. 

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Mexican Pro-Choice Groups Fight Pro-Life Reforms

Émilie Béland

The Legislative Assembly in the Mexican state of Veracruz amended its constitution on Nov. 18, 2009 in order to ensure the right to life from the moment of conception. It also revised the penal code to require that women who had an abortion attend education programs, in addition to enforcing prison sentences for women who continue to have abortions. Thus, Veracruz became the 17th state to join the pro-life wave of constitutional reforms in Mexico. This has pushed pro-choice groups to revise their strategy to safeguard the depenalization in force since 2007 in Mexico's Federal District (D.F.) and to plead in favour of reproductive rights elsewhere in the country.

The pro-choice series of legislative reforms started in 2008 after the Mexican Supreme Court confirmed the validity of the law adopted by the D.F. Legislative Assembly depenalizing abortion during the first 12 weeks of pregnancy. This legislation, liberal for a Latin American country, made the D.F. one of the only places in the region where a woman can have access to an abortion upon request, along with Cuba, Guyana and Puerto Rico. Following this ruling, groups for the defence of reproductive rights hoped that access to legal and safe services for induced abortion could eventually expand to other states in Mexico. Instead, they have witnessed a wave of pro-life reforms that restrict access to reproductive health services.

The promoters of pro-life reforms argue that they act out of necessity to legislate the rights of the unborn persons. However, many journalists and reproductive rights defenders maintain that this is a strategy of the Institutional Revolutionary Party (PRI)—in power in many Mexican states—to gain support of the Catholic Church in light of the forthcoming 2012 presidential elections in hopes that this backing would undermine its conservative rival, the National Action Party (PAN), currently in power at the federal level. Moreover, considering the similarity of the various reforms and their passing at short intervals, this could signal a coordinated action aimed at changing the federal constitution in order to include the same type of provision and eventually reverse the depenalization of abortion in the D.F.

In reaction, NGOs supporting reproductive rights have mobilized to counteract the reforms and denounce the current situation with regard to abortion, which represents an important public health and social justice problem. Indeed, according to the Guttmacher Institute—a think tank specializing in sexual and reproductive health—the country's restrictive legislations push many women, most of them living in poverty, to use illegal abortion services or to use unsafe methods to terminate their pregnancies.

However, the political class outside of the Mexican capital does not appear to be sensitive to these argu-

ments, no more than public institutions at the regional level, such as Human Rights Commissions, Ministries of Health and Women's Institutes. In most cases, they are either silent on the issue, or they support the reforms in progress. While some opposition to the reforms was expressed in street demonstrations and in the corridors of assemblies throughout the country, there has been a general lack of support from the political milieu and the population has been reluctant to engage in a debate on this poorly accepted practice. For these reasons, the reproductive rights NGOs must turn to other strategies.

The NGOs outside the capital, particularly those working closely with organizations from the D.F., aim to inform women of their rights. They offer the possibility of going to D.F. to receive induced abortion services, in certain cases with the financial assistance of NGOs from the capital. The pro-choice groups also inform women of the existence of legal clauses that still allow for abortions in the states. They remind their governments of the obligation to guarantee access to induced abortion services within the circumstances allowed by law, mostly in cases of rape, danger for the mother's life and security or fetus malformations. These clauses are rarely respected, as recently denounced by Human Rights Watch who deplored that in the state of Guanajuato, where abortion is legal in cases of rape, no victim has been able to access this service in the last eight years and 130 women have been imprisoned after having resorted to illegal abortion services.

The situation also pushes the pro-choice groups to turn to different legal means at the national and regional levels to protect women's rights. The country's Supreme Court has agreed

to look into the validity of the amendment adopted in the state of Baja California following a request presented by Francisco Javier Sánchez, the former Director of the state's Human Rights Commission. However, in the majority of states, public institutions are close to the government and thus refuse to launch such a process.


Before the exhaustion of legal recourse at the national level, the NGOs turn to regional human rights mechanisms. In that context, the Inter-American Commission on Human Rights, at the request of Mexican NGOs, has agreed to investigate the reform adopted by the state of Morelos that contravenes the federal norm and allows abortions in cases of rape throughout the country.

The wave of constitutional reforms has also been the subject of a recent declaration by Alberto Brunori, representative of the United Nations' Office of the High Commissioner for Human Rights in Mexico, who deplored this year's adoption of reforms that threaten to turn into "structural violence against women's rights."

Given the general tendency to rigid legislations regarding abortion in Latin America, the use of regional human rights instruments is increasingly emerging as the main recourse to defend women's access to abortion in the region. However, governments are often slow or reluctant to apply the recommendations put forward by these organizations.

Furthermore, legislation regarding abortion seems to be dependent on power relations between governments and conservative elites, such as the Church, leaving little room for the voices of civil society.

The organizations working on reproductive rights in Mexico therefore have little hope of seeing abortion

depenalized outside of the D.F. in the short term. Nonetheless, they are striving to put a brake on the wave of pro-life legislation that is still in progress and to maintain the depenalization in force in the capital. 

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Peru forced sterilization culprits called to justice

The Inter-American Commission on Human Rights (IACHR) is calling on the Peruvian government to bring to justice those responsible for the 1990 to 2000 Voluntary Surgical Contraception (VSC) program. During that decade, tens of thousands of women were compelled to be sterilized under the Alberto Fujimori regime.

Luz Patricia Mejía, the IACHR chair, stated during the Washington, D.C. hearings that took place from Oct. 28 to Nov. 13 that the Peruvian government must act against the perpetrators.

The Fujimori regime implemented the VSC program in order to reduce the birth rate in Peru's more impoverished areas.

Peru's office of the ombudsman reported that from 1996 to 2000, 2,074 women were sterilized without their consent. In contrast, human rights groups have stated the number of women sterilized during this time was more than 300,000.

Des groupes pro-choix combattent les réformes pro-vie au Mexique

Émilie Béland

Le 18 novembre 2009, l'Assemblée législative de l'État mexicain de Veracruz modifiait sa constitution afin de garantir le droit à la vie dès le moment de la conception, en plus de revoir le code pénal afin d'obliger les femmes ayant eu un avortement à participer à un programme d'éducation et de prévoir des peines de prison pour les récidivistes. Veracruz devient ainsi le 17^e État à joindre la vague de réformes constitutionnelles pro-vie au Mexique, situation qui force les groupes pro-choix à revoir leur stratégie pour sauvegarder la dépénalisation en vigueur dans le District Fédéral (D.F.) de Mexico depuis 2007 et plaider en faveur des droits reproductifs ailleurs au pays.

Cette série de réformes pro-vie s'est déclenchée en 2008 après que la Cour suprême mexicaine ait confirmé la validité de la loi adoptée par l'Assemblée législative du D.F. dépénalisant l'avortement durant les 12 premières semaines de grossesse.

Cette législation, étonnement libérale pour un pays latino-américain, fait du D.F. l'un des seuls endroits en Amérique latine, avec Cuba, la Guyane et Puerto Rico où une femme peut avoir accès à un avortement sur demande. À la suite de ce jugement, les groupes de défense des droits reproductifs avaient espoir que l'accès à des services d'interruption volontaire de grossesse (IVG) légaux et sécuritaires pourrait éventuellement s'étendre à d'autres États au Mexique. Plutôt, en contrecoup, ils ont assisté à une vague de réformes restreignant l'accès aux services de santé reproductive.

Les promoteurs de ces réformes affirment qu'ils agissent par nécessité de légiférer sur les droits des personnes à naître. Toutefois, plusieurs journalistes et défenseurs des droits reproductifs affirment qu'il s'agirait plutôt d'une stratégie du Parti révolutionnaire institutionnalisé (PRI), au pouvoir dans plusieurs États mexicains, pour gagner l'appui de

l'Église catholique en vue des élections présidentielles de 2012, dans l'espoir que cet appui puisse lui permettre de défaire son rival conservateur, le Parti Action nationale (PAN), actuellement au pouvoir au niveau fédéral. De plus, étant donné la similitude des réformes et leur adoption rapprochée, ceci pourrait signaler une action coordonnée visant à changer la constitution au niveau fédéral afin d'y inclure le même genre de disposition pour éventuellement remettre en question la dépénalisation de l'avortement dans le D.F.

En réaction, les ONG de droits reproductifs se mobilisent pour contrecarrer les réformes et lutter contre l'important problème de santé publique et de justice sociale que représente la situation actuelle. En effet, selon l'Institut Guttmacher, think tank spécialisé en santé sexuelle et reproductive, les législations restrictives du pays poussent de nombreuses femmes, pro-

Argentina judge blocks planned gay marriage

On Nov. 30, an Argentine judge put a ruling on hold for review that would have allowed the first same-sex marriage in Latin America, which was slated for Dec. 1.

Judge Marta Gomez Alsina filed an injunction to halt the earlier Nov. 10 ruling from a different judge that would have permitted the marriage. The first ruling stated city laws that ban same-sex marriage were unconstitutional. She wrote in the injunction that her decision should not be interpreted as discriminatory against homosexuals. This earlier ruling will be reviewed in depth while the marriage is temporarily put on hold.

The two men planning to marry, José María Di Bello and Alex Freyre, said they have a "firm and irrevocable" ruling that grants them permission to marry.

Argentina was the first country in Latin America to permit civil unions for same-sex partners in 2002. Currently, some other jurisdictions in Latin America permit same-sex partners to form civil unions.

venant majoritairement de milieux pauvres, à recourir à des services d'avortement clandestin ou à utiliser des méthodes non sécuritaires pour terminer leur grossesse.

La classe politique à l'extérieur de la capitale mexicaine ne semble toutefois pas sensible à ces arguments, pas plus que les institutions publiques au niveau régional telles que les Commissions de droits humains, les Ministères de la Santé et les Instituts de la Femme. Dans la majorité des cas, soit ils sont muets sur la question, soit ils appuient les réformes en cours. Différentes manifestations d'opposition aux réformes ont été observées dans les rues et les corridors des assemblées à travers le pays, mais devant un manque d'appui généralisé du milieu politique et une population réticente à s'exprimer sur cette pratique toujours mal acceptée socialement, les ONG de droits reproductifs doivent se tourner vers d'autres stratégies.

Les ONG à l'extérieur de la capitale, particulièrement celles travaillant de près avec les organisations du D.F., oeuvrent à informer les femmes sur leurs droits. Elles offrent la possibilité de se rendre dans le D.F. pour recevoir des services d'IVG, dans certains cas avec le soutien financier d'ONG de la capitale. Les groupes pro-choix informent aussi les femmes de l'existence de clauses légales qui permettent toujours l'avortement dans les États et rappellent à leur gouvernement l'obligation de garantir l'accès à des services d'IVG dans les circonstances permises par la loi, soit la plupart du temps en cas de viol, de danger pour la vie et la sécurité de la mère ou de malformations du fœtus. Ces clauses sont rarement respectées, tel que dénoncé récemment par Human Rights

Watch qui déplorait que dans l'État de Guanajuato, où l'avortement est légal en cas de viol, aucune victime n'a pu avoir accès à ce service au cours des huit dernières années alors que 130 autres ont été mises en prison après avoir eu recours à des services d'avortement illégal.

La situation pousse aussi les groupes pro-choix à se tourner vers divers moyens légaux aux niveaux national et régional pour protéger les droits des femmes. La Cour suprême du pays a accepté de se pencher sur la validité de l'amendement ayant été adopté dans l'État de Baja California, à la suite d'une demande présentée par Francisco Javier Sánchez, ancien directeur de la Commission des droits de l'Homme de cet État. Cependant, dans la majorité des États, les institutions publiques, proches du gouvernement, refusent de déclencher un tel processus.


Devant l'épuisement des recours légaux au niveau national, les ONG se tournent vers les mécanismes régionaux de droits humains. C'est ainsi que la Commission interaméricaine des droits de l'Homme, à la demande d'ONG mexicaines, a accepté d'étudier la réforme adoptée dans l'État de Morelos qui contreviendrait à la norme fédérale permettant l'avortement en cas de viol pour les femmes à travers le pays.

La vague de réformes constitutionnelles a aussi fait l'objet d'une déclaration récente du représentant pour le Mexique du Haut-Commissaire aux droits de l'Homme de l'ONU, Alberto Brunori, qui a déploré l'adoption au cours de la dernière année de réformes qui menacent de se transformer en « violence structurelle contre les droits des femmes ».

Devant la tendance générale au durcissement des législations en ma-

tière d'avortement qui s'observe en Amérique latine, l'utilisation des instruments régionaux de droits humains se dessine de plus en plus comme le principal recours pour défendre l'accès des femmes à l'avortement dans la région. Toutefois, les gouvernements sont souvent lents ou réticents à appliquer les recommandations émises par ces organismes.

De plus, les législations en matière d'avortement semblent être dépendantes des relations de pouvoir entre les gouvernements et les élites conservatrices, dont l'Église, ce qui laisse peu de place aux revendications de la société civile.

Au Mexique, les groupes de droits reproductifs ont donc peu d'espoir à court terme de voir l'avortement dépenalisé à l'extérieur du D.F., mais ils continuent de lutter pour freiner la vague de législations pro-vie en cours et pour maintenir la dépénalisation en vigueur dans la capitale. 

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Fighting the Rise of HIV-AIDS Among Haitian Women

Anne Marie Mercie Thimothé Robert

The prevalence of HIV-AIDS in Haiti has reached epidemic proportions at 2.2 per cent, the highest in the world apart from Africa. One of the factors fuelling this alarming trend is gender inequality, at times acted out through sexual abuse, which makes women increasingly vulnerable to infection. To reverse this trend and halt the spread of HIV-AIDS over the long haul, it is necessary to further empower women and redefine masculinity.

Faced with this challenge, the Haitian Government and the Canadian International Development Agency (CIDA) launched the Project To Support the Fight Against STI (sexually transmitted infections)/HIV-AIDS (PALIH) in 2002. This project, jointly led by the Center for International Cooperation in Health and Development (CCISD) and the Canadian Centre for International Studies and Cooperation (CECI) based in Quebec, Canada, seeks to combat and reduce the transmission of STI/HIV-AIDS on a long-term basis within the Haitian population.

The project deals with various social factors that have worsened the situation, namely a precarious health infrastructure, poor institutional governance, the erroneous views of youth on sexuality, the low use of condoms especially by young people and sex workers, as well as the core inequality between men and women. This inequality has a major impact on the spread of the infection by reducing women's ability to negotiate with their sexual partners. In fact, according to the 2005-2006 Mor-

tality, Morbidity and Utilization of Services Survey (Enquête Mortalité, Morbidité et Utilisation des Services, EMMUS-IV) conducted by the Haitian Children's Institute (Institut Haïtien de l'Enfance), the prevalence of HIV-AIDS has surged in women and young girls to a ratio of 115 for every 100 men.

As part of the project, the Gender Equality strategy, as a key area of intervention, seeks to raise the awareness of all those concerned about this issue and to ensure the effective participation of women in the search for solutions. In line with this strategy, the project focused initially on the empowerment of women by increasing their knowledge of STI/HIV-AIDS and advocating for their rights as well as participation in consultation processes.

However, in light of numerous cases of sexual abuse reported by advocacy groups and healthcare organizations (Haitian Women's Solidarity, SOFA; Women's House, KAY FANM; the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections, GHESKIO), the Gender Equality strategy has been reviewed to take this problem into account. Indeed, violence against women in Haiti is a widespread problem that affects women of any social class, family status and educational level. A February 2008 behaviour monitoring survey estimates the incidence of violence in intimate relationships of 15 to 24-year-olds is 17.2 per cent. According to a World Health Organization report on women and

health released in June 2009, this type of violence increases the risks of HIV transmission.

Accordingly, the Gender Equality strategy has been expanded to include concrete steps aimed at making the project team and partners aware of the problem of sexual abuse and developing intervention methodologies to empower women. This shift in approach has yielded some positive results in that specific services relating to sexual abuse and women's rights are now offered in 10 community health centres in the Artibonite department. These services provide victims with the help required in a timely fashion, which reduces the impact of abuse. In addition, these centres work with other groups such as justice and police to provide support to the victims on a global level. Though effective, this approach has one key limitation in that the underlying problems are not resolved since violence is also linked to the way in which relationships between women and men are structured and understood. Thus, a major awareness campaign is needed to create the lasting social change.

The effort against sexual abuse encountered another challenge in reducing the vulnerability of women. In order to tackle the feminization of HIV-AIDS, there is also the need to redefine a responsible masculinity. Given that the sexual behaviour of both male adults and adolescents is linked to the high prevalence of infection among women, men need to be encouraged to think about the

impact gender inequality is having on the spread of the epidemic. The projects' second phase, PALIH 2, integrates this theme and, in doing so, expects to harmonize men's concept of masculinity with the need for protection voiced by women. To this end, strategies have been developed, in particular, the training of peer counsellors who will serve as positive role models for men in the area of sexual health.

Focus groups were also organized regarding youth perceptions as well as their need for information and communication. In addition, a peer-counsellor training manual has been developed to encourage the debate on these issues. The strategy is being developed through various interventions with youth and clients of sex workers. The expected outcomes are a reduction in health risk behaviours and the development of gender relations conducive to the well-being of both men and women.

The promotion of gender equality is no doubt a major challenge. However, the battle against the increasing incidence of HIV-AIDS in women cannot be won if the underlying causes go unchallenged. It is therefore absolutely necessary to address the gender inequality that compounds women's biological role in passing along the illness to new generations by implementing programs centred upon the needs of women and by redefining social norms. 🌐

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Contre la féminisation du VIH/SIDA en Haïti

Anne Marie Mercie Thimothé Robert

L'ampleur de l'épidémie de VIH/SIDA en Haïti est alarmante, avec une prévalence de 2,2 pourcent, la plus élevée au monde, outre le continent africain. Un des facteurs sociaux y contribuant est l'inégalité des femmes dans leur relation avec les hommes qui s'exprime notamment à travers la violence sexuelle, ce qui les rend très vulnérables à l'infection. Le renforcement des capacités des femmes et une redéfinition de la masculinité sont donc essentiels pour enregistrer des avancées durables dans la lutte contre le VIH/SIDA en Haïti.

Face à l'épidémie, dès 2002 le gouvernement haïtien et l'Agence canadienne de développement international mettent en place le Projet d'appui à la lutte contre les IST (infections sexuellement transmissibles)/VIH/SIDA en Haïti (PALIH). Mené conjointement par le Centre de coopération internationale en santé et développement (CCISD) et le Centre canadien d'étude et de coopération internationale (CECI) basés au Québec, Canada, ce projet vise à combattre l'épidémie et à réduire de façon durable la transmission de ces infections dans la population haïtienne.

Le projet s'attaque à de nombreux facteurs sociaux aggravant la situation tels que la précarité des infrastructures de santé et la mauvaise gouvernance institutionnelle, les connaissances erronées

des jeunes en matière de sexualité, la faible utilisation des préservatifs notamment par les jeunes et les travailleurs sexuels, ainsi que les relations inégalitaires entre hommes et femmes. Ces dernières ont un impact important sur la propagation de l'infection, en réduisant la capacité de négociation sexuelle des femmes. De fait, un accroissement de la prévalence chez les femmes et les filles a été observé dans l'Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-IV) de 2005-2006 de l'Institut Haïtien de l'Enfance, avec une nette tendance à la féminisation de l'épidémie, soit un ratio de 115 femmes pour 100 hommes.

C'est pourquoi le projet inclut une stratégie Égalité Femmes-Hommes (EFH) qui constitue un axe prioritaire d'intervention afin de sensibiliser tous les acteurs engagés dans la lutte à cette problématique et d'assurer la participation effective des femmes dans la recherche de solutions. En lien avec cette stratégie, le projet abordait initialement l'habilitation des femmes en terme de renforcement de leurs connaissances sur les IST/VIH/SIDA, de plaider pour la défense de leurs droits et de participation aux instances de concertation.

Mais, à la lumière des nombreux cas de violences sexuelles sur les femmes rapportés par les organisations militantes et les structures de soins (Solidarité des Femmes Haï-

tiennes, SOFA; La maison des femmes, KAY FANM; Le Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes, GHESKIO), la stratégie EFH a été revue pour prendre en compte cette problématique. En effet, en Haïti, la violence contre les femmes est un phénomène social répandu qui affecte les femmes de tous niveaux d'instruction et états matrimoniaux. Une enquête de surveillance comportementale réalisée en février 2008 estime à 17,2 pourcent l'incidence de la violence dans les rapports sexuels entre les jeunes de 15 à 24 ans. Or, selon un rapport de l'Organisation mondiale de la Santé sur les femmes et la santé de 2009, la violence contre les femmes augmente les risques de transmission du VIH.


La stratégie EFH est donc élargie pour permettre des actions concrètes en vue de sensibiliser l'équipe et les partenaires du projet à la problématique de la violence sexuelle et ensuite, de développer des méthodologies d'intervention favorisant le renforcement des capacités des femmes. L'intégration de la problématique de la violence contre les femmes en tant qu'approche EFH a généré plusieurs résultats positifs. En effet, des services spécifiques reliés à la violence sexuelle et aux droits des femmes sont maintenant offerts à travers 10 centres d'accueil du département de l'Artibonite, fonctionnant en collaboration avec des services de soins. Cette articulation entre les services permet aux victimes de recevoir l'aide nécessaire dans les délais prévus et de réduire les conséquences des agressions. Ces centres travaillent en concertation avec d'autres acteurs comme la justice et la police afin de

favoriser une prise en charge globale des victimes. Une des limites de ces interventions, c'est qu'elles ne règlent pas les problèmes sous-jacents, car la violence est aussi liée à la construction des rapports sociaux de sexe. Une campagne de sensibilisation s'avère donc importante afin de favoriser un changement social durable.

Par ailleurs, le travail en lien avec la violence a permis de mettre en lumière un autre défi dans la réduction de la vulnérabilité des femmes. En effet, la féminisation de l'épidémie interpelle sur la nécessité d'appuyer la construction d'une masculinité responsable pour freiner ce phénomène. Les comportements sexuels des hommes liés à cette forte prévalence démontrent l'importance de travailler avec les adolescents et les hommes afin de les amener à réfléchir sur l'impact des relations inégalitaires dans la propagation des IST/VIH/SIDA. L'intégration de cette thématique aux interventions dans la deuxième phase du projet (PALIH 2) vise ainsi à harmoniser leur conception de la masculinité avec les besoins de protection exprimés par les femmes. Une des stratégies développées pour y arriver préconise la formation de pairs éducateurs disposés à incarner des modèles plus favorables à la santé sexuelle des hommes.

Des groupes de discussions ont été organisés sur les perceptions des jeunes, ainsi que sur leurs besoins d'information et de communication. Un manuel de formation destiné aux pairs éducateurs est élaboré en vue de favoriser les débats sur cette thématique. Cette stratégie se développe de façon transversale, à travers différentes interventions

auprès des jeunes et des clients des travailleuses du sexe. Les résultats escomptés visent l'amélioration des comportements à risque pour la santé et le développement des rapports de genre favorables au bien-être de chacun.

La promotion de l'égalité entre les hommes et les femmes constitue certes un défi majeur. Mais, la féminisation du VIH/SIDA ne sera pas renversée tant que l'on ne s'attaquera aux causes qui la soutiennent. La redéfinition de nouvelles normes sociales se révèle donc incontournable afin d'apporter des réponses appropriées aux inégalités entre les sexes et de mettre en place des programmes centrés à la fois sur les besoins des femmes et leur rôle biologique dans la transmission de la maladie. 

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Bolivia: Education to Improve Reproductive Health in Indigenous Communities

Erika Silva de la Vega

One third of Bolivians inhabit rural areas of which 90 per cent live in poverty and most are members of two indigenous ethnic groups, the Quechua and Aymara. Regarding health indicators, the country's high maternal mortality rate of 310 per 100,000 live births is alarming and it is estimated that it is at least 20 per cent higher in rural areas, according to preliminary data from the 2008 National Demographics and Health Survey (ENDSA). Given this reality, in 2004-2005 Project Warmi II educated indigenous women in rural areas on sexual and reproductive health with a gender focus in order to reduce maternal mortality in Calamarca and Morochata. This strategy is a best practice to follow according to the Pan American Health Organization.

Women in rural areas have an average of 4.9 children by the end of their fertile lives; this is nearly twice as many as women in urban areas. Only 44 per cent of rural births are supervised by health professionals, compared to 89 per cent in urban areas. This is reflected in the high maternal mortality rates.

This imbalance is partly due to the lack of healthcare services or their limited capacity, as 50 per cent of the rural health services are attended by nursing assistants. However, the main problems are due to lack of education in sexual and reproductive health and gender in-

equalities that both lead to delays in seeking healthcare services. Indeed, factors such as illiteracy and lack of educational attainment among women, as well as a lack of capacity to independently make health-related decisions due to power inequalities within the family and the community, exacerbate these delays. In addition, healthcare services are physically and culturally distant.

Project Warmi II was designed within this context, with the goal of reducing the number of maternal deaths in rural indigenous communities through improvements in sexual and reproductive health, the integration of a gender perspective, the encouragement of community participation and the empowerment of women. These elements were developed so that women could become more independent and better understand themselves, their circumstances and their social environment. Women were encouraged to become aware of power dynamics within their households, to develop the necessary capabilities to achieve a reasonable degree of control over their lives, and to communicate effectively in order to pass on their knowledge to others in the community and explain and negotiate their demands with their partners, local authorities and healthcare services.

Project Warmi II was implemented from 2004 to 2005 by two NGOs from the network of the Coordinated Program in Integrated Health

(PROCOSI) in Calamarca and Morochata, two rural municipalities with mostly Aymara and Quechua populations respectively. The NGOs worked with women's community organizations (WCOs), which prioritized the more important and prevalent sexual and reproductive health issues in their communities, created a project to solve them and received the funds to implement, monitor and evaluate the project.

The WCOs selected community organizers that could train other women in the community in all aspects of sexual and reproductive health in the local language. The project, while mainly based on education in sexual and reproductive rights, also sought to build the capacity of the WCOs. They were also encouraged to purchase equipment to be donated to the healthcare system and to provide other input that would help improve the quality of health services.

In early 2004, the baseline findings at the beginning of the project indicated that indigenous women did not utilize the healthcare system, or took too long to turn to it because they were unable to recognize pregnancy complications that put their lives at risk (see Figure 1). They had little knowledge of sexual and reproductive health and no concept of how to avoid unwanted pregnancies. Even though most of the women polled did not express a desire to have more children, none

of them knew at which moment of their menstrual cycles they could become pregnant (see Figure 2). Instead, they avoided intercourse during menstruation, believing that this was their fertile period; however, almost half the women also said that they did not decide jointly with their partner when to have sexual relations (see Figure 3). They attributed sexually transmitted infections (STIs) to external factors (e.g. "I caught a cold" or "It's the heat").

After the project was implemented and later evaluated in 2006, it was observed that women had significantly improved their knowledge, attitudes and practices related to their health, their bodies and their reproductive cycles (see Figure 2), and were more aware of the origin of some STIs. Most women said they can now have sexual relations when they wish (see Figure 3), and that they can also decide how many children they want and when they want to have them.


Since then, women have used the healthcare system more frequently and they have learned to detect complications during pregnancy and to seek the necessary help (see Figure 1). Overall, Project Warmi II contributed to a 75 per cent decrease in the number of maternal deaths between 2004 and 2006 in Calamarca and Morochata.

In addition, women identified what factors in their opinion contributed to the poor quality of healthcare services —issues such as

cold environments, lack of privacy, and poor attention and bedside manner on the part of healthcare

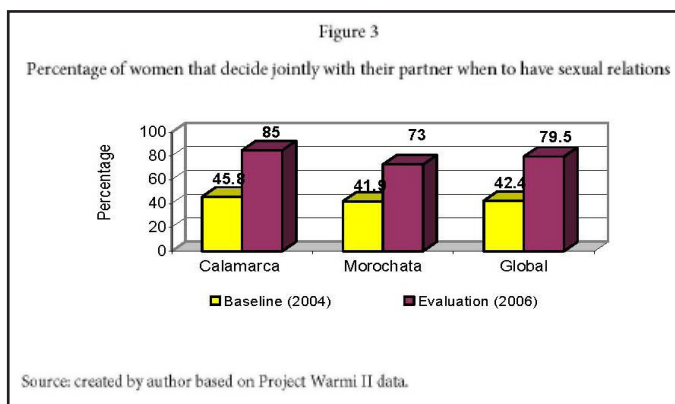
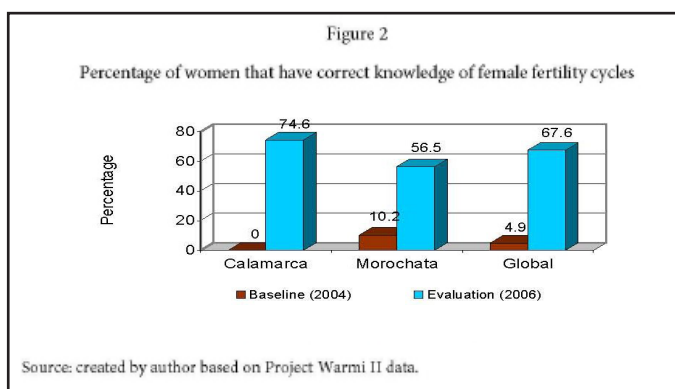
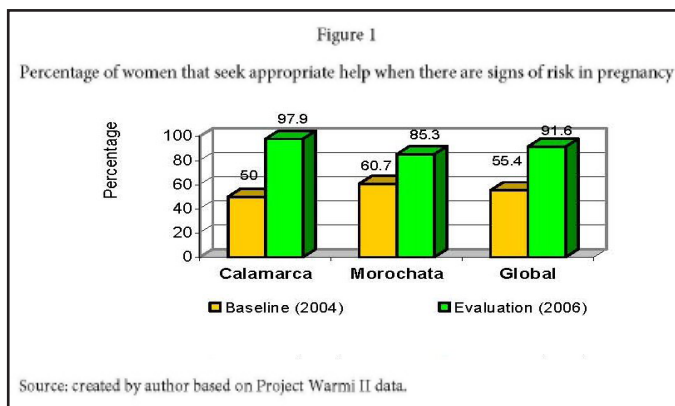
exercise their civil rights and contribute to the development of their communities.

Project Warmi II highlights relevant lessons for other indigenous communities and for the government. This intervention proves that delays in seeking healthcare services that cause maternal mortality can be reduced through inexpensive actions at the local level, helping women to independently overcome the obstacles that prevent them from receiving potentially life-saving medical attention.

These results also prove that policies to improve the health of women, especially indigenous women, should not only be designed to improve health systems, but also to empower women, improve their knowledge of sexual and reproductive health and enhance their ability to make health decisions for themselves. 

Erika Silva is a health consultant for CIDA in Bolivia. In her former position as Research and New Initiative Manager at PROCOSI, she coordinated the Warmi

II Project, which received the 2008 Pan American Health Organization Award for Best Practices Incorporating a Gender Equality Perspective in Health.



professionals— and supported the implementation of changes.

After receiving training on their reproductive rights, women say that they feel more comfortable expressing their feelings and thoughts in public and exercising their rights to health as well as their right to live free of violence. The WCOs involved in Project Warmi II say the women have also improved their ability to

Bolivia: Educación para mejorar la salud reproductiva en comunidades indígenas

Erika Silva de la Vega

Un tercio de la población boliviana vive en áreas rurales, del cual el 90 por ciento vive bajo condiciones de pobreza, la mayoría es indígena y pertenece esencialmente a dos grupos étnicos, aimaras y quechuas. En cuanto a indicadores de salud, de acuerdo a los datos preliminares de la Encuesta Nacional de Demografía y Salud (ENDSA) 2008, la alta tasa de mortalidad materna de 310 por 100,000 nacidos vivos a nivel nacional es alarmante y se calcula que en áreas rurales sería por lo menos 20 por ciento más alta. En este marco, en 2004-2005 el Proyecto Warmi II educó a mujeres indígenas en el área rural en salud sexual y reproductiva con enfoque de género para reducir muertes maternas en Calamarca y Morochata, una mejor práctica a seguir según la Organización Panamericana de la Salud.

Las mujeres en el área rural tendrían al final de su vida fértil 4.9 hijos, casi el doble de las mujeres de área urbana, y el parto en el servicio de salud sólo llega al 44 por ciento comparado con 89 por ciento en las áreas urbanas, lo que se refleja en las altas tasas de mortalidad materna.

Esto se debe en parte a la carencia o limitada capacidad resolutoria de los servicios de salud ya que en el área rural el 50 por ciento están atendidos únicamente por auxiliares de enfermería, pero principalmente a una falta de educación en

salud sexual y reproductiva y a las desigualdades de género que se traducen en demoras en la búsqueda de servicios de salud. Factores como el analfabetismo o la baja escolaridad de las mujeres y la incapacidad de decidir sobre su propia salud debido a relaciones desiguales de poder en la pareja y en la comunidad, entre otras, exacerban las demoras. Adicionalmente, los servicios de salud se encuentran física y culturalmente distantes.

Ante esta situación fue diseñado el Proyecto Warmi II, con el objetivo de reducir las muertes maternas en las comunidades indígenas del área rural a través de mejorar la educación en salud sexual y reproductiva, incluir un enfoque de género, fomentar la participación comunitaria y apoyar el empoderamiento de las mujeres. Estos elementos fueron trabajados para que las mujeres se conviertan en sujetos de sus propias vidas y desarrollen una comprensión de sí mismas, sus circunstancias y entorno social. Se impulsó a que las mujeres tomen conciencia de las dinámicas de poder que operan en sus hogares y desarrollen capacidades necesarias para lograr un control razonable sobre sus vidas y ejerciten sus habilidades comunicacionales tanto para capacitar a otros miembros de sus comunidades como para explicar y negociar sus demandas a sus parejas, autoridades locales y servicios de salud.

El Proyecto Warmi II, fue implementado en los años 2004 y 2005 por dos ONGs de la red del Programa de Coordinación en Salud Integral (PROCOSI) en Calamarca y Morochata, dos municipios rurales de población aimara y quechua respectivamente, y trabajó con Organizaciones Comunitarias de Mujeres (OCM). Las OCM priorizaron los problemas de salud sexual y reproductiva más importantes y prevalentes de sus comunidades, elaboraron un proyecto para solucionar estos problemas, recibieron los fondos para ejecutarlo, lo monitorearon y lo evaluaron.

Las OCM seleccionaron promotoras comunitarias a fin de capacitar en el idioma local a otras mujeres de la comunidad en todos los aspectos de salud sexual y reproductiva. El proyecto aunque era principalmente educativo en salud sexual y reproductiva tuvo también actividades para el fortalecimiento de las OCM y para la adquisición de equipamiento e insumos que ellas donarían al servicio de salud para cambiar los aspectos que ellas consideraban necesarios para una mejor calidad.

Al inicio del proyecto, la línea de base realizada a inicios del 2004 reveló que las mujeres indígenas no recurrían o tardaban en llegar al servicio de salud por no reconocer cuando sus vidas estaban en peligro de muerte al presentar complicaciones en el embarazo (ver Figura 1). Además, no conocían su salud sexual y

reproductiva, ni cómo cuidarse para no tener un embarazo no deseado. Pese a que la mayoría de las mujeres expresaron su deseo de no tener más hijos, ninguna mujer encuestada conocía correctamente en qué momento podía quedar embarazada en su ciclo menstrual (ver Figura 2). Más bien evitaban tener relaciones sexuales en los momentos de su menstruación, pensando que era su periodo fértil, aunque casi la mitad de las mujeres dijeron que no decidían con su pareja cuando tener relaciones sexuales (ver Figura 3). Las infecciones de transmisión sexual (ITS) estaban atribuidas a factores externos (e.g. “he tenido mucho frío” o “me ha dado el calor”).


Con la ejecución del proyecto y la evaluación posterior de 2006 se observó una mejora significativa de los conocimientos, actitudes y prácticas de las mujeres en relación con su salud, con el funcionamiento de su cuerpo y del ciclo reproductivo (ver Figura 1), y con el origen de algunas ITS. La mayoría de las mujeres relatan que ahora pueden tener relaciones sexuales cuando ellas lo deseen (ver Figura 3) y decidir cuántos hijos quieren y cuándo tenerlos.

Desde entonces, las mujeres utilizan más los servicios de salud y han aprendido a reconocer los riesgos del embarazo y a buscar la ayuda necesaria (ver Figura 2). Por cierto, el Proyecto Warmi II contribuyó en la reducción del número de muertes maternas en 75 por ciento entre los años 2004 y 2006 en Calamarca y Morochata.

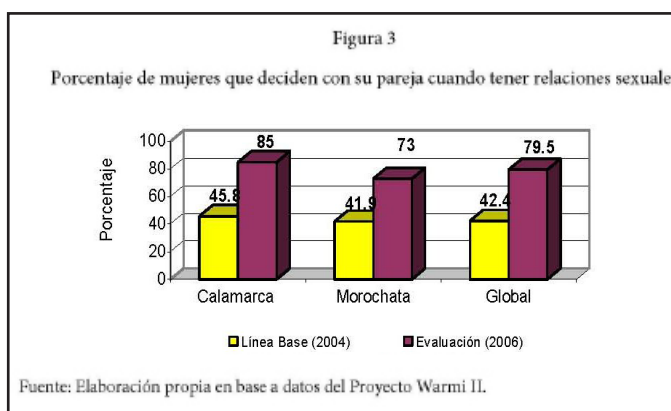
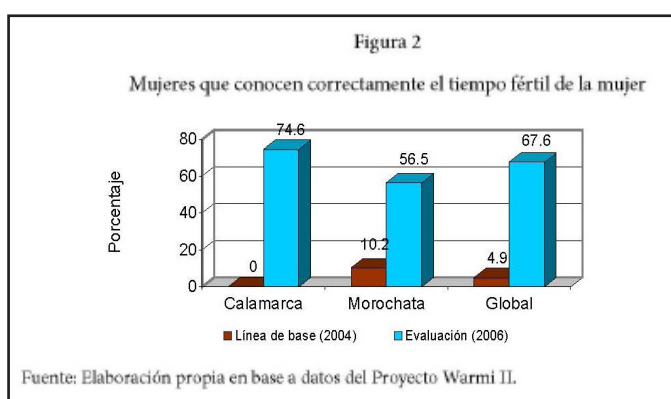
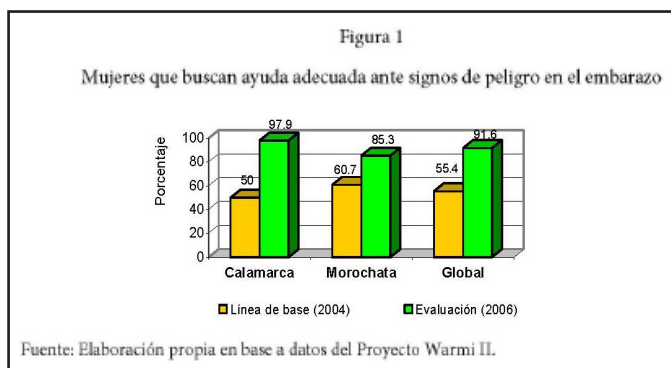
Por otra parte, las mujeres identificaron los factores relativos a la falta de calidad de los servicios de salud

involucradas en el Proyecto Warmi II ven que ellas también han empezado a ejercer sus derechos ciudadanos y contribuir en el desarrollo de su comunidad.

El Proyecto Warmi II presenta lecciones relevantes para otras comunidades indígenas y el gobierno. Esta intervención nos demuestra que las demoras relacionadas con la mortalidad materna pueden reducirse con acciones a nivel local de pocos recursos, ayudando a las mujeres a superar por sí mismas los obstáculos que les impiden recibir atención que les puede salvar la vida.

Efectivamente, estos resultados nos enseñan que las políticas para mejorar la salud de las mujeres, especialmente indígenas, no solamente deben estar dirigidas a mejorar los servicios de salud sino también a empoderar a las mujeres, a mejorar sus conocimientos en salud sexual y reproductiva y su capacidad de decisión sobre su propia salud. 

Erika Silva es consultora en salud para la Cooperación Canadiense en Bolivia. Anteriormente coordinó varios proyectos de salud en Bolivia, incluido el Proyecto Warmi II, cuando se desempeñaba como Gerente de Investigación y Nuevas Iniciativas en PROCOSI. El Proyecto Warmi II ha recibido el premio de la Organización Panamericana de la Salud 2008 como Mejores prácticas en género, etnia y salud.



desde su perspectiva —ambientes fríos, carencia de privacidad, trato y atención de los recursos humanos de salud— y apoyaron a la realización de los cambios.

Al haber capacitado a las mujeres para ejercer sus derechos reproductivos, ellas dicen que ahora están más cómodas para expresar sus sentimientos y pensamientos en público, ejercitar su derecho a vivir sin violencia y su derecho a la salud. Las OCM

Anteriormente coordinó varios proyectos de salud en Bolivia, incluido el Proyecto Warmi II, cuando se desempeñaba como Gerente de Investigación y Nuevas Iniciativas en PROCOSI. El Proyecto Warmi II ha recibido el premio de la Organización Panamericana de la Salud 2008 como Mejores prácticas en género, etnia y salud.

Challenging the Polarized Abortion Debate in Brazil, Chile, Mexico and Nicaragua

Claudia Dides

The results of an opinion poll on abortion conducted by the Chile branch of the Latin American Faculty of Social Sciences (FLASCO) in Brazil, Chile, Mexico and Nicaragua reveal that the traditional ideological polarization of the pro-life versus pro-choice debate does not reflect the attitude of the majority of the population. The results of the poll, performed from April to May 2009, uncover a third position that favours the legalization of abortion in certain traumatic circumstances and signals that the population wants greater openness, flexibility, information, debate and participation in public policy decisions.

FLASCO-Chile's Gender and Equity Program developed a public opinion poll within the framework of the research project "Sexual and Reproductive Rights, Social Inequality and Politics in Latin America," financed by the International Development Research Centre (IDRC) in Canada. In each country featured in the study, a representative sample of approximately 1,200 men and women over 18 years old from both rural and urban settings was polled. The main objective was to understand people's perceptions, opinions, knowledge and expectations concerning abortion.

Key results

There is a broad consensus in the four countries that abortion is a serious problem in itself (82.5 per cent on average), supported by the

perception that a large number of women in those countries die as a result of abortion complications. Respondents also perceive a two-fold insecurity for women who have abortions: on the one hand, clandestine abortions are carried out in precarious conditions; on the other, they have physical, psychological and social consequences. Furthermore, 78 per cent of respondents think that women who live in poverty have a greater risk of resorting to dangerous abortions.

Consequently, in Brazil, Chile, Mexico and Nicaragua, the population supports more flexibility in abortion laws in certain circumstances, such as when the life of the mother is in danger (66 per cent on average), in cases of rape (56 per cent on average) or in cases of fetal malformation (61 per cent on average). Nevertheless, these circumstances do not coincide with the main reasons why respondents think women have abortions; support for legalizing abortions for these reasons is quite low. For example, on average only 7.2 per cent support legalization when the mother has been abandoned by her partner, 17.5 per cent if the woman is underage and 10 per cent if the mother lacks the economic resources to raise a child.

In all of the countries, the respondents recognize the importance of having national debates and discussions about abortion laws. Further, 90 per cent on average agree that governments have to

change current legal frameworks on abortion. The majority of respondents prefer that the changes be debated publicly through plebiscites or public consultations (65.7 per cent), while fewer prefer that changes be made by the legislative branch (17.5 per cent).

However, the poll reveals that people consider themselves poorly informed about laws on abortion (87 per cent indicated they knew little or nothing about them) and say that they have rarely seen or read news on the theme. Further, they say they have not discussed the subject with friends or family, having few opportunities to bring it into everyday conversations. In relation to personal proximity with the reality of abortion, 34 per cent of respondents in Chile, 38 per cent in Mexico, 45 per cent in Nicaragua and 52 per cent in Brazil indicated they knew someone who had had an abortion. These results are important in that those who consider themselves better informed on abortion and have a closer personal proximity to it tend to support its legalization to a greater extent than those who have had less contact with this reality.

Conclusions

There is an area that is neither covered by current legislation nor by the ideological debate coined as pro-life versus pro-choice; this debate does not reflect the position of the majority of the population in the four countries. Faced with the polarized arguments that dominate

the traditional debate, society is looking for a third way by considering specific traumatic circumstances of pregnancy to evaluate whether the mother's life or the fetus' should be prioritized.

A common feature in the four countries polled is that people want more flexibility in laws penalizing abortion and ask for greater participation in the debate and in the decisions related to these laws. Evidently, these societies are demanding democratization of the debate and of decisions related to abortion, bringing them out of the exclusive sphere of the elites.

Along the spectrum between penalization and depenalization of abortion in the four societies, there emerges a moderate attitude when abortion is sought due to critical circumstances. Therefore, the real question is: In what circumstances do people favour depenalization and in what others do they support penalization of abortion?

This poll shows, as previous studies have, that certain traumatic pregnancy circumstances (risk to the life of the mother, inviability of the fetus or rape) prompt a majority of respondents to favour depenalization of abortion, whereas other circumstances (financial difficulties, being abandoned by a partner, etc.) prompt most to favour penalization.


Finally, one of the most relevant conclusions of this poll is that it is possible to discern attitudes supporting penalization and depenalization (absolute or relative) not only across sociocultural and socioeconomic lines that affect value scales from conservative to liberal, but also according to respondents' life experiences. Personal proximity to women who have endured difficult

Cuestionando la polarización sobre el aborto en Brasil, Chile, México y Nicaragua

Claudia Dides

Los resultados de una encuesta de opinión sobre el aborto realizada por la sede Chile de la Facultad Latinoamericana de Ciencias Sociales (FLASCO) en Brasil, Chile, México y Nicaragua entre abril y mayo de 2009 revelan que la polarización del debate ideológico tradicional "pro-vida" contra "pro-elección" no refleja la actitud de la mayoría de la población. Más bien, se evidencia una tercera postura que favorece la despenalización del aborto en determinadas circunstancias asociadas al embarazo, respecto de las cuales la población demanda mayor apertura, flexibilidad, información, debate y participación en las decisiones de política pública.

El Programa de Género y Equidad de FLACSO-Chile desarrolló un estudio de opinión pública en el marco del Proyecto de Investigación "Las Políticas del Aborto en Latinoamérica" financiado por el Centro Internacional de Investigaciones para el Desarrollo (IDRC)

pregnancy circumstances (losses, unwanted pregnancies, unwanted children or abortions) influences their attitudes on abortion. This indicates the presence of individual motivation, distinct from ideology or value systems, that allows permitting circumstantial exceptions for abortion and relates more directly to people's backgrounds and life experiences. 

de Canadá. En cada país se encuestaron con un muestreo de tipo probabilístico en todas sus etapas aproximadamente a 1,200 hombres y mujeres mayores de 18 años tanto en zona rural y urbana. El objetivo principal fue conocer las percepciones, opiniones, conocimientos y expectativas de la sociedad sobre el aborto.

Resultados más relevantes

En los cuatro países existe un amplio consenso en que el aborto es un problema grave en sí mismo (82.5 por ciento en promedio), lo que se sustenta además en la percepción de que una gran cantidad de mujeres han muerto en los respectivos países producto de un aborto. Adicionalmente, se visualiza una doble desprotección de las mujeres que abortan, ya que por un lado están las precarias condiciones en las cuales se realizan los abortos clandestinos y por otro, están las consecuencias físicas, psicológicas o sociales asociadas a esta situación. Además, existe la percepción,

(Continúa en la página 17)

Claudia Dides is a sociologist and research professor for FLASCO-Chile, as well as director of FLASCO's Gender and Equity Program. The other researchers involved in conducting this poll are Isabel Sáez, Cristina Benavente and José Manuel Morán of the Gender and Equity Program.

compartida por el 78 por ciento de los encuestados, de que las mujeres que viven en condiciones de pobreza tienen un riesgo mayor a recurrir a abortos inseguros.

Consecuentemente, en Brasil, Chile, México y Nicaragua se espera una flexibilización de las leyes del aborto delimitadas a ciertas circunstancias, tales como cuando se encuentra en peligro la vida de la madre (66 por ciento en promedio), en caso de violación (56 por ciento en promedio) o cuando existe malformación del feto (61 por ciento en promedio). No obstante, estas circunstancias no coinciden con las principales razones por las que los encuestados creen que las mujeres abortan; en éstas el apoyo a la legalización del aborto es bastante bajo. Por ejemplo, en promedio es solamente 7.2 por ciento cuando hay abandono de pareja, 17.5 por ciento si la mujer es menor de edad y 10 por ciento si es por falta de recursos económicos para mantener al hijo.

No obstante, en todos los países los encuestados reconocen la importancia de debatir y discutir sobre las leyes del aborto a nivel nacional. Así, es posible constatar que en promedio el nivel de aceptación respecto a la afirmación de que los respectivos gobiernos deberían revisar el marco legal vigente relativo al aborto es de un 90 por ciento. Adicionalmente, manifiestan una mayor preferencia para que estos temas sean debatidos públicamente en plebiscitos o consultas públicas (65.7 por ciento), y en menor medida que sean materia de decisión en el poder legislativo (17.5 por ciento).

Sin embargo, según el estudio, la gente se considera poco informada en torno a las leyes sobre aborto (86.7 por ciento señalaron conocer poco o nada respecto a éstas) ya que raramente han visto o leído noticias sobre este tema. Tampoco han tenido discusiones con

amistades y familiares, habiendo pocas oportunidades para que el tema se transforme en contenido de conversación cotidiana. En relación a la proximidad personal con situaciones de aborto, 34 por ciento de la población encuestada de Chile, un 38 por ciento de México, un 45 por ciento de Nicaragua y un 52 por ciento de Brasil señala conocer personalmente a alguien que ha abortado. Estas informaciones son importantes, ya que según el análisis de los resultados quienes se muestran más informados y tienen una mayor proximidad personal, tienden a aprobar la legalización del aborto en mayor medida que quienes tienen un menor contacto con dichas experiencias.

Conclusiones


Se percibe un espacio no cubierto ni por las legislaciones vigentes ni por el debate ideológico “pro-vida” contra “pro-elección”, al no reflejar la posición de la mayoría de la población. Ante estas posiciones polarizadas que dominan el debate tradicional, la población comienza a preguntarse “¿qué vida: la de la madre o la del feto?” ante distintas circunstancias traumáticas del embarazo.

La aspiración por una mayor flexibilidad en las legislaciones penalizadoras del aborto y por una mayor participación en el debate y en las decisiones al respecto aparece como un rasgo común en los cuatro países estudiados. Las personas parecen estar claramente orientadas hacia un proceso de demanda de democratización en el debate y de decisión sobre este tema, sacándolo del ámbito exclusivo de las élites.

En el continuo que va desde la penalización hasta la despenalización del aborto en las cuatro sociedades, surge una actitud moderada cuando las circunstancias en las que se da el aborto son críticas. Entonces, la verdadera pregunta es ¿qué circunstancias acercan a

las personas a la penalización y cuáles a la despenalización del aborto?

Tanto el presente estudio como otros anteriores muestran que ciertas circunstancias traumáticas asociadas a un embarazo (riesgo de vida de la madre, inviabilidad del feto, violación) son aquellas que mayoritariamente favorecen una actitud despenalizadora, mientras otras (dificultades económicas, abandono de la pareja u otras) no la favorecen, y en cambio sostienen una actitud favorable a la penalización.

Finalmente, una de las conclusiones más relevantes de este estudio es que es posible diferenciar una actitud de penalización con una de despenalización (absoluta o relativa) no sólo a través de variables estructurales socioculturales y socioeconómicas de la población, que afectan las escalas de valores desde conservadores a liberales, sino también con la experiencia vivida por las personas. Así, la proximidad con casos de mujeres que han atravesado por circunstancias críticas de embarazo (pérdidas, embarazos no deseados, hijos no deseados o abortos) influye en la actitud sobre el aborto. Esto es indicativo de la presencia de una motivación distinta de la ideología o posición valórica, que induce a admitir excepciones de circunstancia y que se relacionan más directamente con factores biográficos o experienciales de las personas. 

Claudia Dides es Socióloga y Profesora Investigadora de FLACSO-Chile, además de ser directora del Programa de Género y Equidad en dicha institución. Los otros investigadores del estudio son Isabel Sáez, Cristina Benavente y José Manuel Morán de este último Programa.

Sexual and Reproductive Rights Promotion in Guatemala

Christine Butt

Canadian and Guatemalan obstetricians and gynaecologists are cooperating to improve and promote the sexual and reproductive rights of women in Guatemala. Working with the Society of Obstetricians and Gynaecologists of Canada (SOGC), the Asociación de Ginecología y Obstetricia de Guatemala (AGOG) has taken on a leadership role for the promotion of these rights. The program is funded by the Canadian International Development Agency.

Many women in Guatemala face challenges when it comes to sexual and reproductive health. For many, lack of access to a skilled attendant at birth or to proper health services means a one in 71 risk of dying during pregnancy or childbirth. These challenges may also mean facing an unplanned or unwanted pregnancy due to lack of contraceptives

or sexuality education; contraction of a sexually transmitted disease, including HIV-AIDS; an unsafe abortion due to constricting laws banning access to proper services; or sexual violence and abuse due to a lack of power in relationships. Such challenges are complicated even further when we take into account the impact of poverty, lack of education, discrimination and weak healthcare systems.

Obstetricians, gynaecologists, family physicians, midwives, nurses and other healthcare providers, along with their professional association, are well positioned to address the root causes of many reproductive health problems such as discrimination, gender and economic inequalities. Over the past 10 years, the SOGC has sought to strengthen its Guatemalan counterpart's status and ability to influence individual practice, hospi-

tal and clinic service delivery and national protocols. Integrating a rights-based approach and women's empowerment into the daily practice of health professionals and into national protocols was a daunting and difficult task. This was a major achievement in light of the Church's opposition to sexual and reproductive rights protocols in Guatemala.

The SOGC provided tools to the AGOG to sensitize its members to the importance of sexual and reproductive health as a human right and to the advantages of promoting women's empowerment in order to influence sexual and reproductive health. Members also broadened their understanding of the social, economic, cultural and legal factors that impact sexual and reproductive health outcomes. AGOG was encouraged to progressively work at organizational and programmatic changes to build support

Guatemala encouraging sex education and family planning

A law designed to increase sex education and family planning in Guatemala was implemented Oct. 30 after a four-year delay due to challenges from the Catholic Church.

The law's tactics are twofold: to introduce comprehensive sex education in the country's schools and to increase the availability of contraceptives for women and men. Supporters of the law insist it is necessary in order to mitigate health issues faced by women in the country. Nearly 65,000 girls and women get abortions in Guatemala each year, as reported in a 2006 study by the Guttmacher Institute. The law may help combat widespread abortion complications, which lead to hospitalization for roughly 22,000 Guatemalan women per year.

Guatemala has some of the highest rates of maternal and infant mortality in the Americas —30 deaths per 1,000 live births, as reported by a 2008-2009 maternal-infant health survey that was presented in November by Guatemalan authorities. Yet, the country follows closely behind Nicaragua as the fastest growing population in the region, and it has seen an increase in teenage pregnancies.

The Catholic Church challenged the law after it was first passed in 2005. Rodolfo Quezada, the Archbishop of Guatemala City, announced on Nov. 15 he would seek an injunction from the Constitutional Court because he believes the law violates freedom of religion.

for a rights-based approach and women's empowerment among its membership.

Within the past five years, the AGOG has assumed a strong advocacy role. For example, during the last national elections it held a public meeting to question all party representatives on the party's position regarding a number of issues related to sexual and reproductive health. In collaboration with other stakeholders in the field, AGOG has also lobbied for the passing of a Family Planning Law, guaranteeing universal and public access to reproductive health services for the population, while taking an active role in disseminating the findings of a national study related to violence in the family and the Social Justice Law.

Some of the other changes toward sexual and reproductive health and rights promotion that AGOG has undertaken includes the adoption of a code of ethics regarding sexual and reproductive rights. This process took two years of discussion and debate before members ratified it. Furthermore, its new strategic plan (2008-2013) encourages the participation and commitment of women within the association. For the first time in its history, the association elected a woman as president in 2007.

AGOG has established partnerships with leaders in the field of women's health, including the United Nations as well as Planned Parenthood for America, the National Nursing School for a pro-

gram directed at Mayan midwives, the Guatemalan Medical Women's Association and Terra Viva, a national women's non-governmental organization working for the promotion of sexual and reproductive rights.


At the service delivery level,

A sexual and reproductive rights approach can work through a capacity building strategy with professional health associations working in low-resource countries.

AGOG has collaborated with the Guatemalan Women's Medical Association to develop national guidelines regarding medical services to victims of sexual assault or violence. Currently, AGOG is participating in national committees, such as the Observatorio en Salud Reproductiva and the National Commission to Ensure Contraceptive Provisions, and it is establishing national baseline data regarding the context of abortion in Guatemala.

The promotion of sexual and reproductive health through women's empowerment and a rights-based approach is also strongly supported within the Advances in Labour and Risk Management (ALARM) international program, a training

course in emergency obstetrics developed by the SOGC and disseminated throughout Guatemala by AGOG.

Drawing from this experience in Guatemala, a sexual and reproductive rights approach can work through a capacity building strategy with professional health associations working in low-resource countries. This experience could be replicated by SOGC to reinforce the commitment of health associations everywhere to sexual and reproductive health promotion and provide guidance toward implementing a rights-based approach and women's empowerment. 

*Christine Butt works for the International Women's Health Program at the Society of Obstetricians and Gynaecologists of Canada (SOGC). The SOGC recently published the second edition of a booklet entitled *Improving Sexual and Reproductive Health: Integrating Women's Empowerment and Reproductive Rights*.*

ANNOUNCEMENTS

FOCAL's Canada-Mexico Initiative

Carlo Dade, the Executive Director of FOCAL, presented on the Canada-Mexico Initiative on Dec. 8 at the "Overview of the Canada-Mexico Relation: Building Roads Towards the Future" conference organized by the Mexican Senate in light of the state visit of Michaëlle Jean, Governor General of Canada (Dec. 6-9). This event is part of the commemoration of the 65th Anniversary of diplomatic relations between Canada and Mexico. He also participated in the conference "Canada and Mexico: Challenges and Perspectives," organized by the Mexican Association of Canadian Studies in Morelia, Mexico from Dec. 3 to Dec. 4.

Colombian Anti-Union Violence and the Canada Free Trade Agreement

Daniel Mejía, a professor of economics from the Universidad de los Andes in Colombia, came to FOCAL on Nov. 24 to present the findings of his study entitled "Is Violence Against Unions in Colombia Systematic and Targeted?", which was released in November. He has also written another article on the subject that was published in the November 2009 issue of *FOCALPoint*.

Cuba Futures: Past and Present International Symposium March 31 – April 2, 2011 New York, United States

The Bildner Center/Cuba project is organizing an international and interdisciplinary conference at the Graduate Center of the City University of New York, which will feature specialists on Cuba from around the world. The symposium's goal is to demonstrate and further the academic work on Cuban studies. To participate with a paper presentation, please send a one page paper proposal to cubaproject@gc.cuny.edu.

The views expressed in *FOCALPoint* are those of the authors and do not necessarily reflect the opinions of FOCAL, its Board or staff.

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