ATENEA: Monitoring as women's civic practice
march 2013

LATIN AMERICAN AND CARIBBEAN REPORT

LACWHN looks at six Latin America and Caribbean countries: Argentina – Brazil – Colombia – Mexico – Nicaragua – Dominican Republic Cairo +20, 2012

Red de Salud de las Mujeres Latinoamericanas y del Caribe, RSMLAC

by
latin american and
caribbean women's health
network- LACWHN

As member of the Latin American and Caribbean Women´s Health Network, LACWHN, we will continue to respond to the callenge of forgoing a new history: one in wich relations between women and men are based on equality, respect and peace.

We defend women´s right to live their lives free from all forms of violence and discrimination.

We promote and defend their Human Rights, Sexual Rights, Reproductive Rights and their Right to Comprehensive Health at all stages of their lives.

We affirm women´s historic struggle for sexual and reproductive freedom and control over their bodies.

We affirm women´s full citizenship from a feminista, antiracist and intercultural perspective.

We defend the separation of church and state as a requirement for guaranteeing pluralistic, diverse and inclusive societies, and reject all fundamentalisms.

Red de Salud de las Mujeres Latinoamericanas y del Caribe, RSMLAC

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GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
AMEU	Manual Endo-uterine Aspiration
CDH	Human Rights Committee
CRC	Convention on the Rights of the Child
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CENIDH	Nicaraguan Human Rights Centre
CENSIDA	National Centre for the Prevention and Control of HIV/AIDS in Mexico
CONASIDA	National Centre for the Prevention and Control of HIV/AIDS
CONPES	National Economic and Social Planning Council
CTA	Testing and Advisory Centre
DAWN	Development Alternatives with Women for a New Era
DDHH	Human Rights
DHS	Demography and Health Survey
DRE	Digital Rectal Examination
ELISA	Enzyme Linked Immuno-Sorbent Assay
ENDESA	See DHS
ECLAC	Economic Commission for Latin America and the Caribbean
GII	Gender Inequality Index
GNI	Gross National Income
GLOBOCAN	International Agency for Research on Cancer
GPI	Gender Parity Index
HDI	Human Development Index
HIV/AIDS	Acquired Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HIV	Acquired Immunodeficiency Virus
HPV	Human Papillomavirus
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICPD	International Conference on Population and Development
ICESCR	International Covenant on Economic, Social and Cultural Rights
INSS	Nicaraguan Social Security Institute
IHDI	Inequality-adjusted Human Development Index
ILE	Legal Interruption of the Pregnancy
ILO	International Labour Organization
IPG	Index of Gender Parity
IUD	Inter-uterine Device
IVE	Voluntary Interruption of a Pregnancy
LAC	Latin America and the Caribbean
LACWHN	Latin American and Caribbean Women's Health Network
LGTBI	Lesbian, Gay, Transsexual, Bisexual and Intersexual
MDG	Millennium Development Goals
MPI	Multidimensional Poverty Index
OHCHR	United Nations Office of the High Commissioner for Human Rights
PAHO	Pan-American Health Organization
PAP	Papanicolaou
LACWHN	See LACWHN
SESPAS	State Secretariat of Public Health and Social Assistance
SILAIS	Local Comprehensive Health Care System
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	UN General Assembly Special Session on HIV/ AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
UNICEF	United Nations Children's Fund
UN Women	United Nations agency for Gender Equality and Women's Empowerment
WHO	World Health Organization

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INTRODUCTION

In July of 1993, in Oaxtepex, Mexico, the Latin American and Caribbean Women's Health Network convened the first meeting on "Women and Population Policies in Latin America and the Caribbean", attended by 70 women from 18 countries, setting the tone for the feminist debate in the region and initiating the full incorporation of their membership to the process, long before the International Conference on Population and Development held in Cairo, Egypt, in September of 1994.

The LACWHN spread across the region the need of defining population policies in the context of development models based on social justice and equity. It promoted the idea that sexual and reproductive rights ought to be explicit and clearly formulated concepts, so that population policies can be defined from the perspective of women. It demanded responsibility from the States and civil society in ensuring the sexual and reproductive rights, as well as the need for women's empowerment in the individual context, in families and societies and in the development of collective power.

From that perspective, the LACWHN undertook an active and belligerent role and determined the formulation of the Programme of Action, and subsequently monitored government commitments 5, 10 and 15 year after the ICPD, kept watch on laws, policies, programs, financial and human resources and the adequacy of institutions to implement all measures that respond to the needs of women throughout their life cycle efficiently and in a timely manner.

Shortly before reaching the twentieth anniversary of the ICPD, once again —and this time in alliance with The Asian-Pacific Resource and Research Centre for Women, (ARROW)— the LACWHN presents a study of six regions: Argentina, Brazil and Southern Cone Colombia, Nicaragua, Dominican Republic and Central Mexico, North America and the Caribbean.

From the look of feminist leaders who are members of the LACWHN, several subjects were discussed: the regional context and its interactions with the challenges of Cairo, reproductive health and reproductive rights, sexual health and sexual rights, the diversity of women and emblematic cases that —in summary and in detail— reflect the dramatic risks, damages and discrimination that are lashed against women as a result of violations of their human rights, their rights to decide and to live free of violence.

Progress is mentioned and highlighted, when States are willing to recognize the needs and listen to the demands of women, acting positively, showing political responsibility and getting results.

From a feminist point of view —which allows zero concessions—, the underlying causes that prevent the advancement of the ICPD agenda are identified, as well as sectors that publicly and privately act continuously pressuring States, whose officials obey de facto powers and apply specific religious criteria instead of carrying out their obligations to the citizenry.

The many barriers to the implementation of existing laws are also discussed, along with the reduction of budgets, constraints and barriers to the access to information, education and services, the lack of registration systems or useful statistics that prevent measuring results and having timely information.

The belligerence of women in the region and the continued presence of the LACWHN where the main debates occur show the regional landscape with all its lights and shadows. It is also useful as an inventory of the needs and demands beyond 2014, opening a collective path which the next steps shall follow.

Key Definitions

Reproductive Health

Reproductive Health implies that people are able to have a responsible, satisfying and safe sex life and have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (WHO)

Reproductive Rights

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (ICPD)

Sexual Health

Sexual health implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations as well as counselling and care related to reproduction and sexually transmitted diseases. (adapted, UN)

Sexual Rights

Sexual rights embrace human rights that are already recognised 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 and reproductive health care services; seek, to receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; to decide to be sexually active or not; consensual sexual relations; consensual marriage; to decide whether and when to have children; and to pursue a satisfying, safe and pleasurable sexual life. (WHO working definition)

CHAPTER 1

lacwhn and ICPD monitoring

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CHAPTER I. LACWHN AND ICPD MONITORING

This chapter incorporates the introduction to the Monitoring Documents for Cairo+5 titled *La mirada de la LACWHN en cinco países de América Latina Brasil /Chile /Colombia /Nicaragua /Perú 1998 - 1999;* for Cairo+10 titled *Informe Latinoamericano ATENEA: El monitoreo como práctica ciudadana de las mujeres.*

Una mirada de la LACWHN en siete países de América Latina Brazil / Chile /Colombia /México /Nicaragua / Perú /Surinam 2000 - 2004; and for Cairo+15 titled *Reafirmando nuevos y antiguos desafíos en la agenda feminista latinoamericana,* written by Ana María Pizarro of SI Mujer Nicaragua in February 2009.

In both the process prior to the International Conference on Population and Development (ICPD) in 1994 and its later development, the Latin American and Caribbean Women's Health Network (LACWHN) participated through many of its members and organizations as part of the international women's movement and as a leader of the process developed in the region. Together with other women's initiatives at a world level, it has ensured that its membership received the agreements of the Programme of Action, and promoted their fulfilment and implementation by the States as a substantial part of their strategies.

LACWHN took on the commitment to implement the humanizing proposal assumed in the Programme of Action, defining as a long-term objective to promote its implementation in the region's countries by putting into effect public policies, inter-sectoral coordination, dialogue between the governmental and non-governmental spheres and among the feminist and women's organizations and movements as well as through follow-up and monitoring mechanisms by civil society. This process, which is a new exercise of the expression of citizenship by the region's women, was made possible by the financial and technical support of the United Nations Population Fund between 1995 and 2003.

To promote follow-up to the implementation of the Programme of Action, LACWHN proposed that it work on a monitoring matrix that could be applied in the countries by women's organizations and/or civil society movements as an effective social control instrument. That is how citizens' monitoring of the ICPD Programme of Action got underway in 1996 and continued developing over the course of eight years in three projects called Follow-up Project of the International Conference on Population and Development (1996-1997), Advocacy and Monitoring Project of the Cairo+5 Process (1998-1999) and Follow-up Project to the implementation of the ICPD Programme of Action (2000-2003), whose product was the ATENEA database.

Brazil's Rede Nacional Feminista de Saúde e Direitos Reprodutivos, Chile's Red Foro Abierto de Salud y Derechos Sexuales y Reproductivos, Colombia's Corporación Casa de la Mujer of Bogotá, Nicaragua's Servicios Integrales para la Mujer (SI Mujer), Peru's Centro de la Mujer Peruana Flora Tristán and Movimiento Manuela Ramos headed up the first monitoring of Cairo+5. For Cairo+0 they were joined by Mexico's Foro Nacional de Mujeres y Políticas de Población through Asesores para el Avance Social (APIS), Centro Mujeres and the Red de Mujeres pro Derechos de Educación y Salud and Surinam's Pro Health.

This systematic monitoring showed the commitments by the governments and public and private institutions and was done with the participation of Latin American women researchers and activists. In 1999 LACWHN presented it at The Hague[1] for Cairo+5 and in 2004 in Puerto Rico for Cairo+10.[2] Other feminist and women's initiatives took on the Monitoring of the ICPD Programme of Action nationally and internationally. It was done by Development Alternatives with Women for a New Era (DAWN) for Cairo+5 while both DAWN and *Católicas por el Derecho a Decidir* monitored the Programme of Action during the Cairo+10 process.

The monitoring objectives in Latin America

Monitoring is an action of citizens' control that in an informed way sees whether the legislation, regulations, public policies, programmes, standards, services and actions of the State in the participating countries are complying with the agreements and commitments it assumed, establishing a relationship with the government authorities in order to get published or unpublished information. The Thematic Areas defined in accord with the importance of women's reality are:

1. Sexual violence against girls
2. Male responsibility in sexuality and reproduction
3. Participation of women's organizations in decision-making entities
4. Access by adolescents to sexual and reproductive health services and information
5. Quality of care of the sexual and reproductive health services
6. Humanized attention to unsafe abortion
7. Prevention and comprehensive care of people affected by HIV-AIDS

Given the large number of topics and consequences of the Programme of Action, the first six thematic areas were chosen for Cairo+5 and HIV-AIDS was added for Cairo+10. The same seven thematic areas were selected for Cairo +20 and monitoring of

the international pacts and conventions was added, together with the analysis in the region of national mechanisms for empowering women and women's empowerment measurements, such as the Human Development Index (HDI) and Gender-related Development Index (GDI).

The most relevant accomplishments of the monitoring from the LACWHN perspective:

By strengthening women's civic practice, the results opened ample arenas for reflection in the international women's movement and sustained renewed debates that went beyond the seven countries in which ATENEA was developed. The search for evidence about the thematic areas—analysed via 147 indicators—was expanded as not all countries had information that would permit a comparison of before and after 1994.

It opened the way in the region for a practical monitoring exercise with a gender perspective, demonstrating that, despite the difficulties and limitations, it is not only possible but also provides the LACWHN organizations with a finished product of knowledge about the national realities and an experience of dialogue with the governmental authorities.

It buttressed the establishment or strengthening of links with governmental sectors through more finely tuned and consistent advocacy work. It allowed a participatory work model to be implemented among government, civil society and international agencies in some countries.

It sensitized people to sexual violence against girls, male responsibility and adolescents' access to information and services; it contributed to the humanizing of attention to unsafe abortion and to the abortion permitted by law in some hospitals of the region, which is a reference point for the countries that have not yet initiated efforts to improve the quality of care according to the recommendations of paragraph 8.25 of the Programme of Action.

It opened arenas from which the feminist and women's movements can denounce the imminence of the feminization of the HIV and AIDS pandemic in the region.

Twenty years after the ICPD we can state without debate that the Latin American feminist movement has constructed and articulated discourses and instruments to recover sexuality and reproduction as arenas of women's freedom and autonomy and has conceptualized sexual and reproductive rights as fundamental components of human and civil rights. It has thus dissolved the traditional division between public and private arenas, contributed new meanings to the universality of rights and provided an emphatic coherence to equality and freedom.

The ICPD was the main motor force to getting its commitments and legislative changes related to the legal protection of sexual rights and reproductive rights incorporated, although not to the degree demanded. As a product of the enormous effort made by feminists, their organizations and alliances, the legislation regarding abortion was changed in three countries of the region; it was approved based on causal grounds or deadlines as in Colombia and Mexico, and is recently being approval in Uruguay.

As Latin American feminists, we formulated important contributions to the drafting of the Programme of Action and organized the participation process, procuring consensus before, during and after the ICPD. We developed a national and regional lobbying process and coordination with state authorities, succeeding in bringing positions closer together, promoting knowledge of the commitments contracted and their fulfilment.

In the extensive process of training Latin American women in public defence of the movement's priority areas, the Programme of Action was publicised at all levels, incorporating the relevant issues into the national agendas. The organised women exerted ongoing public pressure to get the commitments contracted in the Programme of Action fulfilled together with the requirements that the secular nature of the State, the struggles against discrimination and sexual violence and the movement's demands to incorporate the sexual rights of gay, lesbian, bisexual and transgender individuals be respected. The feminist's commitment to recover the content of language from cooptation by agencies and governments prevailed. It became possible to have more participation by feminists in the official delegations of the countries more favourable to the ICPD agenda.

Legislative proposals were presented on sexual rights and reproductive rights, citizen participation, nonviolence and other issues related to the areas of the Programme of Action. Their application was demanded in the framework of international human rights instruments such as CEDAW, Belém do Pará and the International Covenant on Economic, Social and Cultural Rights.

Alliances were strengthened with the women's networks as were initiatives in the region aimed at following up on the application of the Programme of Action, promoting effective participation by women's organizations in mixed decision-making entities. Regional, national and local political action was strengthened, identifying the critical knots of non-application of the Programme of Action. Its promotion was expanded into the social movement during various stages of the World Social Forum. Social auditing processes were conducted by the women's movements, incorporating the ICPD agenda.

At the regional level the campaigns were a direct communication channel with women in the territories for spreading information, training and drafting proposals that ended up presented in different official entities. The May 28 Campaign, International Day of Action for Women's Health, September 28 Campaign for the Decriminalization of Abortion in Latin America and the Caribbean, November 25 Campaign, International Day against Violence toward Women, Campaign against Fundamentalisms and Campaign for an Inter-American Convention of Sexual Rights and Reproductive Rights promoted and demanded the governments' commitment, at the same time underscoring the contradictions, lack of commitment and barriers imposed by conservative sectors to the process initiated in 1994.

Scope of the ATENEA indicators

Parameters were defined for characterizing the national contexts via the application of indicators that would reflect the political will and the projection prevailing in each country up to Cairo, giving shape to more or less progressive trends. As a consequence, more or less favourable contexts permitted the establishment of the following as parameters: the juridical-legal framework that reflects the efforts made in each country to adjust national legislation to international legal norms; and the programmes and their implementation based on the assigning of resources that expresses the way each country puts into operation the official resources and civil society's participation, particularly that of the women's movement, to makes visible the focus and existing will with respect to citizen participation and shows the fulfilment of the recommendations in the public sphere.

The monitoring indicators

To do the monitoring, LACWHN constructed a matrix of qualitative and quantitative indicators, building a database called ATENEA in which was recorded the actions implemented following international public policy evaluation directives. The indicators used in ATENEA measure the degree of progress, stagnation or backpedalling in fulfilling the Cairo agreements.

ATENEA was updated in 2005 at the initiative of SI Mujer in Nicaragua, reducing the indicators to 145 and making it simpler and more flexible. In 2007, via a consultation process with 136 women leaders of the two Caribbean Coast Autonomous Regions in Nicaragua, SI Mujer began to define ATENEA for those regions. Now in 2012, after a review and updating process, it is being applied by the Multiethnic Women's Research Centre of the University of the Autonomous Regions of Nicaragua's Caribbean Coast (URACCAN), with advice from SI Mujer, to measure Cairo+20 in four municipalities there.

Quantitative indicators were defined as quantifiable variables and qualitative ones that provide sensitive signals with periodicity were also defined, providing important information about decisions. The indicators were grouped into Context or Input indicators, Process indicators and Result or Advocacy Impact indicators. Four analytic categories were established with specific descriptors: Overall Context, Process, Impact and Transparency.

The juridical framework was included in the Overall Context: It expresses the political will of the Sates to assume the international agreements and guarantee respect for human rights and the adjustment of the national legislative framework. Political will includes the Human Development Index, the Gender-related Development Index, the Gender Inequality Index and the international commitments. Process includes curricular adjustment, normative interface, generating of opinion and sectoral programmatic strategies as institutional capability. Resource expresses the State's political will and commitment to provide sufficient resources. Outcomes refer to the putting into operation of changes occurred as a product of the State's regulatory decision and the existence of mechanisms on behalf of gender equity in daily life. Generation of opinion and strategies to sensitize public opinion reflect the level of influence in the construction of cultural patterns. Impact demonstrates in figures and new situations the effect of the effort, political will, sensitivity level in decision-making and institutional capacity and measures the prevailing gaps. Transparency measures the opportunity for information and the consistency, veracity, adjustment and disaggregation levels of the data.

The Impact descriptors group together indicators such as institutional capacity, gender democracy, citizen participation, political will, international commitments, legal framework, resources and transparency.

Monitoring obstacles or difficulties

Not all countries maintain updated socio-demographic information; several of them do not have national coverage; and data inconsistencies are frequent. There is a dearth of disaggregated information, insufficient information and ignorance of the ICPD by the majority of human resources in the state institutions.

The content of the conceptual framework of gender is simplified and/or has gaps, reducing it on numerous occasions to the statistical differentiation of women from men. In some countries the non-validation of sexual and reproductive rights impedes or limits the adequate addressing of promotion, prevention and recovery in sexual and reproductive health from a comprehensive focus, especially with respect to adolescents. It influences the lack of correlation among the Programme of Action's recommendations and the real situations generated based on sectoral reforms in health and social security.

In some countries, the difficulties in generating inter-sectoral consensus about certain concepts or ways of addressing issues and problems provoke a leadership vacuum in the governmental arena. Pressures from religious, especially Catholic, hierarchies on the governments reduce, omit or modify operative concepts, contents and criteria regarding gender, reproductive health and sexual and reproductive rights; together with weakening governmental autonomy, they halt or set back the concretising of the Programme of Action. In addition, the slowness with which necessary cultural transformations take place can be seen in many cases to be buttressed by insufficient communication policies or by censorship practices.

Monitoring Cairo + 20

In the monitoring of Cairo+20 in 2012, LACWHN, in alliance with ARROW, developed a new monitoring process in six Latin American countries: Brazil, Colombia, Nicaragua and Mexico (which had participated in the previous processes) plus Argentina and the Dominican Republic, which participated for the first time in the present monitoring.

The LACWHN organizations were the Fundación para Estudio e Investigación de la Mujer (FEIM) in Argentina; the Coletivo Feminino Plural of the Rede Feminista de Saúde Direitos Sexuais and Direitos Reprodutivos of Porto Alegre, Rio Grande do Sul and Salvador de Bahia in Brazil; the Fundación SI Mujer of Cali in Colombia; the Consorcio para el Diálogo Parlamentario y la Equidad A.C., Equidad de Género, Ciudadanía, Trabajo y Familia A.C., the Grupo de Información en Reproducción Elegida (GIRE A.C.), IPAS México A.C., Elige Red de Jóvenes por los Derechos Sexuales y Reproductivos A.C., Afluentes S.C., Católicas por el Derecho a Decidir A.C., the Observatorio Ciudadano Nacional del Feminicidio, and Balance Promoción para el Desarrollo y Juventud A.C. in Mexico; Servicios Integrales para la Mujer SI Mujer in Nicaragua and the Colectiva Mujer y Salud in the Dominican Republic.

In 1999 LACWHN published the document *La mirada de la LACWHN in cinco países de América Latina Brasil /Chile / Colombia /Nicaragua /Perú 1998 – 1999,* for Cairo+5, which was compiled by María Isabel Matamala of Chile, Mabel Bianco of Argentina and Teresita De Barbieri of Mexico.

The *Informe Latinoamericano ATENEA: El monitoreo como práctica ciudadana de las mujeres. Una mirada de la LACWHN in cinco países de América Latina Brasil / Chile / Colombia / Nicaragua / Perú 1998 - 1999* was published for Cairo +10 and *Reafirmando nuevos y antiguos desafíos in la agenda feminista latinoamericana,* written by Ana María Pizarro of SI Mujer Nicaragua, was published for Cairo+15 in February 2009.

In 2004, in the Cairo+10 monitoring process, the research team of SI Mujer in Nicaragua compiled the *Informe Latinoamericano ATENEA: El monitoreo como práctica ciudadana de las mujeres*, done in seven countries. It was published in print, in a CD and in seven Fact Sheets.

During the 2012 Cairo+20 process, the SI Mujer research team also coordinated the gathering, and did the compiling and drafting of this monitoring of six countries of the region. In both processes, LACWHN took responsibility for the two regional reports.

Challenges to the Latin American women's movement on the Cairo route

The ICPD posed a comprehensive challenge by addressing poverty, resources, social justice, sustainable development and the struggle for secularism, human rights and peace. Twenty years later the Programme of Action is totally in effect and offers an opportunity to defend specific rights—sexual and reproductive—within the larger set of human rights.

The Cairo process generated a contradiction in the international women's movement in that some of us considered the international agreements on population policies an opportunity to have a positive influence from our perspective, while others stated that population policies were synonymous with intrusion regarding women's bodies and thus should not exist and we should not participate.

In 1994 the Declaration "Women's voices of Latin America and the Caribbean" was criticised for being under the supposed influence of the "agenda of women from the North." Criticisms were also expressed during the nineties regarding the feminist agenda for "being dictated by the UN," as there were evidently women allies inside the UN, such as UNFPA Executive Director Nafis Sadik or UNFPA Director for Latin America and the Caribbean Marisela Padrón, and at a global level Hillary Clinton, once a promoter of sexual and reproductive rights, as well as participation by women based on their influence in the US government.

The exclusion of access to abortion was reaffirmed in Honduras, El Salvador and Nicaragua, leaving the possibility of saving women's lives completely prohibited even in the worst risk conditions, while in Chile, the Dominican Republic and Haiti the existing penalization was maintained. Public defence of the right to free and safe abortion was also subject to political persecution of feminist human rights defence leaders and their organizations, as in Nicaragua.

The existence of progressive or so-called "leftist" regimes, as in Argentina, Bolivia, Ecuador, Brazil, Venezuela or Nicaragua, did not ensure the exercise of women's rights in the sphere of sexuality, reproduction or their organizations' political participation. The religious pressures had an impact on the legislative

assemblies and on the political leadership of even those who called themselves leftists. In countries where officials governed in the name of "the people," they gave priority to the demands of the Catholic or Evangelist hierarchs, relegating women. Thus the struggle for the secular nature of the State is one of the greatest challenges in that women's autonomy and freedom cannot exist when the intimacy of their body is subjected to the whim of external criteria.

ENDNOTES

1 *Consensos de El Cairo. Monitoreo como práctica ciudadana de las mujeres*. La mirada de la LACWHN in cinco países de América Latina: Brasil / Chile / Colombia /Nicaragua / Perú. Proceso Cairo+5, 1998-1999.

2 ATENEA: *El monitoreo como práctica ciudadana de las mujeres*. Informe Latinoamericano. *Brasil, Chile, Colombia, México, Nicaragua, Perú y Surinam*. Proyecto de seguimiento a la implementación del *Programa de Acción* de la CIPD. 2000-2003.

CHAPTER 2

context

CHAPTER II.
CONTEXT

Changes in the region that affect implementation of the Programme of Action

a) Main barriers or challenges for women's organizations working on sexual and reproductive rights and health issues

Inexistence of laws that ensure citizens' participation

The Federal Constitution of Brazil establishes both representative and participatory democracy. Decisions on public policy result from consulting people in National Conferences. The obstacles faced are: how to guarantee that the national plans are converted into policies, how to finance them and how to ensure their effective monitoring.

In Colombia the legal framework is defined based on a Political Constitution characterized by its breadth in the arenas of citizen participation, recognition and defence of Civil and Political Rights and recognition and valuing of the ethnic and cultural diversity that characterises the population. The territorial decentralization of the State is defined and for that reason the arenas of participation can be community, municipal, departmental or national. Laws exist that ensure citizen participation at various levels.[3]

In Nicaragua the Constitution grants women equal political rights, although their participation in conditions equal to men is still far from being a reality. Women's participation was determined by the creation of the Women's Institute in 1987[4] and was reaffirmed in 1993 by its Organizational Law.[5] In 1996 a Consultative Council on Gender was created in the National Police.[6] Ten years passed after the ICPD without the establishment of any affirmative action legislation to promote the participation of women's organizations in decision-making entities.

Law No. 475, the Law of Citizens' Participation, was published in December 2003, establishing that the citizenry in general will be able to participate in formulating national and sectoral public policies through the National Economic and Social Planning Council (CONPES) and any other sectoral entity,[7] and regulates that Nicaraguan citizens, whether as individuals or in groups, have the right to issue their opinions to the established consultation bodies and legislative commissions.[8] These laws totally ceased being respected starting in 2007, given that all civil society organizations were excluded.

In the Dominican Republic, a large number of laws guarantee citizen participation, including the General Health Law 42/01, the General Social Security Law 87/01, Law 135/11 on HIV and AIDS and Law 176-07 of the National District and Municipalities, among others. The difficulty is lack of implementation of the mechanisms for citizen participation created in the laws.

Lack of compliance with participation laws and closing of mixed State-Civil Society arenas

The lack of compliance with the laws in Brazil is related to governmental priorities and to a lack of pressure from society on issues concerning women's rights. Many arenas of participation exist, but it is necessary to pressure the different sectors of society and debate with the conservative and religious sectors, which also permeate these spaces, especially on the issue of health.

In Mexico's current context, the government has promoted initiatives aimed at protecting human rights defenders: the objective of the Law of Protection for Human Rights Defenders and Journalists[9] is to establish cooperation between the federation and the federated entities to implement and operate the Prevention Measures and Urgent Protection Measures that guarantee the life, integrity, liberty and security of people at risk as a consequence of their defence or promotion of human rights and exercise of freedom of expression and journalism. The Protection Mechanism for Human Rights Defenders and Journalists was created in compliance with that law. Nonetheless, these advances by the State have not guaranteed the effective participation of nongovernmental organizations.

In Nicaragua in the nineties, while mixed participation entities existed, there was no systematised follow-up on their functioning or their achievements, given the informality of the calls to participate. Since 2007, the mixed arenas in which women's and civil society organizations had representation, such as CONPES, the National Health Council and the National Commission of Struggle against Violence, have disappeared. The National Commission of Struggle against Maternal Mortality and the National Centre for the Prevention and Control of HIV/AIDS (CONISIDA) have been closed. Even though Law 238 establishes participation, only organizations allied with the government are called upon. In addition, the representation of women's organizations in the Municipal and the Departmental Development Councils has been eliminated in the large majority of the country's municipal governments.

With respect to access to information in the Cairo, Cairo+5, Cairo+10 and Cairo+15 processes in 1994, 1999, 2004 and 2009, the social organizations never had access to the reports that the four governments of those periods sent to the United Nations. Neither the government of Nicaragua nor the UNFPA fulfilled the commitment adopted in the Programme of Action regarding the participation of women's organizations and those of civil society in drafting those reports.[10]

In the Dominican Republic, the laws establishing citizen participation are not complied with and there is no active participation by society in decision-making. Nor is there dialogue between the State and civil society organizations.

Persecution of human rights defenders

In Brazil between 2007 and 2008, nearly a thousand women were imprisoned for getting abortions in the State of Mato Grosso do Sul and human rights defenders suffered threats and persecution for trying to support the denounced women. The problem is also often very serious in regions such as the Amazon, where major companies still go after peasant leaders. Finally, it can also happen in some communities in the big metropolises, Río de Janeiro in particular, in the context of the struggle against drug-trafficking.

In Colombia, one of the greatest difficulties in complying with and ensuring women's rights in general is the complex security situation experienced by human rights defenders. Women leaders have been systematically threatened, attacked, intimidated and raped due to their performance as spokespeople for populations claiming their rights. According to one denunciation published by the technical secretary of the Organization of Displaced Population,[11] 71 leaders of displaced people demanding restitution of their lands, 11 of them women, were murdered between 2005 and 2011, triggering indignation and rejection by women's organizations and human rights defenders in the region such as the Committee of Latin America and the Caribbean for the Defence of Women's Rights (CLADEM).[12] Mónica Roa, defender of sexual and human rights and the woman who organised the demand that decriminalized abortion in Colombia, has been a victim of attacks by the attorney general himself, who instead of defending women's rights, attacks them. Mónica has been a victim of robberies and recently her office was shot up.[13] Women human rights activists receive threats and some have been killed by rightwing sectors. The attorney general has persecuted organizations that work on the issue of sexual and reproductive rights.[14]

In Mexico, human rights defenders face numerous obstacles in attempting to do their work as, despite some advances, norms and practices still exist that are incompatible with the international standards of protection of human rights because they restrict the space for the activities of those defending those rights. This trend in Mexico is because "the setting in which [the defenders] develop their activities has been seriously and increasingly affected, as in various other countries, by threats, intimidation, acts of harassment, arbitrary detentions, interposition of unfounded legal actions, murders and other forms of aggression."[15] A trend to criminalize the activities implemented by human rights defenders is also being revealed. Because of their gender condition, the defenders must resist additional obstacles to the exercise of their work resulting from the persisting patriarchal practices and social and cultural stereotypes in diverse spheres, including the institutional one. Being a woman and being a human rights defender increase the risks and discrimination, exposing them to the violation of their own rights by both state agents and diverse other power groups.

In Nicaragua the Prosecutor General's Office issued an investigation order in November 2007 against nine feminists, all of them known as human rights defenders with extensive experience on the issues of sexual health, women's rights, work with survivors of violence and sexual abuse and promotion of rights of the child. They were summoned to respond for "Offenses against the administration of justice, cover-up of the crime of rape, illicit association to commit a crime and apology for the crime of abortion." This first charge went on for two and a half years until it was finally dismissed in February 2010. But in October 2008, after several weeks of public harassment by the government media, the Second District Penal Court of Managua, at the Public Ministry's request, issued a search warrant and order to sequester goods against networks, organizations and international NGOs. Two of the feminists accused in 2006 were also included in this new accusation.

International human rights organizations demonstrated against the charge, which was finally dropped in January 2009 for the obvious lack of evidence to sustain it. During the last months of 2008, however, the privacy and security of the homes of some members of the attacked women's organizations were invaded via night-time phone calls threatening to kidnap their relatives, and other kinds of intimidating actions such as damage to the property of a woman leader with aerosol and throwing oil on it. Another related act was the various aggressions suffered by Nicaraguan Human Rights Centre president Vilma Núñez for the purpose of intimidating and frightening her.

In the Dominican Republic persecution exists against defenders that is expressed in public defamation, insults and boycott of activities. That persecution comes fundamentally from ultra-conservative sectors, the Catholic hierarchy, media controlled by the Right and groups calling themselves "pro life."

Lack of financing or withdrawal of international cooperation

International cooperation agencies began to pull out of Brazil in 1996, bringing enormous difficulties for the work of the women's and feminist movement. One impact of the reduction of international cooperation was the cutting of the organizations' personnel, particularly in the case of women's and feminist organizations, and the closure of many of them, which thus led to the cessation of programmes and services. In 2008 the Ford Foundation concluded its activities in support of Sexual and Reproductive Health and the UNFPA reduced its efforts to 10%

of what they had been previously. Brazil ceased being a priority for international financing because the demographic curve had concluded, it had become a creditor country of the International Monetary Fund and it enjoyed sustained economic growth.

The current situation puts at risk the existence of a women's movement able to respond to the process of strengthening women's citizen rights and the full exercise of those rights and to make possible monitoring and follow-up to the formulation, implementation and fulfilment of public policies, as well as advocacy actions for their rights, especially sexual and reproductive rights. An increase in violence against women is showing up and the situation regarding the HIV and AIDS epidemic is worsening, which itself requires greater investments.

According to a recent study of the dimension of International Cooperation for Development for Colombia, that country was the second largest recipient of development aid in 2010 with U$910 million, 8% of the total aid for Latin America. Per-capita aid grew from US$5 to US$20 in less than a decade. Nonetheless, development aid does not occupy a significant part of the Colombian economy.[16]

Since 2007 the government of Nicaragua has sustained an aggressive policy regarding international cooperation, directing frequent disqualifications to countries and high-level Embassy personnel as well as financed projects for Nicaragua. The progressive withdrawal of European development cooperation and its redirection to African countries is encountering this hostile environment. To this is added the global economic crisis. Nicaragua has progressively lost support for civil society organizations due to the full withdrawal of some cooperation, especially the Scandinavian countries as important donors on issues of governance, citizen participation, and sexual and reproductive rights and health. The recent change of strategies of the World Fund, setting aside its priorities of women, adolescents and youths, has had an important negative impact on eight civil society organizations that work on prevention and treatment of people affected by the HIV and AIDS pandemic.

In the Dominican Republic, the majority of women's organizations today are facing a reduction of their financing, which has involved closing programmes, reducing the areas of work, a drop in social activism, personnel reduction and a part-time hiring modality and thus greater work load for the remaining personnel. The resources for development, sustainability and institutional strengthening are very limited, as the majority of agencies do not finance institutional development, current expenses, personnel or infrastructure. A large part of the cooperation agencies do not consider the payment of taxes and labour obligations, so the contribution of those aspects falls to the NGOs. The organizations that do work in defence of sexual and reproductive rights, sexual diversity and against fundamentalisms have even more difficulties getting access to cooperation resources because these issues clash with their agendas or involve questioning and transgression of the norms, regulations and decisions of the States or the powers behind them.

b) Barriers to the application of the ICPD Programme of Action with respect to health and reproductive rights

Development and application of the ICPD Programme of Action merits the existence of sexual and reproductive health legislation, policies and programmes based on women's human rights in the entire cycle of their life. The Latin American and Caribbean context is strongly influenced by the interference of the religious hierarchies in public policies related to sexual and reproductive rights. The health and education programmes have suffered ongoing cuts or have disappeared due to the obedience of public officials to the dictates of the Vatican in the region, even in countries such as Nicaragua, where the Constitution establishes that the State be secular.

Inexistence of legislation that ensures the exercise of sexual rights and reproductive rights

As recently as 2002, while going through a major social, economic and political crisis, Argentina approved Law 25,673 on Sexual Health and Responsible Procreation, radically changing its policy, especially the one developed during the nineties, even though between late 2001 and early 2002 women, youths and children were going through the worst levels of poverty and indigence due to the profound crisis. Paradoxically, the crisis brought to light how the population's sexual and reproductive health was being affected, which lentweight to the political commitment by the top authorities to approve this law.[17] Nonetheless, its fulfilment is deficient and doesn't achieve the intended objectives given that it is not enough to have a legal instrument; it must be accompanied by political will and by human and financial resources and mechanisms for its implementation.

In Brazil the legislation on sexual and reproductive rights is restricted to family planning. With respect to abortion it includes barely three cases in which it is not sanctioned.

Colombia has sex education programmes, provides birth control methods and permits abortion for three causes. The problem is not inexistence of legislation but the difficulty of implementing and adequately complying with it.

In Nicaragua no specific legislation guarantees sexual rights, much less reproductive rights; abortion is absolutely criminalized and frequent episodes are portrayed as social conflicts in

the media, for example when the media reveal the refusal to interrupt pregnancies of raped girls who are put into hospitals to wait for the birth despite serious complications resulting from the rape given their bodily immaturity. The lack of adequate standards generates anxiety in the population, which does not know what will finally happen.

No legislative framework exists in the Dominican Republic to ensure sexual rights and reproductive rights.

Influences of the religious hierarchies on public policies and education programmes

At the initiative of President Carlos Menem, the Day of the Unborn Child was instituted in Argentina in 1999 through a decree the previous year establishing March 25 as the date. To push through Law 25,673 on Sexual Health and Responsible Procreation, the Argentine Congress had to surmount strong opposition from the Catholic Church and several legislators. NGO representatives, elected authorities and health officials interviewed by Human Rights Watch mentioned the impact of the Catholic Church's efforts to obstruct fulfilment of policies and laws related to access to birth control methods, information on sexual and reproductive health and sex education.

The influence of the Catholic hierarchies on public policies is very strong in Brazil. A Parliamentary Front against Abortion exists in the National Congress, made up of more than 250 representatives and senators of different parties, many of whom form part of the government bench or that of its allies. They also have representatives in the executive branch although they are not easily identifiable. The religious sectors are struggling for spaces in the different councils, particularly the National Health Council. They managed to prevent Brazil's current President from committing herself to the abortion legalization and keep a permanent vigilance.

The religious hierarchies have a huge space in determining health and human rights policies. They play an important role in the radio and television media. These churches promote ongoing strategies of pressure on councillors, mayors, congressional representatives and governors to prevent changes in the legislation that would expand rights. Instead they work to cut the rights already won and to see that existing laws are not implemented and that the services do not offer the inputs and procedures to which women have a right, for example emergency contraceptives or interruption of the pregnancy in the cases specified by law, or even the expanding of the use of Misoprostol.

Although the 1991 Constitution establishes that Colombia is a secular State, the Catholic Church still has major influence or is at least consulted in an ongoing manner on important issues of national life.

In Mexico, the institutions of the Mexican State are being subjected to the order of the powers behind the scene, influencing the State's responsibilities as well as public policies and legislation. In 2012, according to the report *"Defensoras de derechos humanos en México. Diagnóstico 2010-2011"* (Human rights defenders in Mexico: 2010-2011 Assessment), three actors stand out as real powers that hinder the defenders' work: the conservative groups, organised crime and the media.[18] Just before the new school cycle there was a new offensive to undermine secular education, given that conservative groups[19] argue that the biology textbooks approved by the Secretariat of Public Education are tendentious and deficient by promoting the early initiation of sexual activity.[20]

A reform to the Law on Religious Freedoms is currently being debated to modify articles 24, 130 and 3 of the Constitution, which refer to the right of religious freedom in basic teaching in both public and private schools. This reform is underpinned by the argument that education should be in accord with the religious or moral convictions of the minor's parents or tutors, violating the secular nature of the State.

In Nicaragua in 2000, President Arnoldo Alemán, following the Vatican current and the position of President Menem of Argentina, declared March 25 the "National Day of the Child to be Born" with the ultimate goal of eliminating therapeutic abortion from the Penal Code. In March 2000 the state ministers and officials attended a Mass organized by the Episcopal Conference, in which the Ministry of the Family read the decree. Thus, a decree issued by the head of a secular State was consecrated in a religious ceremony.

In 2003, the Ministry of Education, with support from UNFPA, published a manual titled "Education for Life," a tool for teachers that the State intended to apply to help them prepare for teaching sexuality more capably. The controversy generated around this document by religious sectors led then-President Enrique Bolaños to withdraw it from circulation "so that the manual will reflect our values, our customs, our philosophy of the Christian life and values of ethical and moral principles." Seven years later, in October 2010, the Ministry of Education published the document "Education on Sexuality, Basic Consultation Guide for Teachers," with a print run of 30,000 copies, which had still not been fully distributed among the teachers by late 2012, so it is not yet known by those who deal with student demands, especially those of adolescents and young adults, on a daily basis.

In the Dominican Republic the Day of the Unborn Child was approved in early 2001. The law institutionalising the celebration considers it "appropriate and necessary to consign a day to the Unborn Child for the purpose of encouraging reflection on the

important role a pregnant woman represents for the destiny of humanity and the value of the human life she carries within her."

The religious hierarchies, especially that of the Catholic Church, interfere in and influence the adoption and implementation of public policies, especially those that allude to the field of women's rights, sexual rights and reproductive rights. The consequences of the churches' moral tutelage are most clear in the case of abortion, where the Catholic hierarchy has actively intervened in the political process to avoid its decriminalization. They exercise direct pressure and even threats against members of Congress, manipulating and exploiting the access of religious figures and their acolytes to the media. As a consequence, Dominican law impedes abortion even when the pregnancy threatens the woman's life or is the product of rape or incest.

In opposing the use of condoms, the religious pressures limit in diverse ways the prevention activities of the Presidential Council on AIDS (COPRESIDA), the Secretariat of Education, which cannot include the issue in the Sex Education curriculum, and even NGOs. As a consequence there is no publicity of any kind promoting the use of condoms to prevent HIV.

Elimination of sexual and reproductive education and rights programmes

In Nicaragua in January 2002, the first actions of the Bolaños government's Ministry of Health (MINSA) created favourable expectations: with the administration barely initiated, it issued a call for the public presentation of a National Sexual and Reproductive Health Programme. In the prologue to the document, the terms "sexual and reproductive rights" were mentioned, although they were not addressed in its content. A Ministry of Health official took it to the Episcopal Conference for consultation. Again these four words unleashed inquisitorial impulses, which revealed that the Vatican conceives of sexual health as a topic outside of human rights. In February 2002, the document was withdrawn and the distributed copies recovered.

In November 2006 the same government published a National Sexual and Reproductive Health Strategy, where reproductive rights and sexual rights are mentioned, sexuality is addressed from a rights perspective and the rights of sexual diversity are also mentioned. This document, however, is not known by the health personnel that must apply it, so its favourable content is lost as an opportunity for a conceptual advance in the public services.

c) Latin American and Caribbean regional trends

Democracies and women's rights

In Latin America and the Caribbean the framework of neoliberal globalization, structural adjustment policies and the empire of the market have combined to create a series of phenomena that work against the exercise of the general population's rights and those of women in particular. With the installation of structural reform processes for the State—whose social costs have yet to be fully appreciated—and the weakening of the State's role as the guarantor of rights, broad strata of the population have seen a restriction of their access to social goods such as health, education, decent jobs, social protection, housing, culture and recreation. The wave of privatization of public goods and services has become unstoppable in recent decades.[21]

The deepening gaps in income distribution and people's access to the benefits of development make them increasingly unequal. In other words, the distance is continuing to grow between the wealthy few and the poor majority. This inequity has been persistently stressed by institutions dedicated to the analysis of population and development. For women, neoliberalism is unquestionably an ally of the patriarchy that has encouraged the increase in violence in all its forms and expressions, especially sexist violence, racism, intolerance and xenophobia; it has also bolstered the boom in the arms race and militarism, disguised by the false discourse of security.

Women make up the majority of poor people, are the main ones excluded from access to health, education and social services; are the bulk of the cheap and flexible labour force that works in unhealthy and dangerous conditions and enslaving modalities unprotected by labour laws and must deal with gender-skewed violence that is reproduced and strengthened in these contexts.

Neoliberal globalization and human rights

It is known that neoliberal globalization encourages social injustices. The Latin American region is currently the most inequitable on the planet. There are strong contrasts between the human rights discourse used in the international community, reiteration of the region's sustained economic growth and the persistence of a high proportion of poverty with increased inequalities. The global crisis of 2008 and 2009 had an impact that has made it clear that the predominant model does not assure growth with equity, which would include all the sectors that are excluded today.[22]

The States and their debt to equity in health, welfare and coverage

In this context, women have been the most adversely affected. The countries of the Organization for Economic Cooperation and Development have moved quickly toward universal health coverage with greater or lesser participation by the public and private sectors, but the majority of countries still do not have this universal coverage for their population. The trend has rather been on the one hand setting up private health providers

with a market logic and on the other a progressive worsening and weakening of the public health systems' services.[23]

Despite women's lesser capacity to pay and their over-representation in the poorest quintiles in all countries, their payment for insurance purchases and their out-of-pocket expenses are greater than men's, which amounts to an imposed tax punishment on their reproductive function and to their greater longevity with precarious health conditions, circumstances that represent an obscene, structurally based discrimination that endangers their right to health as well as their economic, social, civil and political rights.

Market fundamentalism

Women have increased their presence in the labour market but have not attained equality despite important educational achievements. The numerous inequities and discriminations that prevail against women in the world of remunerated work are usually linked to their difficulties in harmonizing their reproductive obligations and productive activities.

According to the information produced by the Economic Commission for Latin America and the Caribbean (ECLAC), it is observed that the crisis will more intensely affect the countries with a greater trade opening, such as the Central American countries and Mexico, whose major exports buyer is the United States. Latin American countries are facing a scenario characterized by a strong fall in global demand and thus reduced external demand for the goods and services the region exports. There is evidence of the benefits of the opening up of the region's economies, but the shock associated with the decline of exports will have differentiated effects on involved countries and population groups.

The traditional focus of market economies often makes women's national contribution from the spheres of both paid and unpaid work invisible. The social protection policies do not include important programmes of conciliation between the family and labour spheres, which is indispensible for their access in equal conditions. These policies of conciliating family and work life are a pending issue in the region.[24]

Making employment, rights and women's lives precarious

Human labour has become capital for businesses, carried out by what they call human capital, the essential element for ensuring profits. The new forms of making labour precarious now go beyond informal labour and underemployment, which were previously the manifestations of precariousness, to also reach formal businesses. Many of its disadvantageous clauses are aimed at women, increasing their marginalization and exploitation.

To these new forms or precariousness is added what are called household or domestic workers, 80% of whom are women who do not have a contractual relationship with the companies they benefit because they are cynically considered autonomous micro-businesswomen who provide services, when in reality they are sent by and dependent on the company. They do not receive an explicit salary, lack social protection, assume the infrastructure costs in their households and put their own relationships and resources at stake as both their schedules and the intensity of their work are often stretched without limit, all of which comes back as benefits for the company.[25] There are few expectations that these abusive labour relations will change because the workers generally do not have strong unions that can apply enough social and political pressure to alter them.

The agricultural sector is removed from labour law and in many places seasonable work is not applicable to any form of regulation. Injuries, acute or chronic poisoning from working exposed to toxic chemicals with no protection, muscular-skeletal problems due to the forced postures required by harvesting, stress and other forms of compromised psychological health due to the work load, as well as labour and/or sexual harassment are all part of the reality of women who work on these harvests. Teleworking now has legislative projects in countries such as Colombia and Argentina[26] where this labour modality takes up nearly 6% of the employed population.

Unpaid domestic work

Various factors such as the aging of the overall population, the increased incidence of debilitating chronic illnesses and greater emphasis on outpatient health care[27] combine in the other sphere of the economy—the non-commercial sphere of domestic labour—to increase women's unpaid work load.

Mexico is one of the countries in which most unpaid domestic work is done and men contribute fewer hours to it; it is another indicator of the sexism that structures that society's social relations.[28] ECLAC reports on the unpaid working hours in Argentina, Nicaragua, Brazil, Colombia and Mexico, in which Brazil appeared in 2008 with the fewest hours and with a slight trend to increased contribution by men,[29] while Colombia's poor sectors have the greatest number of hours, alluding to women's position in society.

Climate change and poverty exacerbate women's health risks, as their physical and psychological health is particularly vulnerable. Of the deaths associated with climate change, 99% are due to alteration of the patterns of epidemics and illnesses at a global scale. Natural catastrophes expose people to storms and flooding, destroy homes and livelihoods and cause physical injuries and psychological disorders, which in turn causes a disproportionate number of deaths of women and children.

Extreme heat and droughts also affect livelihoods; by reducing family income, both health and food, which are commonly women's responsibility, deteriorate. These disasters can also cause forced displacements that entail sanitary complications.[30]

The harm and risks women suffer in situations of armed conflict have been the subject of attention by women's organizations and the social movement of women through humanitarian assistance, human rights promotion and protection, support to peace initiatives favouring the nonviolent resolution of conflicts and development and reconstruction strategies. These social movements must not only deal with the difficulty of a lack of resources, but must also assume specific risks such as threats, attacks, kidnapping of personnel and often displacement from the area in which they are operating.[31] In Colombia, the traditional discrimination and exclusion experienced by women over history have been aggravated by the armed conflict in rural, indigenous and marginal urban sectors.[32]

The drug-trafficking mafias in Latin America not only benefit from the illegality of and illicit market in such drugs, but also enjoy the protection of local and national administrations. They have also benefited from their popularity among a population that, in the absence of social policies, considers them its protectors. In this scheme involving exorbitant capital, bribes and corruption, the life of young poor women who are kidnapped, tortured, raped and killed is one of the major costs provoked by the vicious circle. In this context, the crimes are the result of extreme forms of reinforcing masculinities and punishing women and their family groups.[33]

The fundamentalist religions impede an opening to new currents of thinking and keep women locked into strict family and social norms. In Latin America, religion plays a dual role by attempting to politically influence the State, even co-opting and dominating it in many cases, and by manipulating beliefs. In subtle or direct ways and even by imposition, the fundamentalisms create aversion to anyone who does not profess the dominant religion, with consequent discrimination and social isolation; it imposes norms on private and social life that restrict women's freedom even within their own homes.[34]

For women to oppose religious fundamentalisms, they must face the dual challenge of seeking to carry out their rights in freedom and autonomy in a social and religious environment that does not favour these options as well as questioning the imposed norms that bring them social castigation as a consequence.

Instrumental social relations are constructed and regulated to the neoliberal model via expressions of bio-politics that impact women's bodies and lives. Traditional leftist governments in the region have also applied policies that more subtly but no less ferociously sow terror and intimidate women human rights defenders or criminalize abortion, such as in Nicaragua.[35]

d) Signatories of the international human rights instruments and conferences

For the ICPD agenda to be fulfilled, national legal norms underpinned by women's Human Rights need to be drafted or modified. They must be based on ratification of the main international and regional conventions and pacts. Latin American monitoring includes recognition and application of these commitments in the six countries analyzed, taking into account the Convention on the Elimination of Al. Forms of Discrimination against Women (CEDAW), the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention for the Elimination of All Forms of Racial Discrimination and at the regional level the Inter-American Convention to Prevent, Punish and Eradicate Violence against Women, Belém do Pará.

Argentina, Brazil, Colombia, Mexico, Nicaragua and the Dominican Republic ratified the main pacts and conventions between the sixties and the nineties related to civil, political, cultural, social and economic rights and women's right to non-discrimination. Only Nicaragua has not ratified the CEDAW Optional Protocol.

Convention on the Elimination of All Forms of Discrimination against Women

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was approved by the United Nations General Assembly in 1979. The following year, in the Copenhagen Conference, 74 States signed the document and it went into effect in 1981.[36] As of November 2005 there were 180 States Parties, a figure that includes all countries in Latin America and the Caribbean. It is the human rights instrument that has gone into effect the fastest and is the second most widely ratified convention in the world. In 1993, during the Human Rights Conference of Vienna, the Commission on the Legal and Social Status of Women and the CEDAW Committee began to prepare an Optional Protocol for the Convention, and it was put into effect in 2000.[37] CEDAW now has 185 member countries, of which only 87 have ratified the Optional Protocol.[38]

CEDAW's Optional Protocol is a complementary instrument of the Convention that permits States parties to recognize the competence of the Follow-up Committee and allow it to receive collective or individual denunciations, as long as all authorities of national law have been exhausted. The Optional Protocol serves to improve or increase the already existing

mechanisms for the defence of women's human rights, improve the knowledge of CEDAW, the States and individuals, stimulate the States to make advances in applying CEDAW, as well as modify discriminatory laws and practices, reinforce the existing mechanisms for the application of human rights within the United Nations system and create greater social awareness of the human rights related to discrimination against women.

CEDAW's central theme is the elimination of all forms of discrimination against women and includes gender-motivated violence; by dealing with sexual exploitation, trafficking in women and the denial of fundamental rights and freedoms, gender violence is implicit.[39]

In Latin America, Argentina, Brazil and Colombia stand out for the work of their women's organizations, which fought for the incorporation of their demands in the national Constitutions. CEDAW was signed in Argentina in 1980 and ratified in 1985. In 1983 a national mechanism was created for the advance of women which in 1992 became the National Women's Council (CNM); it is currently the institution responsible for reporting to the President on the situation of women. In 2002 the CNM's work continued growing in the area of drafting public policies with a gender focus. Laws have been created that sanction certain forms of violence against women in the provinces, such as Sexual Harassment Law 12,764 of Buenos Aires, adopted in 2011, and Law 11,948 of Santa Fe the same year.[40]

Colombia ratified CEDAW in 1982 and in 1991 incorporated it into the new Constitution, where discrimination for reasons of sex is prohibited. Article 13 of the Colombian Constitution guarantees legal equality between women and men not only by prohibiting discrimination, but also by obliging the government to actively promote the conditions needed to make legal equality real and effective. The Colombian Constitution also guarantees women the right to found a family, choose the number of children, access health education and information, enjoy a healthy environment and receive medical care. Colombia's health policy details and expands these rights via a specific health rights programme for women and establishes basic measures.

Brazil ratified CEDAW in 1984. Brazil's Constitution was rewritten in 1988 and includes ample guarantees for women's human rights. It contains provisions on equality of sexes, violence based on sexual difference, the State's responsibility in preventing domestic violence, equal rights within marriage, family planning and equality in employment, all of which figure in the CEDAW previsions. For example, the Constitution repealed the principle still in existence of the husband's leadership (*chefia*) in the family unit and established that "the rights and obligations related to the conjugal unit are exercised equally by the man and the woman."[41]

Mexico signed the Convention in 1980 and ratified it and put it into effect in 1981. It ratified the Facultative Protocol in 1999. The 2006 report on compliance highlighted the creation of the Federal law to prevent and eliminate discrimination, published in 2003, and the law of the National Council for the Prevention of Discrimination (CONAPRE), an institution charged with promoting policies and measures to ensure gender equity. Although Mexico has complied with the CEDAW dispositions, on the issue of violence in the general recommendation no. 19, important problems persist of discrimination and violence against women.

The State of Nicaragua, despite having unreservedly signed and ratified CEDAW in 1980 and 1981, respectively, has still not ratified the Convention's Facultative Protocol. Nicaragua has made important progress with respect to the normative framework as established in the Political Constitution, but equality between women and men and the non-discrimination principle are still pending, especially as the full enjoyment of women's rights is still not guaranteed in the country.

The Dominican Republic signed CEDAW in 1979 and ratified it in 1982. The Facultative Protocol was ratified via Law 111-01 in 2001. These binding international commitments are very little known by the general population, and even among the sectors responsible for drafting, implementing and evaluating public policies. As a result, this international set of norms has had insufficient impact with respect to women's needs and demands outside of the sphere of the women's movement and the State Secretariat of Women.

Country	Signed Cedaw	Ratified cedaw	Signed the optional protocol	Ratified the optional protocol
Argentina	17 July 1980	15 July 1985	28 February 2000	20 March 2007
Brazil	31 March 1981	1 February 1984	13 March 2001	28 June 2002
Colombia	17 July 1980	19 January 1982	10 December 1999	23 January 2007
Mexico	17 July 1980	23 March 1981	10 December 1999	15 March 2002
Nicaragua	17 July 1980	27 October 1981		
Dominican Republic	17 July 1980	2 September 1982	14 March 2000	10 August 2001

Source: Division for the Advancement of Women. United Nations. Short History of CEDAW Convention. http://www.un.org/womenwatch/daw/cedaw/history.htm

Five of the countries ratified the Optional Protocol; only Nicaragua did not, despite the urging of women's organizations ever since late 1999. Curiously, during the Sandinista Popular Revolution, Nicaragua was one of the first countries in Latin America to ratify CEDAW while the current government, which still claims to be revolutionary, systematically refused to ratify its Facultative Protocol.

Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR) has the status of international common law and all countries that are members of the United Nations are obliged to uphold its terms. The UDHR protects the right to equality, life, liberty and security, the right to be free of tortures and other forms of cruel, inhuman or degrading treatment, the right to intimacy, the right to contract marriage and found a family, the right to health and wellbeing, and the right to education. It also grants special protection to "motherhood and childhood."

International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights (ICESCR) was approved by the United Nations General Assembly in 1996, went into effect in 1996 and has been ratified by 148 countries. It is the first human rights treaty that requires States to recognise and progressively guarantee the right to health related to an adequate living standard, the highest achievable levels of physical and mental health, social protection, education, enjoyment of the benefits of cultural freedom, scientific progress and to work under fair and favourable conditions.

The ICESCR was ratified by the six countries studied: Argentina in 1986, Brazil in 1992, Colombia in 1969, Mexico in 1981, Nicaragua in 1981 and the Dominican Republic in 1982.

In Argentina serious difficulties persist in the information provided by the State that make it impossible to assess compliance with the obligations emanating from this covenant. The National Institute of Statistics and Census has received serious complaints and there are no reliable official statistics right now on issues as sensitive as employment, poverty and inflation.

In Colombia sexual violence against women as a weapon of war continues to be common practice. The persistence of malnutrition and food insecurity, qualitative and quantitative deficits with respect to housing, the high rate of young people outside of the educational system, the creating of precarious labour situations of working people, especially women, institutional inequalities in the health system and the persistence of discriminatory practices against women, indigenous and Afro-descendent people and the LGBT population shows the infringement of the population's rights as a whole.

In Mexico in 2006 the Committee of Economic, Social and Cultural Rights (CDESC) reiterated its profound concern about the fact that more than 40 million people, particularly the indigenous communities and other disfavoured and marginalised groups, continue to live in poverty.[42]

In 2006, CEDAW expressed its concern about the multiple forms of discrimination suffered by indigenous women and those from rural areas and the enormous disparities among them in accessing basic social services, in particular education and health care.[43] The health conditions of the indigenous population are way behind those of the rest of the population; the problems of malnutrition in children and high maternal mortality and morbidity indices due to intestinal or respiratory infections are alarming.

Mexico has now received three recommendations given that the State must see to it that salaries assure decent living conditions to all workers, particularly women and indigenous people.

The Mexican State must also ratify the 1949 International Labour Organization (ILO) Convention No. 98 on the right to unionization and collective bargaining and apply the recommendations regarding union freedom.

In Nicaragua, the response to the needs for prevention, protection and justice for women is not obtained by approving laws; it requires a concerted and sustained effort by the justice system and public institutionality in general in demanding the development of prevention measures to modify the cultural patterns on which violence against women is modelled.

Nicaragua ratified the IDESCR in 1980. In 2007 Nicaragua's economy was severely affected by the rise in international oil prices. The projected economic growth rate of 4.2% was reduced, the impact produced inflation that hit consumers very hard. The resources for achieving the goals promised in the field of education, health, potable water and sanitation, housing, infrastructure, rural development, hunger and malnutrition were used to pay on the public debt and transferred to the central Bank as those are the priorities of the programme with the International Monetary Fund, making it impossible to meet these goals. This policy has led to the continued condemnation of large population groups to exclusion, inequality and poverty, without guarantees of the progressive fulfilment of the population's economic, social and cultural rights.

The Dominican Republic ratified the IDESCR in 1978. Since then, denunciations of violations of the covenant have been constant, particularly between 1990 and 1997. The Dominican government has designed a Strategy of Struggle against Poverty up to 2015, in accord with the Millennium Development Goals (MDGs). One of its pillars is 4% annual growth of the economy until 2015, but the economic policies and especially the handling of the banking crisis, among other relevant facts, have resulted in a serious deterioration of the population's living standards.[44]

In recent years, economic, fiscal and political reforms have been undertaken in the Dominican Republic. But this process has had the more immediate effect of benefiting powerful financial and import sectors, favouring a model based on industrial free trade zones, tourism and remittances from Dominicans living abroad. The poverty has expanded to more than 60% of the population, producing exclusions and inequalities that seriously affect the population's social and economic rights.

International Covenant on Civil and Political Rights

The International Covenant on Civil and Political Rights (ICCPR) went into effect in 1976. It was ratified between 1969 and 1992, with Argentina signing it in 1986, Brazil in 1992, Colombia in 1969, Mexico in 1981, Nicaragua in 1980 and the Dominican Republic in 1978.

The ICCPR requires governments to protect the individual's rights to life, liberty and security and the right to intimacy. It states that reproductive rights are an essential condition for women's equality, and the article on the right to life and non-discrimination gives rise to the duty of the States to guarantee a whole array of reproductive health services, including the means to prevent an unwanted pregnancy. The Human Rights Committee (CDH), which monitors compliance with the ICCPR, has considered the treaty to be violated when women have difficulties getting access to birth control methods to prevent unwanted pregnancies.[45] The CDH mandate also explicitly addresses women's right to freedom, bodily integrity and intimacy.[46]

Situation of the International Covenants or Conventions on human rights in six countries of Latin America[1]

Country	ICCPR	ICESCR	CEDAW	CCR
Argentina	1986	1986	1985	1990
Brazil	1992	1992	1984	1990
Colombia	1969	1969	1982	1991
Mexico	1981	1981	1981	1990
Nicaragua	1980	1980	1981	1990
Dominican Republic	1978	1978	1982	1991

Brazil has not ratified the ICCPR Facultative Protocols or the Convention on the Rights of the Child. Article 5 of Brazil's Constitution establishes equality of all individuals under the law and declares that men and women have equal rights and obligations. The new Civil Code of 2003 includes the Constitutional Principle of Equality of Men and Women, but gender equality

does not seem to be a priority. Articles 213, 215, 216 and 217 deal with the crime of rape, article 214 with sexual aggression and article 218 with the corruption of minors.

In Colombia there is a lot of worry about the ignorance of the duties, respect for and guarantee of rights established in the covenant. The Colombian State has not developed effective actions for implementation of the sentences in the Constitutional Court that recognise rights of same-sex couples, for example.[47]

In Mexico[48] article 129 of the Constitution[49] establishes that in peacetime "no military authority may exercise more functions than those that have an exact connection with military discipline." Apart from the unconstitutional nature of the Army's role in public security tasks, military operatives are characterised by acts that violate the civilian population's fundamental rights, such as searches without a warrant, torture of civilians detained in irregular conditions in military installations and extrajudicial executions.[50]

Despite the ratification of international treaties, including the ICCPR, the reality regarding civil and political rights is characterised by generalised severe abuses. This situation has worsened in recent years due to the militarized war against crime in which civilians suffer torture, arbitrary detentions and even executions at the hands of the armed forces. Impunity is also a constant in the abuses committed by the police, including the most noted cases of torture and death of human rights defenders in the past 10 years.[51]

In Nicaragua, the issues related to freedom of association and mobilization with respect to Civil and Political Rights are still pending, as their exercise has been weakened in recent years due to conflict between the state authorities and civil society organizations.[52] The arenas of participation for women in national and local decision-making have been closed, limiting the citizenry's possibilities of direct political participation in development planning and decision-making related to violence against women, children and adolescents.

The reform to Nicaragua's Penal Code in 2006 and the approval of a new Penal Code leave no doubt about the violation of women's human rights, such as the criminalization of therapeutic abortion, the reduction of punishments for rapists, the faculties assigned to the Prosecutor General's Office (Public Ministry) to downplay "less serious offenses" that leave the majority of women who have filed charges for domestic and sexual violence without access to justice, obliging them to turn to private legal representation. The violation of the secular State is a key factor of influence in which women are subjected to religious precepts even against their own life. This situation is unequal for women compared to the condition of men. In September 2006 the law authorizing therapeutic abortion was abolished by the parliament and consequently the absolute criminalization of abortion was maintained within the Penal Code.

Political persecution by state institutions and use of the justice system as a repressive mechanism against human rights defenders is evident, exemplified in the unfounded investigation initiated in October 2007 by the Public Ministry against nine women leaders[53] belonging to organizations that have historically been distinguished for promoting and defending the human rights of women, children and adolescents. In March 2010 the Public Ministry rejected the charge of alleged apology for the crime of abortion and illicit association to commit a crime because it found no evidence. During 2011 incompliance with the preventive and protection measures issued by the Inter-American System of Human Rights was confirmed, above all in the case of CENIDH President Vilma Núñez and its members. Attacks on critical journalism and civil society organizations have been extensive against the Autonomous Women's Movement and the Centre for Communication Research (CINCO), accused of being financed by agencies disqualified as coming from "two imperialist blocs," in a desperate attempt to silence critics of the 2008 elections, who with good reason have alleged they were fraudulent.[54]

The Dominican Republic presented a report in 2012[55] showing that more than 1,584 Dominican men and women have been condemned to death as a consequence of the arbitrary deprivation of their nationality. They cannot exercise their civil rights and are treated as foreigners in their own country; they are denied copies of their birth certificates, ID cards and passports. Women's organizations charged that 1,153 women were killed by their partners between 2005 and 2010. "The average number of dead per year exceeds 190 people. These figures reveal the State's failed intervention, which has not succeeded in guaranteeing women's right to life with dignity and free of violence."[56]

The Dominican State violates freedom of religion and thought by not intervening in the interference of the Catholic Church's top hierarchy, which stands in the way of the approval of abortion and has used strategies of threats, intimidations and defamations, above all of congressional legislators. The State also infringes the rights of gay, lesbian, bisexual and transsexual individuals by permitting their denigration in the media, the expulsion of any expressions of homosexuality or lesbianism in schools, and the failure of judicial authorities to investigate or sanction the killing of members of that population.

Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) went into effect on September 2, 1990, ratified by 191 countries, making it the most widely ratified human rights treaty. It provided strong protection to the health and sexual and reproductive rights of young people and explicitly requires governments to develop family planning services and education. It prohibits discrimination against children and adolescents for various motives, including sex and other statuses, and recognises the right to life, information of all kinds, education, health care and physical freedom and integrity. The Convention also recognises sexual violence, exploitation and abuse.

Argentina ratified the Convention in 1990 and incorporated it into the National Constitution in 1994. In 2005, with the sanction of Law No. 26,061, the process of creating a comprehensive system to protect the rights of children and adolescents began at a national level.[57]

In 2006 Argentina approved the document "Toward a National Plan against Discrimination."[58] Despite the opening of these governmental spaces, the scant development of mechanisms to ensure the principles of non-discrimination is worrying. Similarly, difficulties still persist to the implementation of mechanisms to ensure that the opinions of children and adolescents, specifically those living in poverty and indigence, indigenous children, street children, those with disability and those who live in rural zones are taken into account. The practices of torture and mistreatment of children and adolescents persist throughout the national territory. Bodily punishment and torture against minors[59] are still naturalized practices of certain institutions.

Brazil ratified the Declaration on the Rights of the Child in 1959 and the CRC in 1990. Following international debates, Brazil included important dispositions in its 1988 Constitution. It also promulgated the Statute of the Child and Adolescent and Law 10,97/2000. This comprehensive legal framework affirms the idea that children and adolescents must be a guaranteed priority in the formulation and implementation of social policies and privileges and in allocating public funds for their protection.[60]

Colombia ratified the CRC in 1991 and the Facultative Protocol to the Convention related to the sale of children, child prostitution and use of children in pornography in 2003. It also ratified the Convention on the Worst Forms of Child Labour and immediate action for its elimination in 2005. Child pornography is criminalized in the Penal Code—reformed by Law 890 of 2004—which sanctions its production, purchase and sale. Law 747 of 2002 creates the "migrant trafficking" and "human trafficking" penal classifications. Children and adolescents who are victims of trafficking are considered in the Constitution and in Law 985 of 2005, which introduces measures and regulations for their care and protection.

Mexico ratified the CRC in 1990 and published it in 1991. Other laws related to protections and rights include the Law of the Rights of Boys and Girls in the Federal District and the Law for the Protection of the Rights of Children and Adolescents, both published in 2000.[61]

In Nicaragua the Code of Children and Adolescents was approved in 1997 and has its foundations in the Political Constitution of Nicaragua, whose article 71 establishes the full effect of the Convention on the Rights of the Child. The legal framework of the CRC has been improved during the 2005-2010 period. What has not been sufficiently applied in Nicaragua is the putting into practice of legislation, the national action plan and coordination, data gathering, the minimum age to contract matrimony, the registry of births, corporal punishment, abuse and abandonment of children and teenage pregnancies. The National Commission of Comprehensive Protection of Children and Adolescents lost its authority through Law 290 of 2008, becoming instead part of the Ministry of the Family, Adolescents and Children and totally eliminating social participation.[62]

The Dominican Republic ratified the Convention in 1991 and presented its first report in 1999. The Committee applauded the promulgation of legislation related to respect for the rights of the child, such as Law 14-29, the 1997 Education Law, the 1997 Law against Violence in the Family and the General Youth Law of 2000, but continued to manifest concern about the lack of a general policy that includes the economic and human resources needed and the lack of an indispensable administrative reform for the full application of this legislation.

International Convention on the Elimination of All Forms of Racial Discrimination

The International Convention on the Elimination All Forms of Racial Discrimination (ICERD) went into effect on January 4, 1969 and was ratified by 169 countries.

It analyses the measures that States must undertake to eliminate discrimination based on race, colour, descendents and national or ethnic origin. It guarantees the rights to bodily integrity and to be free of violence, to contract matrimony and found a family, to choose a partner, to inherit and possess goods and to public health, medical care and education.

The Committee for the Elimination of Racial Discrimination has observed links between gender and racial discrimination in the sense that women can be affected by discrimination in ways that violate their sexual and reproductive rights such as "pregnancy resulting from rape motivated by racial prejudice."[63] It has also recognised that forced sterilization or the inability of women to access reproductive health care services for reason of race, ethnicity or national origin are violations of the treaty.[64]

The Inter-American Convention to Prevent, Punish and Eradicate Violence against Women, Belém do Pará

Adopted in Brazil in 1994, this convention reaffirms that violence against women violates their fundamental human rights and freedoms and totally or partially eliminates their recognition, enjoyment and exercise of such rights and freedoms; is an offense to human dignity and a manifestation of the historically unequal power relations between women and men; and it transcends all sectors of society, independent of class, race or ethnic group, income level, culture, educational level, age or religion. It was ratified by Argentina, Brazil, Colombia, Nicaragua, Mexico and the Dominican Republic.

The dispositions assumed by each country as States-parties of the Convention are reflected in the modifications to the legislation and are dealt with in the section called National Legislation for the Elimination of Violence against Women.

Beijing Platform for Action

The Beijing Platform for Action (BPA) was approved by the Fourth World Conference on Women in 1995. Agreed to by 189 countries, it is centred on the obligations of governments to comply with women's rights, creating and guaranteeing the social and economic conditions that allow women to exercise them.

Beijing establishes the need to ensure full application of mechanisms that facility women's progress in all spheres. To that end it is important to know in what way these mechanisms have been applied in Latin America and the Caribbean.

The BPA contains key achievements in the fields of HIV/AIDS, sexual and gender violence and abortion, including an important recommendation that governments review the laws that punish women who have suffered illegal abortions. It stipulates that guaranteeing women's sexual and reproductive rights is crucial to the equality of women and girls and their capacity to participate fully in all spheres of society. It establishes the commitment of States to support the drafting of an Optional Protocol to the Convention on the Elimination of Discrimination approved in 1999. Although the States signed the Platform for Action and in consequence assumed the commitment to ratify the Protocol, Argentina and Colombia have not yet done so.

In Argentina the Senate created a Women's Bench in 2008. In 2006 Law 26,130 was approved, guaranteeing access to female and male sterilization. By Ministry of Health Resolution 232 in 2007, it incorporated emergency hormonal birth control as a hormonal contraceptive method into the Obligatory Medical Programme. In 2006, Law 26,150 was approved, which creates the National Comprehensive Sex Education Programme. In 2005 the autonomous workers' regime was modified resulting in the entry of 1.25 million women into the social security system as housewives, domestic employees or informal workers.[65] In 2012 the law was modified to eliminate the possibility that the victim of a sexual aggression and her aggressor could reach extrajudicial agreements that would allow the latter not to be tried.[66]

In article 107 of Brazil's existing Penal Code, the rapist's subsequent marriage to the victim still serves as a valid excuse to dodge penal responsibility for the rape. The gender and race perspective was incorporated into the multi-year Plan for 2008-2011 as a result of the intervention of the Special Secretariat on Policies for Women. In 2006 the Maria da Penha Law was approved to deal with domestic and family violence. Another initiative is the national Family Planning Policy of 2007, whose actions include male sterilization and the distribution of contraceptives. In 2007, the Comprehensive Plan to deal with the feminization of HIV/AIDS was launched.[67]

In Colombia Law 975 was approved in 2005 with special measures to ensure truth, justice and reparation in the processes of reincorporating the armed groups organized outside of the law. Law 985 was passed with measures against human trafficking and norms are established for the care and protection of the victims. A law was also passed for the creation of the Observatory for Gender Issues within the Presidential Advisory Council for Women's Equity.[68]

Important advances have been registered in sexual and reproductive health since Beijing but also certain backpedalling. Argentina, Brazil and Mexico improved the availability of birth control methods and promoted the spacing of pregnancies. In the past five years, Colombia and Mexico modified their regulatory framework, expanding the causes of unpunishable abortion or legalized access to safe abortion, such as in Mexico's Federal District, where abortion before the 12th week after conception was decriminalized.

Mexico approved the General Law for Equality between Women and Men in 2006, which is aimed at regulating and ensuring equality and proposing institutional guidelines and mechanisms that would lead to achieving substantive equality in the public and private spheres via the promotion of women's empowerment. The National Development Plan for 2007-2012 incorporates the perspective of gender, equality and elimination of any form of discrimination as crosscutting themes for the construction of public policies. In 2008 a budget specially assigned to women was incorporated into the public budget. In 2007, the General Law of Women's Access to a Life Free of Violence was approved together with a national system to prevent, address, sanction and eradicate violence against women. The National System for Equality between Women and Men was created, coordinated by the National Women's Institute, and the National

Programme for Equality between Women and men for 2008-2012 was drafted.

In 2008, Mexico's Health Secretariat implemented a cervical cancer prevention programme, increasing preventive examinations and adding vaccinations against the human papillomavirus for adolescents; in addition, the emergency hormonal contraceptive and family planning for adolescents were incorporated. In 2008, men's right to post-partum paid paternity leave from work was established.

In Nicaragua therapeutic abortion, consigned in the legislation since 1837, was abolished in 2006, making it the worst post-Cairo indicator. The marriage of a rape victim with her aggressor as a valid excuse from penal responsibility was eliminated. A new law was created against violence that includes the crimes of femicide and institutional violence. The penalization of "sodomy" has been excluded from the Penal Code since 2008. The percentage of women who declared that they had suffered some kind of violence went from 29% in 2001 to 50% in 2007.[69]

In the Dominican Republic, the National Plan of Gender Equality and Equity II was created for 2007-2017. A process of reforms is being implemented at a national level. The Women's Secretariat of State directs its actions to achieve gender equity by coordinating these policies.

e) National mechanism that facilitates women's empowerment

Gender equality and women's empowerment

While some countries are advancing in the promotion of gender equality, in others women remain deprived of economic resources and access to essential public services. A large number of international agreements recognise women's human rights but a dominant gender skew means that women have more probabilities than men of suffering malnutrition and having less access to medical care, property titles, credit, training and jobs. They also have more probabilities of being victims of violence and continue to be extremely under-represented in political institutions and in decision-making.

The mechanisms that facilitate women's empowerment at the level of the six countries studied were created between 1980 and 2010. Argentina created them starting in 1984 with the creation of the General Division of Human and Women's Rights, later the National Programme of Promotion of Women and the Family, followed by the Sub-secretariat of Women, the National Council of the Woman and currently the National Women's Council (CNM).

Brazil created the National Council for the Rights of Women in 1985, the Special Secretariat of Women's Policies in 2002 and the National Women's Secretariat in 2010, which is responsible for guaranteeing respect for their rights. In addition, delegations for women exist within the Secretariat of Public Security in each state, although their coverage is limited and the quality of services varies among states.

Colombia created women's empowerment mechanisms between 1980 and 1999. The Presidential Advisory Council for Gender Equity is under the presidency of the Republic, which should take the legislative and financial measures needed to ensure the Council's independence so that it can take effective charge of the gender issues affecting the country.

In Mexico the National Women's Institute (INMUJERES) was created in 2001 as a decentralized autonomous public institution of the Federal Public Administration. It works to create and develop a culture of equality and equity free of violence and discrimination, capable of encouraging the comprehensive development of all Mexican women and permitting both men and women to fully exercise all their rights. It must promote and foster the conditions that make possible non-discrimination, equal opportunities and equal treatment between men and women.

Nicaragua created the Nicaraguan Women's Institute (INIM) in 1987 as a decentralized entity with functional, technical and administrative autonomy. Since 1998 INIM has organizationally depended on the Ministry of the Family, completely losing its autonomy. It receives 0.03% of the national budget and its activities are not known. Since 2007, the FSLN government has changed seven of its executive directors, to the point that no one knows who the latest one is.

To promote equality and equity in the enjoyment of human, civil, political, economic, social and cultural rights between women and men, Nicaragua approved the Law of Equality of Rights and Opportunities in 2008, which does not have effective mechanisms for its application by the branches of the State.

In the Dominican Republic the Women's Secretariat of State was created via Law 86-99 in 1999 as the institution responsible for establishing regulations and coordinating implementation at a sectoral and inter-ministerial level and with civil society of policies, plans and programmes aimed at achieving gender equity and the full exercise of citizenship by women. The Women's Secretariat reassumed its role as coordinator of public policies to achieve gender equality.

f) Elimination of violence against women

National legislation for the Elimination of Violence against Women

As of April 2011, 125 countries in the world had approved laws to eradicate or reduce violence against women, including

almost all of the countries of Latin America and the Caribbean. In the past 50 years the Constitutions of more than half the countries of the world had been rewritten or amended to consecrate gender equality in their Magna Charta. The reforms of gender-sensitive laws are the bedrock of women's access to justice. In recognition of those who survive gender-based violence, they must not have to face barriers in the judicial proceedings. As of that date, 52 countries had modified their penal law, making conjugal rape a crime.[70]

The six countries studied say they have laws on violence against women in the forms of domestic violence, sexual harassment and/or conjugal rape.[71]

The majority of the laws include physical and psychological violence, and others, such as Mexico, include sexual violence. In Argentina, Brazil, Colombia, Mexico and the Dominican Republic, different types of economic violence are also included.[72] The protection of victims in the economic sphere is important, as some research has revealed that one of the greatest needs expressed by women who live in violent situations is support in aspects related to divorce, property and custody of children.[73]

Sexual violence within marriage is only included in the legislation of Colombia, Mexico and the Dominican Republic; in the case of Brazil, it is included within rape as a generic type. It can be said that those countries that do not take up this sort of violence are rendering the problem invisible, ignoring the historical situation that legitimises the violation of women's rights even within a consensual relationship.[74] Regarding laws against sexual harassment, they are included in the legislation of Argentina, Brazil, Colombia, Nicaragua and Mexico.

Argentina, Brazil, Colombia and Mexico have laws that sanction violence against women in the state sphere.[75] In Brazil "arbitrary violence" is sanctioned when it is practiced in the exercise of a function or with the pretext of exercising said function. Colombia's Penal Code refers to the perpetrator in an indeterminate way, which could thus be an individual or a state agent.

Five countries in the study have ratified the international commitment to consider sexual violence like torture, a war crime or a crime against humanity. The exception is Nicaragua. Brazil penalises it in Law 9,455/97, and it is considered even more serious if exercised by a state official. Colombia regulated it in article 137 of the Penal Code; Mexico regulated it in articles 3 and 4 of the Federal Law to Prevent and Sanction Torture; and the Dominican Republic implemented it in article 303-2 of the Penal Code.

In Colombia labour harassment is considered a serious offense in the framework of Labour Relations Law 1,010 of 2006. In the educational sphere this type of violence comes up in forms of abuse of authority, blackmail and coercion. Argentina and Brazil sanction it in their laws on sexual violence in hospitals, educational centres and where people are deprived of their freedom.

In Argentina a new law has been passed that includes physical, psychic and economic aggression in the public and private sphere. The law also goes as far as obstetric violence and violence against reproductive freedom.[76] In Mexico in 2010, the Congress of Veracruz opened debate to include obstetric violence in the Law of Women's Access to a Life Free of Violence, as well as typifying it as a crime in the Penal Code. Chiapas has also integrated the term into its legal framework.[77]

In Brazil, Colombia and Mexico, sterilization of women without their consent is found in the law and is punished as an act leading to genocide when exercised against their will. The penalization for non-consensual insemination is only found in Colombia's Penal Code but is found in the Penal Codes of 11 federated entities in Mexico.

Brazil, Colombia, Nicaragua and the Dominican Republic have evaluated their Action Plans or Strategies and/or have future plans. According to the Implementation Follow-up Mechanism of the Convention of Belém do Pará, called MESECVI,[78] the 2009 National Action Plan for Prevention, Assistance and Eradication of Violence against Women has been designed in Argentina. Brazil has the National Pact for Confronting Violence against Women 2007-2011; Colombia has the Comprehensive Programme against Gender-based Violence while the National Plan for the Eradication of Violence against Women is in the design stage. Mexico has the Comprehensive Programme to Prevent, Address, Sanction and Eradicate Violence against Women, established in the Comprehensive Law for Women's Access to a Life Free of Violence, and the Dominican Republic has the 2007-2017 National Gender Equity Plan.[79]

Type of legislation adopted in each country

Argentina was the first country to adopt the international recommendations and in 2009 approved Law 26,485, "Law of comprehensive protection to prevent, sanction and eradicate violence against women in the spheres in which they develop their interpersonal relationships." It is a civil law that foresees protection and precautionary measures, and seeks to promote and guarantee the elimination of discrimination between women and men, women's right to live a life without violence, and the apt conditions for creating awareness about, preventing and eradicating discrimination and violence against women in any of its manifestations and spheres.

Law 1,688 of Prevention and Assistance to Victims of Family and Domestic Violence was approved in 2005. Its objective, in addition to preventing violence, is the definition of actions for the comprehensive assistance of its victims, be they women,

men, children, adolescents, older adults or people with special needs, in accord with what is established by the law itself.

Brazil approved Law 11,340, known as the María da Penha Law, in 2006 against domestic and family violence. Legislative Decree 107 gives the Belém do Pará Convention the quality of a law, which, unlike other laws only applies to women victims and defines this violence as gender-based. The law also recognises violence as a violation of human rights and includes civil and penal measures.

In Colombia Law 294 was approved in 1996, which further develops article 42 of the Political Constitution and includes norms for preventing, remedying and sanctioning domestic violence. The objective of Law 731 of Rural Women, approved in 2002, is to improve the quality of life of rural women, prioritizing low-income women and consecrating specific measures aimed at accelerating equity between rural men and women.

Mexico approved the General Law of Women's Access to a Life Free of Violence in 2007. There are also laws on domestic violence at the state level, for example the 2002 Law for the Prevention of and Attention to Domestic Violence in the State of Mexico and the 2006 General Law for Equality between Men and Women.

In Nicaragua, Law 230 of 2006 to prevent and sanction domestic violence was the precursor to the new Comprehensive Law against Violence toward Women, Law 779, which went into effect in 2012. Its objective is to act against violence toward women, protect their rights and guarantee them a life free of violence in both the public and private spheres. It establishes comprehensive protective measures to prevent, punish and eradicate violence and provide assistance to women victims of violence. Other laws exist, such as the Law of Equal Rights and Opportunities, approved in 2008, whose main weakness is the lack of mechanisms to make equal opportunities real. This law has not been taken into account by any of the state institutions.

In the Dominican Republic, the Law on Sexual Crimes was created in 1992, Law No. 7,586 against domestic violence in 1996 and the Law of Sexual Offenses in 1998. Law 24-97 on domestic violence was adopted in 1997 and has now been promulgated. Training and educational actions have been done on gender issues for the Public Ministry and National Police personnel and reception centres have been created for women victims of violence.

With respect to preference for male children, no reference to this issue has been found in any of the six Latin American countries studied.

Table 1

Anti-Domestic Violence Laws in 6 countries

The laws against violence toward women began to be promulgated in the six countries studied starting in 1994 in Argentina and culminating in 2012 in Nicaragua. This means that following the Cairo Conference the countries began to incorporate legislation in accord with the demands of the Programme of Action to achieve women's full development in society.

Country	Anti-Domestic Violence Law
Argentina	Law No. 24417 Protection against Family Violence (1994) Law 1688 Prevention and Victim Assistance Family and Domestic Violence. (2005) Alpha Detection and Protocol Assistance to abused women (2008) Resolution 208/08 of the Ministry of National Defence (2008)
Brazil	Law 11,340. The Maria da Penha Law (2006) Law 11.340 creating domestic and family violence courts Law No. 10.886/2004 specifies domestic violence as a crime under Article 129 the Penal Code
Colombia	Law 575 of 2000 (partially modifying Law 294 of 1996) Alpha Law 497 of 1999 provides for the jurisdiction of justices of the peace as an alternative to conflict resolution among which is domestic violence (1997) Law 600 of 2000: Criminal Procedure Code (2000) Decree 652 (2001) Models of care for the Prevention, Detection and Treatment of Domestic Violence in the Health Services Manual prepared by the project ICBF - IDB. (2007) Technical Regulations for Comprehensive Forensic Approach Domestic Violence of Romance (2008)Alpha

continues

Country	Anti-Domestic Violence Law
Mexico	Law to support the prevention of domestic violence and support victims. (1996) Decree to reform the Civil Code and Penal Code with reference to domestic violence and sexual violence (1997) General Law on the Access of Women to a Life Free of Violence (2007)
Nicaragua	National Plan for the Prevention of Domestic and Sexual Violence (2001-2006) Law 779, Act against violence towards women. (2012)
Dominican Republic	Alpha Law 24-97, on domestic violence (1997) Penal Code as amended by Law No. 24-97 of 28 January 1997 (1997) The National Programme of Care and Prevention in the Field of Violence against Women (1999) National Standards for Comprehensive Health Care of Domestic Violence and Violence against Women (2002) Law 88-03 of Shelters and Shelter (2003) Law No. 46-07 "16 Days of Activism Against Violence Against Women" (2007)

Source: Database Secretary General on violence against women. http://sgdatabase.unwomen.org/home.action

Femicide

Femicide is being increasingly revealed as a traditional practice, given the frequency and magnitude with which it presents itself, the lack of action from the authorities and the judicial system's complacency with the aggressors, most of whom go free because they are protected by the official bodies. It is estimated that there are over 24,000 femicides a year in the six countries. Data on femicide were reported only in two countries.

The only existing data on femicides is from the Observatory of Femicides in Argentina, implemented by the "*La Casa del Encuentro*" Civil Association, which reported 237 femicides up to October 2011, a figure that is rising in 2012. Recently, in September 2012, the National Institute of Statistics and Censuses and the National Women's Council signed an agreement fora gender violence statistic. There is no planned date for the publication of the data.

In Brazil the crime of femicide has not been typified. Not until August 2012 was a national commission established to draft the proposal for typifying this crime.[80] According to Studies of Sangari, a Brazilian NGO, a woman is killed every two hours and it is reported that 40% of those victims are between 18 and 30 years old, with the majority of cases are for violence. According to 2010 information from femicidio.net in Brazil, the femicide data are also not systematized.[81]

In Colombia the 2011 modification of the Penal Code did not use the term feminicide or femicide; it has an article that contemplates as an aggravating circumstance of homicide "if it is committed against a woman for the fact of being a woman." Nonetheless, as in most countries in Latin America, there are no official figures about feminicides, although the Colombian NGO Ruta Pacífica de las Mujeres[82] denounced that an average of three women are killed a day and 1,250 a year in that country. The departments that have the most cases of feminicides, according to that organization, are Antioquia, Putumayo, Meta and Pasto.

According to the report on the implementation of Law 1257/2008 and its current fulfilment status by the working group for the right of women to a life free of violence, 1,444 women and 16,015 men were killed in Colombia during 2010 for a total of 17,469 recorded cases.[83] Despite the fact that the women were housewives in 21.61% of the cases, the National Institute of Legal Medicine (IMNL) does not consider the subordination of women in the domestic or family sphere to be a risk factor. The violence exercised by men in the domestic sphere is the main cause of the murder of women in Colombia, with 11.7% of the cases, yet the circumstances in which they occurred are not known in 65% of those murders, which demonstrates the State's clear disinterest in this type of violence. In 2011, 1,214 women were murdered in Colombia, according to the IMNL. Of the cases classified as domestic violence, 73% were intimate feminicides (committed by partners or former partners of the victims).[84]

In Mexico, the concept of feminicide as defined in Article 21 of the Federal law, General law of women's access to a life free of violence, is the extreme form of gender violence against women, product of the violation of her human rights in the public and private spheres, made up of the set of misogynous conducts that could entail social impunity and impunity by the State and could culminate in homicide and other forms of women's violent death.

The Special Commission of Feminicides of Mexico's House of Representatives reports that some 2,500 women are killed each

year. Nonetheless, despite these average figures, there are no official national figures that establish how many women died in Mexico as a result of feminicides since 2010. In 2009 a total of 1,858 female deaths from presumed homicide were recorded in the country.

In February 2011 the National Citizens' Femicide/feminicide Observatory[85] recognized that in the last six years more than 6,000 feminicides had been recorded in only 10 states of Mexico and that from January 2009 to June 2010 there were 890 feminicides in 11 states (Sinaloa, Sonora, Nuevo León, Tamaulipas, Zacatecas, Aguascalientes, Estado de México, Hidalgo, Jalisco, Morelos and Querétaro).[86]

In Nicaragua femicide has been consigned in the Comprehensive Law against Violence toward Women since 2012. Given its high frequency and magnitude, the authorities' complete lack of action and the judicial system's complacency with the aggressors, who for the most part go free because they are protected by the official authorities, it has become a traditional practice. The Network of Women against Violence publishes the National Observatory of Partner Violence, Sexual Violence and Femicide,[87] fed by the Network's member organizations and reports recorded from the written, television and radio media, as well as the official statistics of the Police Stations for Women and Children.

In the first 9 months of 2012, 55 women were recorded as murdered. Thirteen of them had repeatedly made denunciations at the Police Stations for Women and Children in Managua, Matagalpa, Chinandega, the RAAN and the RAAS, but the authorities did not issue the due precautionary measures to safeguard the victims' life. Meanwhile, 15 of the women had not filed charges against their aggressors, 13 were raped before being murdered, and 2 girls were kidnapped and tortured before being murdered and their bodies found half-buried in wasteland, demonstrating the hatred and contempt for life involved.

In the Dominican Republic the crime of femicide is not typified. At the moment a bill to typify it is being analyzed in the Congress. There are, however, data on feminicides, with 199 reported in 2009[88] (out of a total population of 8,562,541, of which 4,297,326 are women) based on information from the Statistics Division of the Attorney General's Office of the Republic.

Type of existing legal care for women survivors of violence (women's police stations, special courts, etc)

Care for women survivors of violence is included in all of the countries' public services and includes comprehensive health; psychological, legal and forensic services; and telephone help lines legally established when favourable changes are made to laws and penal provisions. Colombia includes care for sexual violence as a medical emergency, while in three countries women's centres provide specialised individual and group care for cases of violence.

The judicial entities where women can be attended vary in the six countries, although all have offices designed to receive denunciations with different levels of authority and capacity to resolve the charges.

There are multiple service providers such as the Office of Domestic Violence of Argentina's Supreme Court of Justice, the women's care areas of the different provinces and municipalities, care centres, women's police stations, and some community shelters, but there is still a lack of linkage.[89] The National Women's Council, which is the body responsible for applying Law 26,485, does not exercise those functions and has limited trained personnel and a low budget.

In Brazil, mechanisms have been created to attend to situations of domestic and family violence against women in the terms contained in the Federal Constitution and international conventions. There are provisions that create courts for domestic and family violence against women and change the Penal Procedure Code, the Penal Code and the Law of Penal Execution, among others. The María da Penha Law contemplates a specialised network and a complementary network. Since 1983 there have been specialized women's police stations, referral centres, domestic and family violence courts, branches of the Public Ministry and Public Defenders Office (legal aid), and shelters or temporary lodging. However, in absolute numbers, they do not cover even 10% of the country's 5,300 municipalities.[90]

Before the promulgation of Law 1,257 of 2008 in Colombia, denunciations were made to the Family Police Stations and the Justice Houses. Crimes of domestic violence used to be "*querellables*" (crimes only prosecutable by private action, considered of little harm to society and in which it is up to the victim to decide if there is prosecution) and subject to conciliation, but following the passing of this law this is no longer the case. The Attorney General's Office has a Centre for Attention to Victims of Sexual Violence and a Centre for Attention to Victims of Domestic Violence. These centres do not exist in all of the country's municipalities, but there are branches of the Attorney General's Office, Justice Houses, National Police and National Legal Medicine Institute. According to legal provisions, sexual violence must be attended as a medical emergency and free of charge in the country's whole public and private health network.

In Mexico some of the country's entities have Justice Centres that provide comprehensive attention—psychological, legal and medical—to women survivors of violence. At the Federal level there are bodies such as the Office of Assistant Attorney General for Victim Care and Community Services, the Office of

Assistant Attorney General for Human Rights and the Special Prosecutor's Office to Assist the Victims of Crime. There are also diverse bodies that provide attention in the country's different states.

In Nicaragua women can file their charge in regular police stations in those places where Women's Police Stations do not yet exist. The OAS Inter-American Commission on Human Rights (IACHR) considers that in Nicaragua women receive least attention at police stations, where gender-sensitive attitudes and a willingness to support them are limited.[91] It asserts that the physical spaces are limited in size and do not offer the necessary privacy, which is essential for providing the attention. The particular characteristics of the woman involved are not considered during the attention, as in the case of indigenous, migrant or Afro-descendant women.

The Dominican Republic has Comprehensive Attention Units that are the responsibility of the Attorney General's Office, with multidisciplinary personnel; neighbourhood Public Ministry branches and a Centre of Attention for Survivors of Gender Violence in the capital city; and neighbourhood legal advice and the Justice House in Santiago.

The Ministry of Public Health adopted the National Standards for Comprehensive Care in 2002, and more recently a Guide and Protocol for comprehensive health care for domestic violence and violence against women.

Programmes and services for treating violence

In Brazil it was approved through the Ministry of Health's Technical Norm on prevention and treatment of offenses resulting from sexual violence against women and adolescents in 2005, and through article 9.3 of the María da Penha Law of 2006.[92] In Colombia it was approved through Resolution 412 of 2000 and updated in 2008; in Mexico it is included in the Official Mexican Regulations on Domestic and Sexual Violence and Violence against Women of 2009; and in the Dominican Republic in the National Regulations for Comprehensive Health Care for Domestic Violence and Violence against Women.

Argentina, Brazil, Mexico, Nicaragua and the Dominican Republic have programmes for aggressors, but are encountering difficulties in implementing them. Argentina, Brazil, Colombia, Mexico and the Dominican Republic have implemented activities to provide information or training to legislators or their advisers on gender and violence against women. All six countries studied have legislative commissions on women's affairs although in some countries they work from a traditional family-based focus.

Mexico and Nicaragua have regulations and protocols for treating women victims of violence, and in some parts of Mexico the protocols exist in indigenous languages. There are protection measures for victims in Brazil, Colombia, Nicaragua and the Dominican Republic, but it is not known whether they extend to relatives or witnesses. Except for Argentina, the other five countries studied have diverse forms of free legal counselling for women who suffer violence.[93]

All six countries have shelters for women victims of violence. Mexico reports the greatest number of shelters or houses for indigenous women and a shelter for victims of trafficking. In Argentina, Brazil, Colombia, Mexico and the Dominican Republic the shelters, or reception houses and comprehensive support centres, were established by the State and civil society organizations. In Nicaragua, the three shelters reported belong to the organizations of the Network of Women against Violence. The State has inaugurated a shelter in 2012.

Argentina, Brazil, Colombia, Mexico and the Dominican Republic provide fre**e legal advisory** services prior to and during processing. Legal sponsorship is free in Argentina, Brazil, Colombia, Mexico and Nicaragua and is the responsibility of the Public Defenders' Offices.

Argentina and Brazil have free telephone hot lines for 24-hour-a-day attention. Colombia, Mexico and the Dominican Republic have free telephone lines but not 24-hour ones. In Nicaragua emergency calls are received by the women's centres and organizations that make up the Network of Women against Violence. The State does not have services of this type except in the case of trafficking in women.

Regarding specialised attention to victims of violence, Brazil, Colombia and Mexico have health services or programmes of medical and psychosocial attention, which is the responsibility of their Ministry of Health. Colombia specifies that the attention is provided on issues of maternal mortality, adolescent pregnancy, violence against women and cervical and breast cancer. Colombia and Mexico are the only countries that provide attention in cases of voluntary interruption of a pregnancy. Argentina, Brazil, Colombia, Mexico and the Dominican Republic have promoted the creation of self-help groups as part of the state services. In Nicaragua there are no state self-help groups, but women's centres and organizations such as SI Mujer have promoted support and reflection groups since 1993, promoting the strengthening of women's self-esteem and empowerment.

Argentina, Brazil, Colombia, Mexico and the Dominican Republic report that they have official campaigns to publicise attention services for women victims of violence. In all countries the women's and feminist organizations promote annual campaigns against violence. In Nicaragua they are directed by the Network of Women against Violence and the Movement against Sexual

Abuse. LACWHN promotes annual campaigns throughout the region in commemoration of the International Day of Nonviolence against Women.

Brazil, Colombia, Mexico, Nicaragua and the Dominican Republic do evaluations of the services provided to women victims of sexual violence. In Argentina the gender observatory was implemented following Law 26,485 in 2009. In Brazil an observatory already exists and in Colombia, Mexico and the Dominican Republic evaluations are reported that were done at the level of the Ministry of Health and civil society organizations. The exact percentage of the national budget for violence of each of the countries is not known, because in general the percentages mentioned include various general categories.

In the six countries statistical studies are not accessible to the public for multiple reasons, either because they are not recorded or because of a lack of data and studies. The information available is general and not necessarily focused on violence against women. It can be said that the level of recording in the six countries studied is inadequate, although isolated efforts exist. The weakness in the statistical collection is a consequence of the lack of public policies geared to solving the problem, given that women's security does not seem to be a priority issue on the public agenda

Existence of protocols for attending to violence in each country

Protocols and standards for attending to violence exist in all of the countries, in some cases having resulted from resolutions by international human rights bodies condemning certain countries. One example of this is Mexico in the cases of Paula, a girl who was raped, became pregnant and was forced to give birth; and *Campo Algodonero* [Cotton Field], which established the standardization of criminal investigation in cases of sexual violence, disappearance and homicides of women.

In Argentina, the police intervention protocol for attending to, guiding and referring victims of family violence was issued by the Interior Security Council and the protocol for comprehensive attention for victims of sexual violations was issued by the Ministry of Health. These protocols deal with domestic violence and sexual violence, respectively, without limiting themselves or explicitly making reference to female victims, so the same protocols apply to both boys and girls. The attention to victims of sexual violence protocol includes abused or raped men. The protocol issued by the Ministry of Health was not approved by resolution and the personnel are not trained sufficiently.

The Ministry of Health of Brazil has a Technical Norm for Attention to Offences of Sexual Violence against Women, Children and Adolescents. The justice system has a Technical Norm for the Specialized Police Stations for Women,[94] a Technical Norm for Harmonizing the Referral Centres for Women in Situations of Violence, and a Technical Norm for Shelters. The Technical Norm for the María da Penha Law is in the process of being produced.[95]

In 2010, the Ministry of Health and Social Protection of Colombia formulated the Integral Model of Health Care for Victims of Sexual Violence and Gender Based Violence, which is currently in the dissemination stage. To emphasise the obligatory nature of the model's application, the Ministry of Health and Social Protection issued Resolution 0459 of 2012. The Ministry of the Interior created a Committee for the Evaluation of Risks and Recommendation of Measures to analyse women's cases and which has to follow up on the processes of protecting and restituting the rights of women who are at risk from or are the victims of violence.[96]

In 2009 the Official Mexican Standard came into effect.[97] This was the result of a friendly settlement agreement resulting from the denunciation presented in 2002 regarding the violation of the human rights of Paulina del Carmen Ramírez Jacinto, who was a victim of rape, became pregnant and then had her legal right to interrupt the pregnancy blocked by the authorities. The recent judgment issued to the Mexican State on the *Campo Algodonero* case through Resolution 18 established the standardization of criminal investigation protocols for cases of sexual violence, disappearance and homicide of women, although it is not being discussed or analysed in any of the Attorney General's Offices corresponding to the individual Mexican states.

In 1996, through Decree No. 67-96, the Nicaraguan Ministry of Health (MINSA) recognised that domestic violence was a public health problem. The decree ensured prevention, surveillance and care in the health system for women victims of violence. But the decree was not very well known among the MINSA personnel responsible for applying it. At the end of 2009, through a ministerial agreement, MINSA published the Standards and Protocols for the Prevention, Detection and Care of Domestic and Sexual Violence. The National Police have an internal specialized model of attention that works on three levels: prevention, attention and protection.[98] In addition, an intervention model developed and linked by women's centres and organizations for the individual and collective empowerment of female victims of violence provides comprehensive care that helps the women assume their rights and develop processes to recover their personal power.[99]

In the Dominican Republic the Centre for Women Survivors of Domestic Violence provides psychological and therapeutic assistance. Women can acquire free legal assistance through different governmental and nongovernmental organizations. The nongovernmental organizations and women's organizations

have experience and have worked extensively in prevention, attention and accompaniment.

As the governing body responsible for health in the Dominican Republic, the Ministry of Public Health has a Guide and Protocol to facilitate the application of National Standards for Comprehensive Health Care for Domestic Violence and Violence against Women, whose use is obligatory throughout the National Health System.[100] The management model for the Comprehensive Care Units includes protocols and standards[101] in which institutional actors have participated and which have been agreed with civil society. However, the precautionary measures and protection order are not applied in time and do not protect the women involved. The arrest warrant for the aggressor is sometimes given to the women for them to look for him, which is something that also happens in Nicaragua.

National budget for prevention of and attention to violence. Percentage of national budget allocated to preventing and treating violence against women

It was only possible to identify a national budget for the prevention of and attention to violence in three countries, and in only one of those is it disaggregated by programmes. The proportion of health spending allotted to violence is not known.

In Argentina no figure exists for the national level. At the provincial and municipal levels there are budgets, but they are not available. The budget for violence against women is dispersed among many institutions that have multiple other functions, so it is not possible to itemize it in the national budget. In 2012, the National Women's Council had a budget of approximately US$3,023,255 and in the first seven months of the year it only executed 30%.[102] The Council works on violence and other functions linked to discrimination against women. It is the body created for these functions, but does not assume them. It also has to coordinate with the Violence Observatory, whose mission is to develop the single registry, although it does not do so.

The Brazilian national Budget assigns resources to tackle violence, specifically in the budgetary item for the Secretariat of Policies for Women. However the resources are much lower than what is needed and they suffer cuts year after year.[103]

Colombia has global figures for the percentage of the national budget allocated to attending to and compensating victims in general, which includes all of the programmes. According to the Treasury Ministry, the national budget for 2012 earmarked 2.9 billion pesos for the victims of violence related to the armed conflicts, although there is no figure for the amount allocated to preventing and attending to cases of violence against women.[104]

In Mexico, the budget allocated for attending to and preventing, punishing and eradicating violence against women for 2008 was 0.008% of the GDP. One example is the budget earmarked for the National Fund for the Declaration of Gender Violence Alert, which has been allocated 19 million pesos from 2008 to 2011, of which only 1.3 million had been executed up to September 2012.

According to the Federal Draft Expenditure Budget for 2012, the Government Secretariat had 107.9 million Mexican pesos for the country's demographic planning. A total of US$2,496,666 was budgeted to promote the prevention of and attention to violence against women applied to four programmes: US$676,781 to promote attention and prevention; US$1,467,649 for the Programme to Support Women's Bodies in Federal Entities to implement and execute prevention programmes; U$58,705 to promote attention and prevention; and US$293,529 for the Programme to Support Women's Bodies in Federal Entities, and to implement and execute prevention programmes.[105]

In Nicaragua, despite the existence of laws, enabling regulations, guidelines, plans and programmes to prevent, attend to and punish violence, whose execution demands human and financial resources, there are no budget entries earmarked for funding specific actions. The allocation of budgetary entries does not allow percentages to be established for resources for programmes or funding. This is an issue pending study, along with analysing how many budgetary funds go to programmes aimed at specific populations.[106] The proportion of health spending for violence is not known. Law 779 started to be applied in 2012 without enough resources, and although the national budget for 2013 is in full approval process, there are no initiatives to guarantee a specific line for this issue.

Estimated prevalence of violence against women

It has not been possible to identify the estimated prevalence of violence against women in the six countries studied as there are different sources of information with different criteria. Between 24% and 50% of women has suffered some kind of violence. Forensic reports serve as an input for calculating the magnitude of violence against women. Brazil has reported 60,000 years of women's potential life lost in one year alone.

There is no information on violence against women for the whole of Argentina, just partial information. In the city of Buenos Aires, the Violence Office of the Nation's Supreme Court of Justice reveals an increase over the last 3 years of 30% to 40% (2009-2011). It deals with an average of 700 denunciations per month (8,400 a year) in the city of Buenos Aires, which has a population of 1,328,167 women aged 15 or over. If we add the phone calls to the Justice Ministry's Female Victims against Violence Programme, then 7 cases of violence per 1,000 women are recorded every year.

In 2001 and 2011 Brazil's Perseu Abramo Foundation conducted a public opinion survey[107] revealing that, as in 2001, approximately one in every five women considers she has suffered "some kind of violence from a man, either known or unknown." From a list of 20 kinds of violence cited, two out of every five women (40%) stated they had suffered some kind of violence at least once in their life, with the main types mentioned being some form of control or curtailment (24%), psychic or verbal violence (23%), or some kind of threat or even physical violence (24%). Between 2006 and 2012, a total of 603,906 accusations of violence were recorded, classified in accordance with the María da Penha Law as physical (30%), psychological (12.8%), moral (5.4%), sexual (1%)and patrimonial (0.8%).[108]

According to data from the Colombian Legal Medicine and Forensic Sciences Institute, in 2011 the rate of homicide committed against women 6.1 per 100,000 and represented 61,938 years of potential life lost. In terms of non-fatal violence, the interpersonal rate among women was 220 per 100,000, with 69,461 years of healthy life lost. In terms of domestic violence, the rate among women was 300.83 per 100,000, violence against children and adolescents was 90.65 per 100,000 and violence among girls alone was 100.14 per 100,000. According to data from forensic reports for 2011, the figures from forensic examinations in the country reflect a progressive annual growth of denunciations due to sexual violence from 2003, with the exception of 2010.

In Mexico, 67% of women of 15 or over have been victim to some kind of violence during their life, according to the National Survey on the Dynamic of Household Relations.[109] Meanwhile, a UN Women's Report[110] stated that almost 15,000 denunciations of violence are made every year. According to estimates from the Federal Health Secretariat, there are 120,000 rapes a year, or one every 4 minutes. In 2009, charges were filed for almost 15,000 rapes according to the Offices of Attorney General corresponding to the different Mexican States. The National Citizens' Feminicide Observatory has documented 3,385 feminicides between 2007 and 2011 in less than half of the country's states.

At the national level in Nicaragua,[111] 19% of women surveyed in 2006/2007 had been physically maltreated after the age of 15. The maltreatment was greater among women with lower educational levels and increased with age, while and one in every three separated or divorced women had received some form of physical maltreatment after the age of 15.

The National Headquarters of the Police Stations for Women, Children and Adolescents presented very similar figures for the year 2006, indicating that of the total number of women that suffered maltreatment, 28% were between the ages of 15 and 25. Half of the women that had been married or living in union at some point had experienced at least one of the three kinds of violence during their life and 10% had experienced all three.[112]

According to the Nicaraguan Institute of Legal Medicine's Yearbook 2011, a total of 56,618 clinical examinations were performed on living people, with a predominance of females (75%) among the total evaluated compared to males (25%).[113] Partner violence ranked first. The age group most affected was 23- to 35-year-olds, who accounted for 31% of the examinations. The prevailing educational level among the 2,409 women evaluated for domestic violence was high-school level. Of the total cases of domestic violence assessed in Managua in 2011, 26% were housewives, 18% industrial workers and 17% students.

In the Dominican Republic, an increase was reported in physical violence and sexual violence between 2002 and 2007.[114] The lower the schooling level, the higher the percentage of violence,[115] with 48.8% of the women having only a primary education. Rural women accounted for 21% of those affected.

Violence against women activists

Women activists who promote various rights, such as human rights defenders in the sphere of both civil and political rights, and sexual and reproductive rights, suffer different forms of pressure, harassment and violence in the Latin American and Caribbean region, although positive changes have occurred in relation to specific programmes to protect human rights defenders.

Brazil has a pioneering initiative since it reports a programme to protect people engaged in the fight for ethics, democracy, humanitarian values and social justice; it is the first programme of this kind undertaken by the State.

Since 2004 Brazil has a specific programme to protect human rights defenders. In observance of international protocols the aim of the programme is to protect people involved in the task of fighting for ethics, democracy, humanitarian values and social justice. It is considered a pioneering initiative in the world for being the first programme of this type undertaken by the State. In March 2011 the Secretariat for Human Rights presented it to 32 countries in a parallel event to the Meeting of the Human Rights Council of the United Nations.[116]

In Colombia, women human rights activists receive threats, are attacked and some have been murdered by right wing groups. Organizations working on the issue of sexual and reproductive rights have been persecuted by the Attorney General of the Nation. An example of this is the lawsuit filed by the Delegate Attorney against Monica Roa, a lawyer and executive of the international organization Women's Link Worldwide that

effectively contributed to achieving decriminalization of abortion in Colombia on three grounds. Also in May 2012 its office was the target of gunfire and the headquarters of this organization has been sacked on several occasions.[117]

In the Dominican Republic, activists working on the issue of violence against women are often victims of violence: threats, insults, harassment and blackmail by private actors, especially perpetrators. The State is responsible by default since it does not take measures to ensure the safety of the activists and their organizations.

Capacity-enhancing policies and initiatives for attending to violence form part of the medicine curriculum

The six countries studied have policies and initiatives for strengthening capacities to attend to cases of violence. In most of the countries, violence does not form part of the medicine curriculum, so health professionals are not trained to attend to something that has been declared a public health problem.

In Argentina the most important policy is the one implemented by the Supreme Court of Justice's Women's Office, which while focused on the training of judicial personnel also includes the police. There are no protocols in the Ministry of Health, except for the ones for Attending to Sexual Violence, but this has not been approved by ministerial resolution and no training is being done. Violence against women does not form part of the medicine curriculum at the University of Buenos Aires, which is the biggest in the country. The province of Buenos Aires has a Human Rights Secretariat programme aimed at training providers on how to treat violence against women.

The National Policy for the Fight against Violence against Women of Brazil's Secretariat of Policies for Women guarantees training for health personnel from the different health care levels and for police personnel involved in those processes. It is directly implemented by the states and municipalities, including the police training schools, but this amounts to much less than required. The Maria da Penha Law establishes the implementation of training and sensitization measures for public officials, but the topic of violence is not included in the curriculums and is not part of the Medicine Study Plan. It is one of the topics studied in professions such as nursing and social work, but is not part of the obligatory curriculum. Initiatives that stand out include those of the Campinas Centre for Research of Maternal and Infant Diseases, which every year since 1996 has promoted the Inter-professional Forum for Assistance to Women Victims of Sexual Violence.[118]

In relation to the inclusion of care for victims of violence in the medicine curriculum, the training of the personnel does not include any in-depth addressing of sexual and reproductive rights that would prepare this group to provide the appropriate care. In the experience of the SI Mujer Foundation, it is evident during the health personnel training processes that this kind of shortcoming is one of the most important causes of the repeated re-victimization in the health services of women and children affected by sexual violence.

In Nicaragua, the topic of violence is included as part of the Comprehensive Training Seminar which students of all university courses at the National Autonomous University of Nicaraguan in Managua must take. It is then included in the second year of the Medicine Faculty course and is not addressed again until the end of the course. Violence against women is also included in the Sexual and Reproductive Health Master's Degree.

Despite the existence of a National Standards for Comprehensive Health Care for Domestic Violence and Violence against Women in the Dominican Republic, which includes training for the health personnel in the tertiary health care level and which must be complied with in the public system, it is not widely known or applied. A systematic process has been initiated that includes seminars, sensitization workshops and even training diplomas with the academic endorsement of national universities.[119] Ongoing gender training is implemented for public officials, including the obligatory curriculum for professionals from the decentralized Public Ministry branches. The Secretariat of State for Women has an ongoing training programme on gender, violence against women and human rights, provided by civil society organizations. The topic of violence does not form part of the curriculum of the medicine course, which is at odds with the fact that violence is considered a public health problema.

SUMMARY

Violence against women

The Mirabal sisters of the Dominican Republic are a symbol of the fight against violence against women in Latin America and the date of their murder, November 25, has been promoted as a day against violence towards women since 1981. This date was adopted as International Day for the Elimination of Violence against Women in 1999.

The laws recognise violence against women as a problem that concerns public health and the violation of human rights and citizens' security. They are based on diverse principles, such as the administration of justice itself, non-discrimination, non-violence, gender equality, the protection of the victims, publicity, and compensation.

There are protocols and standards for responding to violence in all of the countries. In some cases they are the result of resolutions from international human rights bodies condemning certain

countries, as happened with Mexico as a result of the case of Paulina, an adolescent girl raped and made pregnant who was forced to give birth; and the *Campo Algodonero* (Cotton Field) case, which established the standardization of criminal investigation protocols for sexual violence and the disappearance and homicide of women.

Meanwhile, women's centres and organizations have care protocols for the individual and collective empowerment of the victims of violence, through comprehensive attention that facilitates the internalization of rights and the development of processes to recover their personal power.

Attention for women survivors of violence is included in the public services of all of the countries and includes integral health; psychological, legal and forensic services; and phone lines, which are established when there have been favourable changes to laws and penal provisions.

It has only been possible to identify the existence of a national budget for prevention of and attention to violence in three countries, only one of which has figures disaggregated according to programmes. The proportion of health spending allotted to violence is not known.

It has not been possible to identify an estimated prevalence of violence against women for the six countries studied. There are different pieces of information using different criteria, but it can be stated that between 24% and 50% of women have suffered some type of violence. Forensic reports serve as an input for calculating the magnitude of violence against women and Brazil has reported over 60,000 potential life years lost due to violence in one year alone.

Femicide is being progressively revealed as a traditional practice, given the frequency and magnitude with which it presents itself, the lack of action from the authorities and the judicial system's indulgence of the aggressors, most of whom go free because they are protected by official bodies. It is estimated that there are over 24,000 femicides a year in the six countries.

In the six countries studied there are policies and initiatives for strengthening capacities to attend to cases of violence. In most of them violence does not form part of the medicine curriculum, so health professionals are not trained to attend to something that has been declared a public health problem.

g) Measurements of women's empowerment

Human Development Index. Gender dimensions in development

The Human Development Index (HDI) evaluates the average progress in three basic dimensions: health, education and income. The first dimension is estimated by life expectancy at birth, the second by average years of schooling and expected years of schooling and the third by per-capita gross national income.

Argentina presents an HDI value of 0.797 for 2011, thus placing 45th in the world ranking and joining the group of countries with very high human development. Considering the Argentina's HDI performance in the past three decades, it was 19% higher in 2011 than in 1980, having grown an average of 0.57% annually.[120]

Brazil is in position number 84 among the 187 countries of the HDI. In the past five years, the country has climbed 24 points to place with an index of 0.718 in 2011. Life expectancy represents 40%, and education and income 30% each. Based on this, Brazil's increase was pushed by the 11-year increase in life expectancy in the period, improvement of 4.6 years of schooling and also by the nearly 40% growth of the per-capita gross national income between 1980 and 2011. Thus, while the HDI average in Latin America was 0.76% between 1990 and 2011, it was 0.86% in Brazil, making it the country with the greatest progress in development.[121]

Colombia's HDI in 2011 was 0.710, putting it in 87th place among 187 countries and territories. Colombia has a GDI value of 0.482, occupying 91st place among 146 countries in the 2011 index. In Colombia, 13.8% of the parliamentary seats are occupied by women and 48.0% of adult women have achieved a secondary or higher level of education compared to 47.6% of men. According to the GDI, 85 women die for every 100,000 live births due to causes related to pregnancy and the adolescent fertility rate is 74.3 of every 1,000 live births.[122]

Between 1980 and 2011 life expectancy at birth in Colombia rose 8.2 years, the mean years of schooling grew 3.1 years and the expected years of schooling grew 4.8 years. The per-capita gross national income increased 59.0% over the past 31 years.[123]

Colombia maintains profound regional inequities that are reflected in unequal living conditions. The great majority living in rural zones do not lead the kind of life they would like and in that regard the exercise of their freedom is very restricted. The struggle for subsistence does not allow them to do what they consider good, and the poverty trap, in which 64.3% live, hinders the exercise of their freedom. There were 17 million poor in Colombia in 1997; in 2008 the figure had dropped to 11.6 million. In 1997, 37% of the population of the departmental capitals and 79% of the inhabitants of the rest of the country were poor. Between 2002 and 2009 the incidence of poverty dropped from 53.7% to 45.5%.[124]

Female participation in the labour market is 40.7% compared to 77.6% for men. According to the most recent data, i.e. the Multidimensional Poverty Index for 2010, 5.4% of the population suffers multiple deprivations while 6.4% is vulnerable to multiple deprivations.

Mexico dropped one place in the Human Development Index in 2011, moving from 56th to 57th place among 187 countries, still a high level.[125] On a scale of one, Mexico obtained an HDI of 0.770, slightly exceeding the 0.767 of 2010, putting it above the regional mean of 0.731 in Latin America and the Caribbean.

Nicaragua's mean HDI in 2011 [126] was qualified as 0.589 and is based on a life expectancy at birth of 74 years, an average schooling level of 5.5 years and a per-capital gross national income of $2,430 in 2005. According to the HDI, Nicaragua occupies 129th place among 187 countries, dropping one place between 2006 and 2011.[127]

The Dominican Republic increased its HDI from 0.686 to 0.689 between 2010 and 2011, making important advances in health, education and basic living standards. It is in 88th place of 169 countries, which puts in the category of medium human development. Nonetheless, education and health care did not improve proportionately with respect to increased per-capita wealth. The Human Development Index not linked to income put the Dominican Republic in 100th place out of 169 countries. In other words, the country continued showing a lag in education and health with respect to the achievement by other countries with a similar or lower level of per-capita wealth.

The Gender-based Development Index (GDI) measures the three basic dimensions of a country's human development: enjoyment of a long and healthy life, access to the knowledge necessary to develop in society and an income that permits a decent life. Comparison of the GDI with the HDI offers a measure of the gender inequalities in a country's human development. The more the two indices differ, the more unequal the human development level of a country will be. On the contrary, the more similar they are, the more egalitarian the development level between men and women.

Argentina's GDI was 0.372 in 2011, placing the country in third place in the Latin American and Caribbean region. It is the country with the greatest percentage of women in parliament, with 37.8%, and 57% of its adult women reached at least the second educational level, while the percentage for men is 54.9%. The GDI/HDI relationship for 2011 is 0.466, which is the best relationship among the six countries studied.[128]

Table 2

Gender Inequality Index (GII)

Taking into account that index 1 indicates the worst situation for women and 0 the best, Argentina is in the best position with respect to gender inequities of the six countries studied.

Country	2005	2008	2011
Argentina	0.3812	0.3714	0.3721
Brasil	0.4706	0.4508	0.4487
Colombia	0.5156	0.5020	0.4822
México	0.4629	0.4510	0.4880
Nicaragua	0.5291	0.5195	0.5057
República Dominicana	0.4978	0.4876	0.4802

Source: Gender Inequality Index, Human Development Reports, United Nations Development Programme, viewed 8 December, 2011, <http://hdr.undp.org/en/statistics/gii/>.

ChartsBin statistics collector team 2011, Gender Inequality Index, ChartsBin.com, viewed 7 December, 2012, <http://chartsbin.com/view/4319>.

The Gender Inequality Index (GII) reflects women's disadvantage in three dimensions—reproductive health, empowerment and the labour market—for as many countries as data of reasonable quality allow. The index shows the loss in human development due to inequality between female and male achievements in these dimensions. It ranges from 0, which indicates that women and men fare equally, to 1, which indicates that women fare as poorly as possible in all measured dimensions.

The health dimension is measured by two indicators: maternal mortality rate and the adolescent fertility rate. The empowerment dimension is also measured by two indicators: the share of parliamentary seats held by each sex and the secondary and higher education attainment levels. The labour dimension is measured by women's participation in the work force.

The GII is designed to reveal the extent to which national achievements in these aspects of human development are eroded by gender inequality, and to provide empirical foundations for policy analysis and advocacy efforts.

Education of Women and Girls

The Gender Parity Index (GPI) is a measurement used to evaluate gender differences in the education indicators, as in Table 3 below. It is defined as the ratio between the value corresponding to the female sex and that corresponding to the male sex for a given indicator. A GPI with a value of 1 means that there is no difference between the indicators of girls and boys; i.e., they are identical. In 2003 UNESCO defined a GPI value of between 0.97 and 1.03 as having achieved gender parity between the sexes. A GPI of less than one signals that the indicator's value is higher for boys than for girls, while a GPI above 1 signals the opposite.

Table 3

Girls' share of primary, secondary and tertiary enrolment (GPI)

Girls and female adolescents are progressively exceeding males in secondary and tertiary education enrolment in the majority of countries analysed. Women's Access to university marks a still greater difference in relation to men.

Country	Enrolment relationship of females/males in primary education	Enrolment relationship of females/males in secondary education	Enrolment relationship of females/males in tertiary education
Argentina	0.99 (2007)	1.1 (2007)	1.5 (2007)
Brazil	0.93 (2008)	1.1 (2008)	1.3 (2008)
Colombia	1.0 (2007)	1.11 (2007)	1.09 (2006)
Mexico	0.98 (2008)	1.1 (2008)	1.0 (2008)
Nicaragua	0.98 (2008)	1.1 (2008)	1.11 (2003)
Dominican Republic	0.86 (2009)	1.1 (2009)	1.59 (2004)

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO)

Participation in the labour force

As Table 4 shows, Brazil has the highest index of urban women's participation in economic activities with 58%, whereas the Dominican Republic has the lowest, with 43%. Brazil also has the lowest disparity between urban men and women in economic activities, with 21%, while Mexico is at the other extreme with a disparity of 31.3% and the Dominican Republic with 30%.

Table 4

Female Economic Activity

Female Economic Activity		
Country	Participation rate in economic activity, urban (percent) women	Participation rate in economic activity, urban (percent) men
Argentina	52 (2009)	77 (2009)
Brazil	58 (2009)	79 (2009)
Colombia	54 (2007)	76 (2007)
Mexico	48.3 (2008)	79.6 (2008)
Nicaragua	50.3 (2005)	78.6 (2005)
Dominican Republic	43 (2009)	73 (2009)

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of special tabulations of household surveys of the respective countries http://www.cepal.org/

Women's political participation in Latin America and the Caribbean

Women's political participation is essential to building democracy as long as it is autonomous, efficient and committed and allows women to develop all their capacities.[129]

At a parliamentary level, the percentage of women in the Senates ranged between 20.3% in 2011 and 21.4% in 2012. In countries with single chamber parliaments, the current percentage is 20.4%, virtually the same as in 2011. In other words, the trend continues that only 1 of every 5 legislators is a woman. The average, however, hides notable differences among the countries. Nicaragua and Argentina have more than 30% women while Brazil and Colombia have 12.7% or less. What they all have in common is the exclusion of women from the maximum power authority within the parliaments.[130]

Country	Legislative branch		Executive branch
	% Upper chamber	% Lower or only chamber	% women ministers
Argentina	38.9	37.4	18.8
Brazil	16	8.6	26.3
Colombia	15.7	12.7	25
Mexico	22.7	25.2.	20
Nicaragua	NA	40.2	42.9
Dominican Republic	9.4	20.8	14.3
Average percentage	20.54	24.15	24.55

In 2010 there were parliamentary elections in two countries studied: Argentina and Nicaragua. Female representatives dropped slightly in Argentina, from 38.5% to 37.4%, while female senators increased from 35.2% to 38.9%. The most favourable case is that of Nicaragua, where the percentage of women doubled, moving from 20.7% to 40.2%.

According to the Inter-parliamentary Union, Brazil was in 107th place among 187 countries in 2009, and was below the mean for America, which was 22.6% for the lower chamber and 20.2 % for the Senate. The Tripartite Commission, created by Brazil's Secretariat of Policies for Women (SPM) to draft the proposal for a revision of the Electoral Law, presented its bill to expand women's political participation in 2009.[131]

Colombia, a country with a long-standing absence of women in parliament, approved Law 581 in 2000 establishing a minimum quota "of 30% of one of the genders" and also represents a normative benchmark on issues of political participation, as it is a binding norm that seeks to ensure "women's real participation in the public sphere that otherwise would not be achieved given the dynamic of the system."[132]

For the 2010-2014 period in Colombia, the percentage of women in the Senate increased 4% with respect to past elections, with a female composition of 16%; participation in the House of Representatives recorded a 2% increase, with 12% women. According to ECLAC,[133] Colombia is in 23rd place out of 36 Latin American and Caribbean countries with respect to the percentage of women in the congress. For its part, the Inter-parliamentary Union's ranking puts Colombia in 90th place among 136, in which 136 is the place with the lowest number of women legislators.[134]

In Nicaragua, despite the percentage increase of women in the National Assembly, they virtually do not intervene in debates, as this is done via the bench chiefs, all of whom are men. Party discipline impedes them from expressing their own idea or contradicting the line defined by the governing party. Women's participation in decision-making is in marked retreat; female ministers are appointed and removed frequently, and with no public evaluation measurement of their performance. Although the Political Constitution consigns equal political rights to women, their participation in equal conditions to men is far from being a reality.[135]

Although there were 1,031 female candidates for mayor, deputy mayor and councillors, only 8.6% won those posts in the municipal elections for the 2001-2004 period.[136] The effort of Nicaraguan women to gain spaces in political participation in

the electoral processes and within the democratic process in general continues to be a major challenge.

Women's participation in the National Assembly increased 18.5% in the 2007-2011 period to 42.4% in the 2011 elections. Nonetheless, those elections were considered by the OAS and European Union observer missions to have had major irregularities, which national observers qualified as "the most documented fraud in Latin America," by means of which the governing party allegedly adjudicated to itself between 12 and 18 seats it did not win to attain 63 of the 91 seats in the National Assembly.[137]

In the Dominican Republic only 17% of congressional seats are occupied by women despite the fact that 50% of adult women have an educational level of secondary or higher compared to only 42% of men, progress that is not reflected in political participation. The country has 2 female and 30 male members of the Senate, and of the members of the House of Representatives, only 24 are women, 16% of the total. In the municipal sphere, there are only 9 female deputy trustees or *síndicos* compared to 116 male ones; in other words 89% are men. Of 787 aldermen, 225, i.e. 28.5%, are women. This leaves women's main participation in posts that concentrate less power.[138]

Argentina, Brazil, Colombia, Mexico and the Dominican Republic now have quota systems. The presence of drug trafficking and the displacement of women from their communities due to the armed conflict are problems that make it difficult for women in Colombia and Mexico to insert themselves and participate in political life and the development of their countries.

The quotas in favour of women's participation is a positive action that in the majority of cases does not transcend to obtaining posts with power due to the development of inadequate, inequity-based political practices, above all when making up the electoral slates, with women placed far enough down that they have less probability of being elected. To this is added the limited economic resources for the candidacies of women within politics.

Table 5

Seats in Parliament Held By Women (% of Total)

Country	1997	2003	2008	2011
Argentina	27.6	30.7	40.0	37.4
Brazil	6.6	8.6	9.0	8.6
Colombia	11.7	12.0	8.4	12.1
Mexico	14.2	22.6	23.2	26.2
Nicaragua	10.8	20.7	18.5	40.2
Dominican Republic	11.7	17.3	19.7	20.8

Source: ECLAC - Gender Statistics - Inter-Parliamentary Union: Women in parliament.
http://websie.eclac.cl/sisgen/ ConsultaIntegrada.asp?idAplicacion=11&idTema=205&idIndicador=178
Judiciary: percentage of women judges in the highest court or Supreme Court / +

Country	1998	2003	2008	2010
Argentina			29	29
Brazil		9	18	18
Colombia		9	17	32
Mexico	9	9	18	18
Nicaragua			25	29
Dominican Republic		31	31	23

Source: Economic Commission for Latin America and the Caribbean (ECLAC) based on special tabulations of household surveys of the respective countries.http://www.cepal.org/
Local power: percentage of women mayors elected

Country	1998	2003	2008	2010
Argentina	6.4	7.4	10.0	10.0
Brazil	4.6	5.7	7.3	9.2
Colombia	4.5		9.0	9.0
Mexico	3.3	3.5	4.6	5.5
Nicaragua	6.3	9.9	8.6	8.6
Dominican Republic	1.7	7.2	11.9	7.7

Source: Economic Commission for Latin America and the Caribbean (ECLAC) based on special tabulations of household surveys of the respective countries.http://www.cepal.org/

Local power: percentage of women councillors elected

Country	1998	2003	2008	2010
Argentina				
Brazil	11.1	11.6	12.6	12.5
Colombia	10.3	12.9	14.5	14.5
Mexico				
Nicaragua			24.0	24.0
Dominican Republic	25.5	29.9	26.8	33.3

Source: Economic Commission for Latin America and the Caribbean (ECLAC) based on special tabulations of household surveys of the respective countries.http://www.cepal.org/

Participation of women's organizations in public arenas

The arenas for promoting sexual and reproductive health policies and programmes that respect women's rights have both expanded and shrunk since the Cairo meeting. In various countries of Latin America and the Caribbean interlocution arenas have closed, especially for feminist and women's organizations, completely contradicting the commitments assumed by the States in multiple treaties, conventions, programmes and platforms that had international consensus. The deficits of citizen participation are expressed particularly in the arenas where debates should be taking place on sexual rights and reproductive rights. The authorities are not demonstrating much interest in listening to the proposals and demands of the women's organizations and of civil society in general. Democratic governance is also compromised by the governmental commitments to the religious authorities, which have shown themselves to be powerful interlocutors of both rightwing and leftwing regimes.

Is there a National Population Commission and is it functioning with the participation of women's organizations?

Argentina has an Advisory Council for the National Sexual Health and Responsible Procreation Programme starting in 2012, but there is no National Population Commission. The participation of women's organizations has gradually been reduced due to resignations over differences in the focus of the work.

In Brazil a National Population and Development Commission was created in 1994, but it has been deactivated, and currently is not playing any positive role in the implementation of the Cairo Agenda. . There is a national civil society group that is acting around this agenda, but it has bi organicity and is not recognized formally by the public institutions. The women's movement as such is occupying spaces of ever less importance. The Feminist Health Network joined this group and worked throughout the Cairo+15 process and continues acting in Cairo+20, although very timidly.

Nor is there a commission dedicated exclusively to this issue in Colombia, although other entities exist, such as the Intersectoral Commission on Sexual Rights and Reproductive Rights, which is briefly reviewed in box No. 71 of this questionnaire. There is no centralized decision-making entity in which women's social organizations participate on population, demography and reproduction issues, and on maternal/infant health.

In Nicaragua three National Population and Development Commissions nominally existed under the regulation of the executive branch in three governmental periods between 1992 and 2002, but none included the participation of women's organizations or other social groups, and their functioning ceased in 1996.[139] In 1999 all population and development issues were moved to the Technical Secretariat of the Presidency, which had the mandate to integrate the social and economic aspect into the government strategy; nonetheless, it was never known what work that secretariat developed. In 2007, via a presidential decree, the Secretariat of the Presidency was created as a successor to the Technical Secretariat of the Presidency; in none of its incarnations was there any participation by civil society.

All population and development affairs are managed outside of the organizations that are working on natality, mortality, migrations, growth, structure and spatial distribution of the population and the environment, among others. The maintenance of the reiterated and deliberate exclusion of the social organizations, particularly women's organizations, confirms the desire to govern behind the population's back; women now do not know if any authority is taking care of the population issues as all the multi-sectoral arenas have been closed and active participation by the petitioning and dissenting social organizations has been replaced with party-based organizations that defend the government's interests.

The Dominican Republic has a National Population and Family Council, which is within the Public Health Ministry, and is an arena of little relevance with no participation by the women's organizations.

Is there a National Commission on Maternal Mortality and/or Sexual and Reproductive Health and is it functioning with the participation of women's organizations?

Although Argentina does not precisely have a commission on maternal mortality, it does have the Advisory Council for the National Sexual Health and Responsible Procreation Programme, made up of representatives of NGOs, academia, scientific societies and the United Nations. In April 2012, five of the eleven members resigned over differences with its policy.

In Brazil the National Pact for the Reduction of Maternal and Neonatal Mortality, established in 2003 with the participation of the Ministry of Health, the Feminist Health Network, the Brazilian Federation of Gynaecology and Obstetrics Associations and the Brazilian Nursing Association, was replaced by a National Mobilization Committee linked to the Stork Network, which is the current national policy aimed at reducing maternal mortality. Feminist organizations participate in this committee, including the Feminist Health Network, which is playing a critical role in it.

In Colombia an ad hoc advisory committee on maternal mortality functioned until 2009.

In Nicaragua the National Commission of Struggle against Maternal Mortality (CNLCMM), created by ministerial resolution in 1992, promoted multi-sectoral and multidisciplinary participation by the women's organizations, who chaired its Executive Secretariat. It was virtually closed in 1997 by presidential decree,[140] in that representation by the women's organizations was eliminated and the President empowered himself to elect "a" representative from civil society.[141] This reveals the pattern of authoritarianism and paternalism that has traditionally oppressed Nicaragua: the government autocratically knows what has to be done, women's organizations have no role in the struggle for their own health and it is enough for there to be a single representative of civil society to validate any decision.

In the Dominican Republic the National Commission on Maternal Mortality was created in the mid-nineties, but it is not functioning now, although the Ministry of Public Health has been making efforts to reactivate it since early 2012.

Is there a National Commission on Adolescence and Youth and is it functioning with the participation of women's organizations?

In Argentina an Advisory Council has existed within the National Comprehensive Health in Adolescence Programme since 2009.

In Brazil there is a National Youth Council in which women's organizations have no expression or presence as such. Colombia has an inter-sectoral commission for the promotion and guarantee of sexual and reproductive rights, with an emphasis on adolescents. Delegates of the state institutes have a presence in it but there is no participation by leaders of social organizations.

In Nicaragua a Youth Council has existed as a coordination body since 1992. One of its achievements has been the Law to Promote the Comprehensive Development of Youth, in compliance with which the National Youth Commission was created in 2003,[142] but it does not include the participation of civil society organizations, including women's organizations, and has not had any relevant work. As part of the Programme

of Comprehensive Attention to Adolescents, the Ministry of Health created the Inter-institutional and Inter-sectoral Commission of Comprehensive Attention to Adolescents, which gave more opening to the participation of civil society organizations, but with the reforms to the health sector this programme was closed. Right now the Family and Community Health Model does not contemplate the existence of adolescent and youth commissions.

In the Dominican Republic the Inter-institutional Adolescent Health Committee has no participation by women's organizations.

Is there a National Commission on Violence against Women and is it functioning with the participation of women's organizations?

Argentina has no national commission on violence against women; women's organizations have laid out the need to create a National Observatory on Violence against Women. Brazil also has no specific commission on violence against women.

In Colombia's case there is the Presidential Advisory Council for Women's Equity, which between 2008 and 2011 coordinated the actions of the Comprehensive Programme against Gender Violence. Follow-up is being given to the national Policy for Equity of Women and an Observatory for Gender Issues linked to this is functioning. A follow-up committee exists for the implementation of Law 1,257 of 2008.

In Nicaragua the National Commission of Struggle against Violence toward Women, Children and Adolescents functioned in 1998 through which the National Plan for the Prevention of Domestic and Sexual Violence was approved, as well as the National Programme of Prevention of and Attention to Gender-based Violence. The Network of Women against Violence participated actively in this commission, which disappeared just like all the multi-sectoral arenas. In 2012, the Comprehensive Law against Violence toward Women made way for the creation of the National Inter-institutional Commission of Struggle against Violence with 14 state institutions and no civil society organization, adding that the organizations would be called when the Commission "deems it suitable" and would have voice but no vote.[143]

In the Dominican Republic there is a National Commission for the Prevention of and Struggle against Domestic Violence and it has participation by women's organizations.

The commitment of the UN agencies

Has the UNFPA committed itself to procuring intermediation between the State and Civil Society?

The Population Fund (UNFPA) is the United Nations entity that should have the greatest link with women's organizations and make efforts to mediate between civil society and the State, but it is not assuming a belligerent role in policies and situations that hurt its own agenda.

In Argentina the Population Fund does not act in correspondence with what the ICPD Programme of Action mandates with respect to encouraging the establishment of coordination between State and civil society to comply with the agreements and commitments assumed.

With respect to Brazil it is mentioned that it plays a productive role, but has lost importance following the creation of UN Women.

Likewise in Colombia the UNFPA does not have an active role that procures intermediation between State and civil society, even though it supports programmes and projects on issues related to sexual health, reproductive health, adolescence and youth, and HIV and AIDS.

In Nicaragua UNFPA has been a silent observer in recent years of the needs and the harsh reality women, adolescents and young adults face with respect to sexual health, reproductive health, sexual rights and reproductive rights. It has not involved itself in the commitment demanded by the Programme of Action to facilitate interlocution between the State and women's organizations. The process of drafting the Cairo+20 questionnaire did not receive UNFPA support for the women's organizations, as the country's situation merits.

Are the rest of the UN agencies committed to procuring intermediation between the State and women's organizations?

Argentina, Nicaragua and the Dominican Republic share a lack of belligerence on the part of the UN agencies in their respective countries. For its part, Colombia says they do not play the role corresponding to them, but annotate that other women's sectors could vary with respect to this opinion. Brazil, on the other hand, says that in general they are somewhat belligerent.

Particularizing the role of the UN agencies to refer to UN Women, Argentina and the Dominican Republic say there is no

express belligerence in supporting relations and coordination between the State and civil organizations, particularly women's organizations. For its part Nicaragua says it knows nothing about its functioning and does not have a close position with the women's organizations. It does not involve itself or speak out against the extremely serious and reiterated rights violations experienced by women, which it is fully aware of.

Colombia says it knows based on web page information that UN Women has an active presence in Colombia and has promoted various programmes and projects specifically supporting women's organizations.[144] But this seems to indicate that it has no direct experience of whether or not the agency acts belligerently in defending the rights of women and girls.

With regard to the Pan-American Health Organization (PAHO), the same panorama of lack of belligerence is presented by what Argentina and the Dominican Republic report; Nicaragua reports that PAHO only dedicates itself to maternal and perinatal issues, far from women's rights and the situation they live in; for its part Brazil reports little belligerence and Colombia reports that it is working on evaluations, follow-up, technical advice and contributing cooperation resources for the implementation of health services and programmes, disease control and a programme for Comprehensive Attention to Women and Newborns.[145]

With respect to UNICEF, Argentina reports partial and very timidly-expressed belligerence: Brazil mentions medium belligerence and Colombia notes the implementation of a specific programme on Quality Education, Development of Adolescents and Prevention of HIV/AIDS aimed at contributing to the quality of education. It also seeks to support the public policy process so that adolescents will be recognised as agents promoting socioeconomic development.[146] Nicaragua claims a total lack of belligerence by this agency with respect to the human rights violations of girls in the sphere of sexuality, or in cases of such importance as the rape of a disabled girl by police agents belonging to the presidential guard. The Dominican Republic also reports a lack of belligerence.

As for the United Nations Development Programme (UNDP), Argentina and the Dominican Republic agree in stating that it shows a lack of belligerence, while Brazil says it is of medium belligerence given that all its activities are aimed at developing and fulfilling the Millennium Development Goals. In Colombia, according to information on the web page in the framework of its commitment to gender equity, the UNDP office has developed its gender strategy with the objective of institutionalizing the gender focus in all its spheres of work, contributing in this way to the achievement of human development and women's empowerment in Colombia.[147] For its part Nicaragua states that UNDP, like the other UN agencies, stays outside of the situation, manifesting support for the government and expressing agreement with the plans and programmes it develops.

SUMMARY

As signatories of international commitments, the six countries of Latin America and the Caribbean show a high level of ratification of the most important conventions and pacts related to women's human rights, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention for the Elimination of All Forms of Racial Discrimination and at the regional level the Inter-American Convention to Prevent, Punish and Eradicate Violence against Women, Belém do Pará.

With respect to the national mechanisms of women's empowerment, after the ICPD and especially after Beijing, all countries monitored have specific institutions aimed at providing follow-up to the application of the public policies. Nonetheless, the hierarchies of these authorities differ with respect to the other ministries or secretariats; their budgets are generally small and their possibilities of actively influencing are limited.

National legislation on the elimination of violence has progressed in the six countries with a wide variety of specific laws, which include sexual violence and trafficking in women. In some countries it now includes the crime of femicide, which is considered an important advance in this material.

The measurements of women's empowerment show the existing disparities, which are directly related to the development achieved by each country, especially in the sphere of education, life expectancy at birth and national per-capita income, among others. The differences among countries are evident. Throughout the analysis it is shown that Nicaragua exhibits the lowest indices related to women's empowerment.

The arenas of participation to promote policies and programs of sexual health and reproductive health are not developed with equal intensity in all the countries. The legislation establishes the right of civil society organizations to participate in affairs related to their interests, but it is not honoured in reality. The participation of women's organizations in entities in which they can influence with their proposals or change an erroneous course are unstable in time and change from one government to the next.

The commitment of the UN agencies has been analyzed as insufficient for virtually all of the countries, despite the fact that the Conventions, International Pacts, the Programme of Action and the Platform of World Action include with all clarity

the responsibilities of the different UN agencies. In each country the women's organizations expect those agreements to be promoted and that the interlocution role will be developed so that civil society and the government find arenas of dialogue and coordination.

g) Financing for health

The ICPD Programme of Action commits the international community and the governments to have sufficient resources for health, especially sexual and reproductive health. Women's rights to sexual health and reproductive health in all their components are expressed in access to services, which can only be ensured when the States fulfil their commitments. Often public information about the figures allocated to those specific categories is not accessible or the national budgets are not disaggregated, making it difficult to learn that information.

The structural adjustment policies have been applied in Latin America and the Caribbean since the seventies. Their most important impact has been the reduction of the State's role, with negative consequences for the region's health systems. With their implementation the economic model designed by the World Bank and the International Monetary Fund, both dominated by the US government, imposed changes via the Washington Consensus in the role of the State, especially in the region's public policies, emphasising reduction of the State's regulatory role to a minimum expression.

The 1993 World Bank Document "Invest in Health" contains measures aimed at modifying the national Constitutions and the regulatory and public contracting mechanisms with the sectoral objective of reducing poverty through rationalization measures and strategies such as targeting health services in what are called "minimum packages" for primary attention, changes in the State's regulatory frameworks, improvement of the economic resource management mechanisms to satisfy the population's needs, the introduction of competition into the provision of public services through concessions to the private sector, health sector reforms accompanied by reforms to the social security system, the decentralization of the health system and the modernization of the State through decentralization.

Among the privatization strategies adopted for the health sector reform, the reduction and reorientation of financing, the decentralization of the sector and the reorientation of the health programs and actions stand out. With respect to financing, it meant reducing total spending in the majority of the countries and the appearance of budgetary calculations to appraise the so-called "out of pocket expenses" that user individuals and their relatives must assume, which is nothing more than the consequence of privatization. Two questions must be taken into account: the trend toward an increase in the Gross Domestic Product in the majority of the countries and the forms of privatizing health by financing the private sector, when more than half of this financing comes directly from the pocket of the households and is used for the purchase of private health services.[148]

Budget: Does the national budget establish defined categories for sexual health and reproductive health programmes?

Argentina and Mexico have a specific budgetary allocation for sexual health and reproductive health. Argentina's 2010 budget assigned US$339,914,901, of which US$86,823,730 is for the Programme of Struggle against AIDS and Sexually Transmitted Infections and US$16,172,160 is for the Development of Sexual Health and Responsible Procreation Programme.[149] This is the Ministry of Health budget that goes fundamentally to purchasing birth control methods and other inputs instrumental to that programme.

All of Brazil's budget for reproductive health in 2009 totalled US$1,034,570,292, 93% of which was to attend to women's sexual health and reproductive health problems: US$41,270,944 for the purchase of contraception methods, US$632,021,837 for hospitalization expenses in obstetrics, US$196,692,062 for treatment of the different levels of genital-mammary cancer, US$18,743,493 for neoplasms at all 4 levels and US$77,741,102 for primary care for genital-urinary illnesses.[150] The total budget assigned for sexual and reproductive health attention to men was US$63,437,302: U$3,828,373 for vasectomy and US$59,572,111 for the detection and treatment of prostate cancer.

In Mexico the budget for sexual health and reproductive health programmes was US$166,367,073 in 2011, of which the amount for diverse programmes such as control of the health status of pregnant women was US$12,830,827, attention to reproductive health and gender equality in health US$3,256,757, attention to reproductive health US$50,010,799, and attention to reproductive health and gender equality in health [sic] US$48,968,437 plus US$1,289,453 for the National Centre of Gender Equality and Reproductive Health.[151]

In 2012 there was a 63.9% drop in the budget for attention to reproductive health and gender equality in health compared to the previous year even though this programme is listed as among the priorities for the current administration in that it is seeking to push forward fulfilment of the Millennium Development Objectives.

In Colombia the health resources in the 2012 National Budget are 11,832,000,000 pesos, which is equivalent to 2% of the GDP. It was not possible to obtain data from official sources on the resources invested in the category of sexual health and reproductive health.

In the Dominican Republic the national budget does not provide disaggregated figures for the sexual health and reproductive health programmes. Public spending on health was 2.6% of the 2010 GDP and 13.6% of the government's general spending for the same year.[152]

In Nicaragua, MINSA's budget is not available disaggregated by programmes. In 2009 the net spending on health was US$257 million, which was reduced to US$248.3 million in 2011. Spending on health has been shrinking progressively, even with an annual population growth of 2.8%. As a percentage of the GDP it was 4.05% in 2009 and dropped to 3.75% in 2010. The spending per person went from US$44.87 in 2009 to US$42.21 in 2010.

Current spending has risen notably in Nicaragua in recent years without a similar growth in capital spending, i.e. investment in infrastructure so the country can respond to the population with better installations. Capital spending in 2007 was US$44.7 million while current spending was US$169 million. In 2011 capital spending was slashed to US$12.1 million.[153]

Argentina, Colombia and the Dominican Republic mention the budgetary allocation of spending on health for HIV/AIDS. Argentina assigns the budget to purchase ARV antiretrovirals, other medications and reagents. In this case each province has its own budget for special expenses, personnel, infrastructure and inputs.

Colombia's specific investment for HIV/AIDS in 2011 is estimated at US$137,862,749. Total health spending was 7.6% of the GDP in 2010 and 6.9% in 2008.[154] The national spending executed for HIV/AIDS in the Dominican Republic in 2008 was US$29,007,380, of which 54.3% came from international funds, 18.6% from private funds and 27.1% from public funds.[155]

Two countries mentioned a budgetary allocation for the reduction of maternal mortality and the cervical and breast cancer rates. Mexico shows a 21.6% reduction with respect to what was approved in 2011, which could affect fulfilment of the proposed targets and make it difficult to consolidate pubic policies such as healthy pregnancy and universal attention to obstetric emergencies. In Brazil in 2004 the Ministry of Health established a new system for managing the financial resources for maternal mortality with the states and the municipalities to be able to quantify women's health.

In the Dominican Republic 50% of all people who receive health care must pay something for the service, either partially or totally. Some 54% of family spending on health is for medications and 11% for laboratory services. While 44% of people do not pay for outpatient consultations, 36% covered all of the costs and an insurance policy partially or totally covered the costs for 12%.[156]

Sexual health and reproductive health coverage by public and/or private social security

In Argentina the National Sexual Health and Responsible Procreation Programme provides public coverage for approximately 50% of the female population. With respect to HIV/IDS the coverage reaches nearly 60%. The supply of non-abortive contraceptives, including emergency contraception and surgical contraception, is included in the Obligatory Medical Programme.

In Colombia, the population between 18 and 59 years of age affiliated actively with the General Social Security System in Health (SGSSS), totalled 23,486,316 in el 2011,[157] achieving 91% coverage. This is comparatively similar to the total national affiliation of 41.9 million people; if the special regimes that provide health care to 2,222,126 people are added, which is equivalent to 4.8% of the population, it increases the coverage to 96.63%. The contribution regime has 11,949,105 active affiliates, equivalent to 51% of the population in this age range, while 11,537,211 active affiliates are found in the subsidised regime, which corresponds to 49%.

Nicaragua's Social Security Institute (INSS) recorded an increase in active insured people of 8.9% in 2011 over December 2010, closing the year with 596,328 active insured people. This figure is 24.52% of the country's economically active population. In gender terms, 57% of those insured are men and 43% are women. The male insured population presents a 9.9% growth over December 2010 and the female insured population 7.6 %. By age groups the insured population is very young, with 65.3% under 39.[158]

According to the INSS Statistical Yearbook for 2011, 311,560 gynaecology and obstetric consultations were provided, which is 6.26% of the total consultations that year. In prenatal care, 108,500 consultations were provided in 2011, of which 60% were considered of high obstetric risk. The use of birth control methods by users of the INSS services were: 48% injectable hormones, 37% pills, 10% condoms and 1% IUDs.

In the Dominican Republic the percentage of the population protected by health insurance in 2010 was 44.8% of men and 43.6% of women.[159] Social security only includes services having to do with prenatal, delivery and postpartum care and some STIs.

Table 6

Basic Types of Service Provision and Financing of Health

	Public Financing	Private Financing
Public Service Provision	Tax revenue financed and government provided	Out-of-pocket financed and government provided
Private Service Provision	Government contracts private provider and pays for it	Out of pocket financed and private provided

Source: TK Sundari Ravindran, Privatization of Health and its Implications for Universal Access to SRH services to all women (PowerPoint presentation).

Table 7

Government expenditure on health as a percentage of total expenditure on health from 2008-2010

Total Expenditure on health as percentage of Gross Domestic Product (GDP)

Country	2005	2010
Argentina	8.5	8.1
Brazil	8.2	9.0
Colombia	7.4	7.6
Mexico	5.9	6.3
Nicaragua	7.9	9.1
Dominican Republic	5.5	6.2

Source: WHO National Health Account
http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_2_WHS

In all the six countries under review the Total Health Expenditure (THE) as a percentage of GDP was above 5%. In 2010, except for Argentina, the total health expenditure as a percentage of GDP increased in the five countries in comparison to 2005. The greatest increases are recorded in Nicaragua, with more than 1%. Nicaragua's national figures, however, indicate that government spending on health in relation to the GDP was 4.05% in 2009 and dropped to 3.75% in 2010, a major difference with what is reported by the international organizations.[160]

General government health expenditure (GHE) as a percentage of total expenditure

Country	2005	2010
Argentina	54.2%	54.6%
Brazil	40.1%	47.0%
Colombia	70.0%	72.7%
Mexico	45.0%	48.9%
Nicaragua	56.5%	53.3%
Dominican Republic	31.6%	43.4%

Source: WHO National Health Account
http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_2_WHS

Privatisation in health can be assessed by monitoring the general government expenditure on health as percentage of total health expenditure. Generally the government health expenditure and private health expenditure add up to the total expenditure on health. An increase in the government expenditure on health would mean a decrease in the private expenditure on health showing a positive trend away from privatisation.

In the above table it is seen that except for Nicaragua, the government expenditure on health (GHE) has increased in the five countries with the greatest increases observed in Dominican Republic and Brazil. However this data has to be interpreted with caution, to take into account on what health issues the government resources are being allocated. At the same time, in the countries under review, the GHE is below 50% in Dominican Republic (43.4%), Brazil (47%) and Mexico (48.9%).

Per Capita Expenditure on Health

Total per-capita expenditure on health in 2010 is higher than 2005 in all six countries under review. In terms of per-capita total expenditure on health in purchasing power parity (PPP), Nicaragua spends the lowest ($253), followed by the Dominican Republic ($578), Colombia ($713), Mexico ($959), Argentina ($1028) and Brazil (US$ 1287). It needs to be kept in mind that the figures reported internationally do not coincide with and are far from the figures obtained nationally. For example, annual per-capita spending on health in Nicaragua fell from $44.87 in 2009 to $42.21 in 2010, including foreign cooperation.[161]

Table 8

Out-Of-Pocket Expenditure as a Percentage of Private Health Expenditure; and translated into Purchasing Power Parity

Country	PHE (2010)	OOP (2010)	PHE in PPP$	OOP in PPP$
Argentina	45.4%	65.8%	466.7	307.0
Brazil	53.0%	57.8%	682.1	394.2
Colombia	27.3%	71.5%	194.6	139.1
Mexico	51.1%	92.2%	490.0	451.7
Nicaragua	46.7%	92.6%	118.1	109.3
Dominican Republic	56.6%	65.7%	327.1	214.9

Source WHO National Health Accounts http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_2_WHS

The private sources of financing include pre-payment schemes, private insurance schemes and out of pocket payments. In the above table we observe that in the six countries under review, out of pocket payment ranges from a very high 92.6% and 92.2% in Nicaragua and Mexico, respectively, to a high 57.8% in Brazil. When this percentage is translated into PPP Dollars, the burden on individuals and households becomes very apparent. For example, in Brazil, for the $682.10 spent on private health expenditure, $394.20 comes from out of pocket of Brazilian households. Similarly in Nicaragua and Mexico, of the $118.10 and $490.00 spent on private health insurance, $109.30 and $451.70 comes out of the pocket of Nicaraguan and Mexican households. This comparison reveals that the official figures reported internationally have little to do with the government funds that are really allocated to health, in that individuals are the ones who assume a high percentage of the cost for their health care.

SUMMARY

It was not possible in all countries to irrefutably demonstrate a state commitment to provide enough public resources at an inter-sectoral level to prevent and comprehensively attend to violence against women and girls with disaggregated information; to achieve greater equity between the two sexes in sexuality and reproduction; to guarantee women's participation in the entities and mechanisms of participation; to undertake programmes that ensure knowledge and favourable transformation on issues of sexual and reproductive health and rights of adolescents; evidence, in the end, that would express the governmental commitment to assure the rights of women and men. In no country was it possible to demonstrate the proportion of health spending for humanised attention to unsafe abortion. With respect to prevention of HIV it was not possible to know how the budget of the public health and education systems earmarked for national campaigns.

National budgets express the policy responsibility and commitment of States to provide enough inter-sectoral resources to the public health, education, justice and other institutions to improve their institutional capacity to prevent and treat the population's diverse problems.

Four indicators have been used to measure the status of public spending on health in the six countries, among them if the national budget establishes defined categories for sexual health and reproductive health programmes and the costs and coverage of the public services; the coverage for sexual and reproductive health by public and/or private social security; access to sexual and reproductive health programmes in the whole national territory and the supplies distributed by the health services with access to a broad array of safe contraceptive methods.

In half of the countries studied no budgetary allocation is defined in its expenditure for sexual health and reproductive health. And when the information does exist, it refers to sexual health and reproductive health programmes, and attention to HIV, AID and STIs, including purchase of antiretroviral treatments and reagents. Only two countries earmark specific resources for reducing maternal mortality and breast and cervical cancer, and those are shrinking.

Thanks to the effect of the privatizations resulting from health system reforms, the resources spent by private sources is gradually increasing in half of the countries; "out of pocket expenses" mask the contributions by families to complete the care and can reach 50% of the population treated, especially for special tests, lab examinations or medications not included in the basic basket. NGOs also contribute resources for providing treatment and accompaniment of women and girls.

It has not been possible to identify either the costs or the coverage of public health services, as health budgets generally express the amount of money available but do not identify what percentage of the needs are covered by the national budgets. Three of the six countries studied are federated and have diverse sources of financing for the central government and the state or provincial governments. The availability and supply come from varied public, private, union or insurance institutions and are not recorded globally, making it impossible to know how much service coverage the population in each country really receives.

Coverage does not reach all programmes; contraceptive methods in their diverse presentations are most accessible in the public system in the region, as are attention to delivery and caesarean births. Female and male surgical sterilization are offered with limitations, as is attention to HIV, AIDS and some STIs; antiretrovirals are offered without cost in the majority of countries, although not to all people who need them.

The universal coverage of public health services ranges between 44% and 91%. There are special contribution systems that ensure health attention via monthly payments as well as subsidised systems that while covering an important percentage of services do not cover them totally.

The social security systems especially cover the economically active population through monthly contributions by both employers and salaried employees. This type of coverage is widespread although some services are limited by lack of availability or saturation due to high demand. In only one country was it possible to identify that the general social security system covers more than 90% of the population; in another country social security due to contributions by workers barely exceeds 20% of the economically active population. Insured men exceed women; and one country reported that 65% of the insured population is under 40 years old.

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CHAPTER 3

reproductive health
and reproductive rights

CHAPTER III. REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

Access to sexual and reproductive health services

Existence of specific sexual health and reproductive health services

All six countries studied have laws, policies, regulations and programmes related to sexual health and reproductive health, specifically access to care services.

In Argentina Law 25,673, the National Law of Sexual and Reproductive Health, of 2002 created the national Sexual Health and Responsible Procreation Programme in 2003.

In Brazil sexual and reproductive health is integrated into the National Women's Comprehensive Health Care Policy with programmes that form part of this policy. Gynaecological care, contraceptive methods, obstetric care, treatment for sexual violence, sex education for adolescents and young adults and health actions for men are included in the area of women's health programmes.

Plans, programmes, regulations and strategies exist that include goals and actions related to reproductive health, including family planning norms, which form part of the norms approved by the Ministry of Health in 2004. There is also a set of laws having to do with assisted reproduction or pregnancy in women with disability, among others. There is no mention of specific rights of adolescents.

Since 2003 Colombia has had a National Sexual and Reproductive Health Policy, which defined the following as lines of action: safe maternity, family planning, sexual and reproductive health in adolescents, cervical cancer, STI, HIV/AIDS, domestic and sexual violence, breast cancer, other cancers of the female and male reproductive apparatus and sexual and reproductive health in older adults.

In Nicaragua the General Health Law was approved in 2002 and quality was established as a principle.[162] Although the law establishes as rights of users of the public health care system "complete and ongoing information, confidentiality and privacy, respect for bodily and human dignity, to not be the object of experimentation, and to informed consent in addition to gratuity,"[163] such rights are not prioritized in public health care and are not well known by the personnel that provide the services. Ten years later no juridical norm regulates the quality of attention in the sexual and reproductive health services. The National Health Plan mandates implementation of the Sexual and Reproductive Health Strategy at the national level with a gender and generational focus.

The 2004-2015 National Health Policy has "gender equity" as a crosscutting focus, establishes that "health care will have ample community participation, with emphasis on sexual and reproductive health." Yet in reality, all participation by the women's organizations that work in health has been eliminated starting in 2007 and there is no possibility of establishing a link with MINSA. In 2008, MINSA issued a new National Health Policy but it is a virtually unknown document.

After Cairo, Nicaragua established the Division and Programme of Comprehensive Women's Care in 1995, separated from the Comprehensive Care of Children and Adolescents, thus fulfilling the commitment to provide special attention to women's comprehensive needs on health issues, moving beyond the reproduction-based approach and care of what was called the "maternal-infant binomial." Nonetheless, starting in 2008, the Family and Community Health Model (MOSAFC) was imposed, in which women have disappeared as a specific group for attention, dissolved within the needs and demands of "the family" in such a way that the only perspective is that of reproduction as well as the satisfaction of and service to the needs of its members, to which is added attention to the needs of the community.

No general mechanisms exist to denounce the infringement of their sexual and reproductive rights, although Law 238[164] on AIDS and Law 779[165] on violence against women establish mechanisms for specific denunciations on the issue. Regarding female surgical contraception, there are no juridical regulations that ensure prior counselling, the granting of written consent or a minimum period between consent and intervention. Forced sterilization is not classified as a crime in the Penal Code so remains at the discretion of the medical personnel.

In the Dominican Republic the Secretariat of State for Public Health and Social Assistance established the Reproductive Health Norm[166] based on fundamental legal elements such as the Political Constitution and laws and regulations that regulate the health sector, of which the different resolutions issued by the Ministry of Public Health and Social Assistance related to maternal-infant and adolescents morbidity and mortality are part. The Reproductive Health Norm establishes specific technical and administrative measures for the implementation of comprehensive health services for adolescents, health promotion, and prevention, care and rehabilitation based on principles of comprehensiveness, universality and confidentiality.

The Ministry of Women in the Dominican Republic has a Department of Sexual and Reproductive Health and Rights that is responsible for promoting and supporting actions aimed at pushing through policies, plans and programmes that ensure women's right to health from a comprehensive health focus with a gender and social participation perspective.

The Programmatic Unit of the Ministry of Public Health and Social Assistance coordinates the comprehensive attention activities in the preventive and assistance services for people living with HIV and AIDS. The vision of the National Strategic STI/HIV Plan is underpinned by universal principles and values such as social equity, gender focus, solidarity and respect for human rights. The 2012-2015 Pluri-annual Strategic Plan assumes as a responsibility the implementation of all measures needed to gradually reduce morbidity and mortality due to cervical cancer. Nonetheless, despite having national regulations for its prevention, diagnosis and treatment,[167] the latter is not free; users must pay for the service.

Services that are provided in the public health system

Sexuality and sex education

In Nicaragua, according to MINSA in 2006, the absence of a sex education programme in the formal education sector and health sector that would take cultural diversity into account and establish defined norms for sexual health care contributes to the prevalent influence among health workers and educators of values and attitudes skewed by concepts deriving from moral and religious judgments, myths and taboos that are introduced in an inappropriate addressing of the topic.[168]

In 2009 MINSA published Ministerial Resolution No. 249 by way of which it mandates that the personnel of "all public and private establishments and health service providers, must promote and support actions aimed at eradicating discrimination against people due to sexual orientation." Despite MINSA's good intentions, which resolution is not well known and is applied even less in the public health services. Since 2010 Nicaragua has had a Basic Guide for educators on Sex Education that is still not fully distributed in the educational institutions. The big demand by teachers is precisely how to address the sex education that continues being put off in the country.

Safe contraception

Argentina, Mexico, Nicaragua and the Dominican Republic have Family Planning or Safe Contraception Programmes. In Argentina contraception includes male condoms, combined hormonal contraceptives, breastfeeding, injectable and emergency hormonal contraceptives, IUDs and female and male surgical sterilization.[169]

In Mexico the Family Planning and Contraception Programme has as its objectives to help modify the determinants that interfere in the knowledge and use of modern contraceptive methods, promoting responsible and protected sexuality and equitable gender roles and relations.

In Nicaragua the public health system offers free modern and safe contraceptive methods for both sexes although long periods of lack of supply have occurred due to storage and distribution problems and lack of resources. With the exception of the diaphragm, all other methods have been available, although female sterilization is developing with limitations due to lack of resources and of a specific programme. Male sterilization has virtually no development in the public system. In 2006, the National Health Strategy in Nicaragua recognised that "the promotion of contraceptive methods in general is insufficient. Family planning activities are not taking the cultural and religious particularities of the communities into account, which limits their capacity to have an impact on the use of modern methods by that population."

In the Dominican Republic family planning includes counselling, information, access to at least three contraceptive methods and access to condoms for men.

Teenage pregnancies

In Argentina the adolescent care programme was reorganized three years ago, linking it to the Sexual Health and Responsible Procreation Programme in the Ministry of Health for the provision of contraceptive methods.

In Colombia fertility in adolescents has increased notably in recent years. Since 2010, with the actions of Agreement 620 between the Ministry of Social Protection and the United Nations Population fund as part of the development of the Model of Adolescent- and Young Adult-Friendly Health Services, work was done on identifying, creating and strengthening youth networks, groups and organizations promoting sexual and reproductive rights and preventing unplanned pregnancy in adolescents.

According to ECLAC, Nicaragua heads all countries in Latin America and the Caribbean for the percentage of teenage pregnancies, with 27% of all women who are mothers. Between 2000 and 2010 there were 367,095 pregnancies in women under 19 years old, and 27.1% of the births in 2010 occurred between ages 10 and 19.[170] According to the National Strategy in Nicaragua, "no differentiated treatment exists in the health services geared to adolescents who require access to professional orientation on their sexual and reproductive health."

Nonetheless, the fertility rate in adolescents and the pregnancies in girls from 10 to 19 years old, which has increased 6.52%

from 33,742 in 2007 to 35,945 in 2010, only appears mentioned once as a "concern" in the National Strategy. According to the UNFPA, the annual births in this age range have increased from 1,066 in 2000 to 1,577, in 2009, a 47% rise.[171] Even given the magnitude of the problem, however, the 2008 National Health Policy, which is still in effect, does not mention any action to prevent and reduce teenage pregnancies or ensure their attention in either its objectives or its guidelines.[172]

Men's sexual and reproductive health

Only Colombia reports the existence of a programme (Profamilia) for men at a nongovernmental level. It includes consultations on fertility, general medicine, internal medicine, family planning, prevention programmes, psychology, sexology, urology, urological surgery, male sterilization, vasectomy without scalpel and microsurgery to reverse a vasectomy.

Nicaragua has sexual and reproductive health services exclusively for men. Male sterilization is not promoted because of the lack of political responsibility and respective programmes, but above all because awareness of male responsibility for contraception is, in the best of cases, incipient in the population in general as well as in the government.

Safe maternity

Of the six countries studied, four report Maternal and Perinatal Health/Safe Maternity programmes. In Argentina and Colombia it is called Safe Maternity and in Nicaragua and the Dominican Republic Maternal Health.

In Argentina safe maternity includes prenatal care and delivery and puerperal care. The national Division of Maternity and Infancy has regulations in coordination with the provincial and municipal assistance services.

In Colombia safe maternity seeks to reduce the national rate of avoidable maternal mortality, improve the coverage and quality of institutional attention to pregnancy, delivery and puerperium and their complications. All modern contraceptive methods are supplied through the Obligatory Health Plan, implementing an Extreme Maternal Morbidity Surveillance Model for continued improvement of the quality of obstetric services. Attention guides exist for access to family planning services, early detection of alterations in the pregnancy, delivery and puerperal care and treatment of hemorrhagic and hypertensive complications.

In Nicaragua the national sexual and reproductive health programme that MINSA presented in February 2002,[173] was withdrawn due to pressure from the Catholic hierarchy. Four years later the National Sexual and Reproductive Health Policy was published and remained until 2006, although the MINSA personnel that must apply it have very limited knowledge of it. Since 2007 institutional births are again attended free of charge in the public services, although the pregnant women defray different costs and contribute medical inputs. Not all examinations or all treatments are available. Although the provision has improved, it is still insufficient.

According to ENDESA,[174] 91% of pregnant women had access to prenatal care, 95% at the urban level and 87% at the rural level. Nonetheless, as of 2010 only 49.1% of pregnant women were brought into prenatal care early in MINSA, in which only 60.4% had 4 prenatal controls and the puerperium coverage is only 71.6% of the deliveries attended.[175]

In the Caribbean regions of Nicaragua prenatal attention is only 77%, which drops to 76.2% among women without education, and to 79.3% among those who had six or more children. Of the total, 62.4% were attended by general doctors or specialists and 27.9% by nurses or midwives.[176] Institutional assistance to the delivery was 70.8% in 2010. Caesarean sections in the public system exceed international percentages, and rose from 14.7% of total births in 2002 to 30% in 2010.[177] Attention to 18,900 births in the Social Security Institute was reported in 2011, 43% via vaginal delivery and 57% via caesarean, exceeding international parameters by 3.8 times.[178]

The programmes offered in the Dominican Republic include information on maternal health, delivery attention by qualified personnel, prenatal care, basic obstetric care, emergency obstetric care, postnatal care and family planning, and post-abortion care.

Prevention of unsafe abortion

Of the six countries studied, only Colombia includes the issue of Voluntary Interruption of the Pregnancy in its programmes. Argentina prepared a Guide for Attention to Unpunishable Abortion but has not yet agreed to its application in all provinces.

The Nicaraguan State seems to demonstrate that if reference is not made to abortion in its programmatic documents, it will disappear automatically. Although no guideline is mentioned in the 2006-2008 National Strategy for its prevention or treatment, it at least says that "furthermore, deaths due to unsafe abortion tend to be hidden by the families."[179]

STI, HIV and AIDS

In Argentina treatment of STIs in women is done through GYN/OBS consultation and in men through urology. There are no unified treatment regulations or unified records for the whole country and the laboratories to detect STI are of varying capacity and extent. In HIV, treatment regulations and unified records do exist and the National Programme provides the medications and antiretrovirals to the provinces and municipalities. There is no HIV/AIDS observatory.

In Brazil attention to lesbians, homosexuals and transsexuals is foreseen in the HIV and AIDS prevention programmes as part of the comprehensive health care, as well as services for the change of sexual characteristics in transsexuals.[180]

In Colombia there is a strategic plan for the elimination of maternal-infant transmission of HIV and congenital syphilis with established treatment guides linked to the regional initiative for the elimination of maternal-infant transmission of HIV and congenital syphilis in Latin America and the Caribbean. Access to timely diagnosis through presumptive Enzyme Linked Immuno-Sorbent Assay (ELISA) tests and Western Blot confirmatory tests are included in the Obligatory Health Plan of both the subsidised system and the contributive system.

In Mexico the programmes include preventing the transmission of HIV and controlling the AIDS epidemic, preventing and controlling STI, providing quality comprehensive health care to people with HIV, strengthening the actions to promote sexual health, promoting policies to reduce the stigma, discrimination, human rights violations and homophobia in key populations and strengthening multi-sectoral, social and citizen participation in formulating HIV/AIDS policies.

In Nicaragua the National Programme of Struggle against AIDS was eliminated in 2007 and care of people living with HIV or AIDS began to be considered a "crosscutting component" of all other programmes, losing its specificity and making attention to the affected people more difficult. The information available on HIV and AIDS is completely out of date, lacks analysis from the gender and generational perspective, does not take into account the sociocultural particularities of the population affected and is not available for research purposes. In 2006, MINSA recognised that "the existence of marked under-recording of information reported about the behaviour of STIs in Nicaragua does not allow well founded appraisals to be made about the magnitude and distribution of the problem."

Programmes exist in the Dominican Republic for sexually transmitted infections, which include prevention, detection/testing, treatment and care. Programmes in HIV exist for prevention, counselling and voluntary tests, treatment and support, prevention of the mother-to-child transmission and treatment for increasing the life expectancy of HIV-positive mothers, and sexual and reproductive health services for people living with the virus.

Violence against women

With respect to violence against women, only three countries report the existence of programmes or attention included in the institutional protocols or regulations: Argentina, Colombia and Nicaragua.

Argentina is limited on sexual violence, covering 50% of the population, although it could reach 70% for emergency treatment. Colombia has Guides for treating Minors and Abused Women and the Comprehensive Health Care Model and Protocol for Victims of Sexual Violence, which establishes that "in the framework of the Colombian health system, all situations of sexual violence are considered a medical urgency that requires immediate attention, both physical and mental, independent of the time that passes between the occurrence of the act of sexual violence and the consultation with the health sector."

Nicaragua has a Regulation for the Prevention, Detection and Treatment of Domestic and Sexual Violence dated 2009, which includes femicide and feminicide, and replaced the 2001 regulation.[181]

Prevention and treatment of reproductive cancer

Prevention and treatment of cervical cancer in Argentina, especially in the most vulnerable areas in the northern part of the country, were prioritized and improved three years ago. In addition, vaccination against HPV of children from 11 years old was incorporated in 2011.

In Mexico educational communication campaigns are conducted to modify the determinants of cervical and breast cancer through the adoption of healthy life habits and the demand for early detection services. Actions have been implemented for the timely prevention and detection of both cancers, mainly in marginal areas, through close linkage with the institutions and the incorporation of new interventions.

In Nicaragua attention is limited to the prevention of cervical cancer and to providing counselling to prevent breast cancer. The other types of gynaecological cancer, of the Fallopian tubes, ovaries or vulva, are only detected in advanced stages and the system's capacity to treat them is extremely limited. According to MINSA, the death rate in women over 35 years old in 2008 was 15 per 100,000 women from breast cancer and 25.9 per 100,000 women from cervical cancer.[182] In 2011 the Social Security Institute reported having done 62,257 Papanicolaou smears and finding 1,155 with alterations, for 1.85%.[183]

Programmes exist in the Dominican Republic for breast, cervical and prostate cancer, in which prevention, detection/testing, treatment and care are offered. WHO statistics for the Dominican Republic report that 1 to 2 women die per day from cervical cancer and 1,032 new cases appear each year. In the Women's Hospital in 2009, 13 cases of cervical cancer and 396 cases of HPV were found out of 853 biopsies done up to October 20.

Post-reproductive health

In Nicaragua little information exists on the prevalence of health problems associated with climacteric/menopause in

women and andropause and erectile dysfunction in men, and their implications for the demand for health services. Treatment of these disorders in the post-reproductive stage has had little development and the absence of attention norms and protocols contributes to the fact that the personnel do not know how to manage the problems in this stage of life. There are no actions to promote healthy life styles as part of women's health in the post-reproductive stage. The only initiatives come from the medical groupings of professionals who deal with these problems in their private practice. There are no specific programmes for attending to the sexual health of older adults.

Access to treatment for infertility, costs and coverage by the public services

Of the six countries studied, Argentina has an assisted fertilization law and Brazil, through its Ministry of Health, established a Comprehensive Assisted Human Reproduction Treatment Policy.[184] Although the health system announced free attention to infertility for couples in 2008, few cases have been treated and there is currently pressure on the Congress to move on the issue as 280,000 couples are waiting to receive infertility treatment.[185]

In Buenos Aires, Argentina, the law obliges the Medical Assistance Works Institute (IOMA), which handles the provincial social work personnel, to provide state and prepaid private health services for assisted fertilization treatment in its regular annual programmes.[186] There is still no approved national law although the project is being debated and is already incorporated in the new Civil Code.

In Colombia treatments for infertility are not covered by public health programmes nor do they form part of the coverage of the obligatory health plans offered by insurance providers ascribed to the health system, justified by the high costs they would represent. Nonetheless, establishing a tutelary action, which is a mechanism to ensure individual and collective rights, could get the health system to cover the costs of infertility treatments.

No data exist on the incidence of infertility in Nicaragua, although given that untreated or poorly treated sexually transmitted infections is one of the main causes of this problem, it is estimated that a high percentage of infertile couples exists in the current conditions of a high prevalence of STI and difficulty accessing adequate treatment.[187]

Programmes or services in women's and other nongovernmental organizations

In two of the six countries studied, Colombia and Nicaragua, NGOs exist that provide comprehensive health services and have specific programmes for the coverage of all target populations, especially directed to women and adolescents.

In Argentina the NGOs develop training, counselling and promotion of rights activities. In Brazil services exist in NGOs that are not feminist, but are called third sector, which could be hospitals, clinics, outpatient services, etc. A few feminist organizations provide legal attention but not health services to women victims of sexual and domestic violence.

Profamilia exists in Colombia, which provides broad national coverage and has the following programmes, among others: Women's Programme; Youth Profamilia, exclusively for adolescents; AVISE, which is a comprehensive attention programme that offers medical, psychological and legal services to victims of sexual violence; Fertile Profamilia, which offers consultation and counselling on female and male fertility; Educa Profamilia, which offers information, training and education via Internet on sexual health and reproductive health issues, prevention of cervical cancer, legal service and legal voluntary interruption of the pregnancy; and a line of Profamilia products for sexual health, reproductive health and family planning that it is seeking to commercialize and distribute throughout Colombia.

In Nicaragua there is SI Mujer, an alternative feminist centre with 21 years of existence that has been promoting the human rights of women, adolescents and youths throughout the national territory since 1991 to achieve a healthy life without violence. It has provided 318,404 consultations to 48,324 different users in all departments of the country. It is a national reference service for the quality of its services. It provides gynaecological, obstetric, genital-mammary cancer detection and prevention and psychology services and has complementary laboratory, ultrasound and foetal monitoring services, colposcopy and treatment of localized cancer lesions.

Of the users attended by SI Mujer, 25.6% are under 19 years old, 51.8% are from 20 to 35 and 22.5% are older than 35. More than 200,000 people come annually to SI Mujer's educational and rights promotion activities, in which they attend training processes, participate in support and reflection groups and receive information on different institutional thematic areas and educational materials. In 1993 SI Mujer founded the Adolescent and Young Adult Programme, which has become the first specific programme for adolescents and youth dedicated to promoting sexual rights and reproductive rights, especially for the lowest income population. It applies the adolescent-to-adolescent methodology in the education programmes and training of youth promoters and the population under 24 years old from the barrios and districts of the municipality of Managua. The Network of SI Mujer Youth Promoters makes more than 20,000 community visits annually, distributing information and safe contraceptives to reduce HIV and teenage pregnancies.

The Ixchen Women's Centre is an organization created in 1988 as a pioneer programme in Nicaragua of comprehensive attention to women under the holistic health approach as a determining condition for development. It has transcended to the promotion and defence of sexual rights, including the right to live without violence, with "woman-to-woman attention." It annually provides more than 300,000 attentions to women in the sphere of sexual health, reproductive health, prevention of genital-mammary cancer, HIV and AIDS and the different forms of violence with an emphasis on women with few economic resources.

After 24 years it has 10 centres, located in Managua's Districts IV and VI, Ciudad Sandino, Tipitapa, Masaya, Matagalpa, Granada, Estelí, León and Bluefields. It applies the vital gender approach for the effective application of the rights approach; the generational approach, which seeks to make visible the place in which society has put children, adolescents and those of third age up to now; and the human rights approach, especially regarding equality, non-discrimination, empowerment, participation and decision-making.

Access to Quality Sexual Health and Reproductive Health Services for Women and Youth

Barriers to the application of the ICDP Programme of Action related to control of fertility and access to population statistics and information

A strong lack of definition has prevailed in Latin America and the Caribbean on formally established population policies. In general population policies are not explicit, although they are applied in different ways. There are countries, such as Argentina, that have historically been considered "unpopulated," where pro-birth policies have prevailed in previous centuries, versus others, such as Mexico, that have established population goals, although they have not been met. Nicaragua has two population policies, which are not coherent with the national reality.

Lack of formally defined population policies

The formulation of a population policy in Argentina is a still-pending task. Advances have been made for many years now with respect to migratory policy, but the migration problem is only one population variable; other variables exist that are analysed by the corresponding dependencies and in fact many studies can be found in this regard, but one notes the lack in such a developed country as Argentina of a public policy that addresses issues such as fertility and mortality, which affect population growth and people's living conditions.

There was never an explicit population policy in Brazil. The population growth rates do not indicate any deceleration and the trend is always downward. The 2010 census data just released in August 2012 reveal that the growth rate is continuing to fall, a trend that began in the 1950s, according to the Brazilian Institute of Geography and Statistics. The average annual growth rate between 2000 and 2010 was 1.17%, lower than 2000, when it was 1.64%. In ten years the Brazilian population increased 12.3% reaching 190,732,694 inhabitants in 2010, in other words 20,933,524 more than in 2000. The fertility rate began an accentuated fall during the eighties, to approximately the levels observed in developed countries.

In Colombia the public system ensures the provision of birth control methods to men and women. Although one cannot speak of the existence of formally defined population policies, there is access to birth control methods. The main problem is probably the social and cultural imaginaries that prevent women and men from turning to birth control methods.

Throughout its history Mexico has had a national population policy, and also has a duly regulated General Population Law. That law mandates that the Government Secretariat approve, execute and/or promote measures to conduct family planning programmes through the public educational and health services and see to it that such programmes as well as those implemented by private agencies are conducted with absolute respect for human rights and preserve the dignity of the families, rationally regulating and stabilising the population growth to achieve the best use of the country's human and natural resources, reduce mortality, and promote women's full integration into the economic, educational, social and cultural process.

In Nicaragua the first population policy was during the Chamorro government, published in September 1996. Fifteen months later, in December 1997, another population policy was published by the Alemán government.

The Dominican Republic does not have a national population policy nor is it seeking to have a document that regulates population and development issues.

Lack of reliable national statistics and unavailability of public information on sexual and reproductive rights and health

Brazil currently has a solid information-gathering system in the general field of health. With respect to research on the health situation, the most important source of data is always the National Survey on Women's Demography and Health; the latest one was conducted in 2006. Nonetheless, because of the criminalization of abortion, defective notification of the causes of maternal death in the death records of women of a reproductive age and the low qualifications of health professionals

or their absence in distant regions such as in northern Brazil, there is surely an under-recording of these events. The feminist survey-takers have made a significant contribution in their search for information aimed at qualifying the quantitative statistical data, particularly in the areas of maternal mortality, violence and HIV.

This is one of the most important gaps in women's access to the exercise of their rights in Brazil. The information—or better said its absence—on rights, policies and services results in many women continuing in violent relationships. The inexistence of services that provide guidance on safe abortion, for example, means that unsafe practices for the interruption of a pregnancy persist. Professionals resist providing this information out of fear of the legislation, which is punitive. Despite the fact that at one point the federal government announced the implementation of an information policy on preventing unsafe abortion, it ultimately backed off from that position. The existing national policy is directed to maternal-infant care.

Statistics exist in Colombia but are limited by serious problems of under-recording of topics related to sexuality and by limitations of geographic coverage in a country that has extremely isolated regions. There are various information systems on health in general, such as the Epidemiological Vigilance System and the Individual Service Provision Records, maintained by the health system. There is also a public health vigilance system on Violence against Women and Domestic and Sexual Violence. Additionally, the National Administrative Department of Statistics makes ongoing reports on socio-demographic indicators and publishes them. The National Institute of Legal Medicine and Forensic Sciences publishes the report FORENSIS on statistics of the attention with a comparative annual analysis that is very useful for learning about the indicators of general violence and gender-based violence.

In Nicaragua, despite having a law[188] since 2007 that establishes the right of all people to access official information, secrecy prevails as official policy. The web pages of the public institutions were progressively closed or maintained with utterly out-of-date information. This non-information policy is aggravated by the fact that the majority of coordination entities between the State and civil society have also been closed.

MINSA's Vital Statistics System (SISNIVEN) is still undergoing strong crises; it is frequently out of date; its web page and Epidemiological Bulletin are suspended; and there are no records of the main health problems of women, adolescents and young adults, such as maternal morbi-mortality, the HIV and AIDS pandemic and fertility in adolescents, among others. The national statistics are unavailable and it is impossible to get information from central MINSA headquarters, given that officials are prohibited from providing it.

It is virtually impossible to have a logical sequence on maternal mortality: since the early nineties, all governments announce "drastic reductions" but never explain what public health measures have been applied to achieve such successes. Figures successively rise and fall, to the degree that maternal mortality is a policy variable. While the international agencies publish three-digit figures, the governments for a decade have been announcing that it does not reach 100 per 100,000 live births, and even currently say that it is barely above 60 per 100,000 live births.

The figures on HIV and AIDS separating sex by age quintiles have not been published for the past two years. Thus people are reported without determining how many are women and how many are men. The national health statistics lack indicators from the gender and generational perspective, are not analysed with social participation and thus lack an independent appraisal that would permit a noting of the national concerns on issues of sexual health and reproductive health. There are no statistical data that include indicators of cultural and ethnic identity and maternal language, despite the fact that Nicaragua is a multicultural, multiethnic and multilingual country. This means there are no specific statistics about the 8% of the population that lives in the Caribbean Coast's autonomous regions.

In the Dominican Republic there is a deficit in the statistics on sexual and reproductive health due to high levels of under-recording, poor quality of the records and lack of disaggregation of data and information. The most reliable source is the Demographic and Health Survey, but it is a limited survey that leaves out a large part of the sexual and reproductive health aspects. The problem that is greater than fulfilment of the General Law of Free Access to Public Information is the unavailability, under-recording or poor quality of the data. If it exists and is requested, they usually provide it because the same law established coercive mechanisms for demanding information in case of refusals.

Dimensions of fertility, access to contraceptive methods and supplies

Progress was made in the application of the ICPD Programme of Action in Latin America with respect to access to contraception methods, which increased notable, thus having an impact on the reduction of fertility in general. Nonetheless, the fertility of adolescents is still high and disparities exist between the urban and rural populations, and among women with less education and those who live in conditions of greater poverty. The supply of contraceptives in the health systems is still unequal, although it has expanded notably in all countries studied.

Total Fertility Rate

The available information on fertility is not always provided in disaggregated form in the countries, which means this information cannot be mentioned for all of them.

Demographic and Health Survey data is not available for all the six countries under review across time trends, however available data on total fertility rate in the four countries-Brazil (1996); Colombia (1995, 2005, 2010), Nicaragua (1998, 2001 and 2006-07), and Dominican Republic (1996, 2002 and 2007)- shows similarities with the Human Development Reports data in these countries (see table on Total Fertility Rate).

The Total Fertility Rate (TFR), has experienced an important drop in all countries. Brazil has the lowest rate with 1.8, followed by Argentina, Mexico with 2.2, and Colombia with 2.3, and finally Nicaragua and the Dominican Republic with 2.5.[189] Demographic and Health Survey data are not available for all the six countries under review across time trends, however available data on total fertility rate in the four countries-Brazil (1996); Colombia (1995, 2005, 2010), Nicaragua (1998, 2001 and 2006-07), and Dominican Republic (1996, 2002 and 2007) show similarities with the Human Development Reports data in these countries.

The Human Development Report Data (2011) shows Brazil, with 1.8, as the country with the lowest fertility rate, followed by Mexico with 2.2, Argentina with 2.2, Colombia with 2.3, the Dominican Republic with 2.5 and Nicaragua with 2.5.

In Nicaragua the TFR was 2.7 in 2006[190] with a 31% reduction since 1998, when it reached 3.9.

In the Dominican Republic the TFR has dropped 35% in 20 years, from 3.7 in 1986 to 2.4 in 2007; in urban areas it is 2.3 and in rural areas 2.8. Among women with more education it is 1.7, while for women with no formal education it is 4.0. Despite this difference between women with more education and those with no formal education, this overall drop reflects the increased use of contraceptives, especially modern methods, during the same period.

Table 9

Total fertility rates in 6 countries in LAC

Country	Total fertility rate		
	1995	2003	2011
Argentina	2.9 (HDR 1995)	2.4 (HDR 2003)	2.2(HDR 2011)
Brazil	2.6 (HDR 1995) 2.5 (DHS1996)	2.2 (HDR 2003)	1.8(HDR 2011)
Colombia	3 (HDR 1995) 3.0 (DHS1995)	2.6 (HDR 2003) 2.4 (DHS 2005)	2.3(HDR 2011) 2.1 (DHS 2010)
Mexico	3.2 (HDR 1995)	2.5 (HDR 2003)	2.2(HDR 2011)
Nicaragua	4.5 (HDR 1995) 3.6 (DHS 1998)	3.7 (HDR 2003) 3.2 (DHS 2001)	2.5(HDR 2011) 2.7 (RHS 2006-07)
Dominican Republic	3.3 (HDR 1995) 3.2 (DHS 1996)	2.7(HDR 2003) 3.0 (DHS 2002)	2.5(HDR 2011) 2.4 (2007 DHS)

Source: Human Development Reports 2003 and 2011. Available online at:
http://hdr.undp.org/en/media/hdr03_sp_complete2.pdf
http://www.undp.org.ni/files/doc/1322678034_Informe%20Completo.pdf
http://www.statcompiler.com/ for data on DHS

The Fertility Rate in Latin America differs, as it does in all parts of the world, from fertility wanted by women. Information is not available to measure this figure in Argentina; and in the other countries the date of the information obtained on desired fertility varies between 1987 and 2007, making it also impossible to adequately analyze it and compare it with the estimated current fertility (2010-2015).

Table 10

Wanted Fertility Rates and Total Fertility Rates in 6 countries in LAC

As in all parts of the world, the Fertility Rate in Latin America differs from the fertility wanted by women. No information is available to measure this data in Argentina, but in the other countries, the information obtained on wanted fertility varies from 1987 to 2007, making it impossible to adequately analyse and compare it with the current estimated fertility (2010-2015). For this reason, we look at the available wanted fertility rates in the countries under review and compare this with the current fertility rate in the same year, to assess how women are able to control their fertility and have the number of children that they actually want to have. Latest available data on wanted fertility rate is presented in the table below with the corresponding total fertility rate for the same year for comparison purposes

Country	Total Fertility Rate	Wanted Fertility Rate
Argentina		-
Brazil	2.5 (DHS 1996)	1.8 (DHS 1996)
Colombia	2.1 (DHS 2010)	1.6(DHS 2010)
Mexico	-	-
Nicaragua	2.7 (RHS 2006-07)	2.3 (RHS 2006-07)(0.4)
Dominican Republic	2.4 ((DHS 2007)	1.9 (DHS 2007)(0.5)

Source: Demographic and Health Survey Data http://www.statcompiler.com/ for data on DHS

From the above table, it is observed that data is available on the total fertility rates and corresponding wanted fertility rates in four countries: Brazil (DHS 1996), Colombia (DHS 2010), Nicaragua (RHS 2006), and Dominican Republic (DHS 2007). Women's Fertility Rate is higher than the wanted fertility rate in all the four countries (refer to above table). The difference between the total fertility rate and the wanted fertility rate is highest in Brazil, followed by Colombia, Dominican Republic and Nicaragua

Prevalence rate of contraceptives by age, sex and method

According to the World Contraceptive Use data 2011, as well as Demographic and Health Surveys (DHS), all countries under review have a high prevalence in the use of contraceptive methods: Brazil 80%, Colombia 79%, México 71%, Nicaragua 72%, the Dominican Republic 73% and Argentina 66%. The figures have slight or important variations according to the official information of the countries studied.[191]

In Argentina the use of contraceptives is below 70%, Pills and Condoms are the preferred contraceptives in the country. The prevailing method is beneficial for women's health. There is evidence of a high use of male condoms (68.7%), which prevails at young ages and drops with the advance of the women's age, reaching 32.7% between 40 and 49 years.[192]

The traditional methods, with limited or no contraceptive effectiveness, increase with age, reaching 20.3% among women from 30 to 39 years old. Female sterilization is increasing with age, reaching a maximum of 19.7% in women over 40. Injectable hormones are used by 2% of those between 15 and 19 years old and 3.8% of those between 20 and 29.[193]

In Brazil in 2006, 81% of all women living in some type of union used contraceptive methods, up from 77% in 1996; among them 77% use modern methods and 4% traditional methods. Female surgical sterilization was maintained as the most frequently used method with 29%, followed by the pill with 25% and the condom with 12%. There is a relative homogeneity in the prevalence of contraceptives in the different regions of the country, in urban and rural areas, in different education levels and in relation to race/colour.

Nonetheless, the differences become more evident when considered in combination with the method used. Vasectomy represents 5% of the contraceptive practices, followed by injectable hormones, with 4%. The IUD has a 2% use level. Between 1996 and 2006, a reduction of female sterilization from 40% to 29% was observed, while the use of condoms increased from 4% to 12%. Meanwhile, 66% of young people between 15 and 19 years old have used some contraceptive method, of which the most used were the following: condoms 33%, pills 27% and injectables 5%.[194]

In Colombia the percentage of women from 15 to 49 years old who are in a union and use birth control methods is high between 2003 and 2010, between 60% and 79% according to the source. According to Colombia DHS 2010, the contraceptive prevalence for modern methods is 72.9%; prevalence of the use of contraceptives in 2011 is 78.2%.[195]

Modern methods are used by 72.9%: the pill by 8%, the IUD by 8%, female sterilization by 35%, male sterilization by 3%, injectable hormones by 9% and the male condom by 7%.[196] According to data of all people over 15 years old, 60% of women and 10% of men use contraceptives, a situation reflecting the fact that reproductive issues continue to be the priority responsibility of women.[197] Emergency contraception is easily accessible through the public health services and is also freely sold in pharmacies.

In Mexico 70.9% of women of fertile age in relationships uses contraceptive methods. The use of modern contraceptive methods is at 66.5%. In the different age groups, 44.7% of the women from 15 to 19 uses some method, as does 62.9% of those between 20 and 24, 66.5% of those between 25 and 29, 73.1% of those between 30 and 34, 80.2% of those between 35 and 39, 81.1 of those between 40 and 45, and finally 74.8% of those between 45 and 49.(reference?)[198]

The use of contraceptives by rural women is 63.7% and by urban women is 75.1%. It is 58.3% among women who speak an indigenous language and 73.5% among those who do not. In women with no schooling the methods are used by 60.5%, by 67.3% of those who did not complete primary school, by 71.3% who did complete primary school and by 74.4% who completed secondary or more. Among those who use some birth control method, female surgical sterilization is used by 5.1%, the IUD by 16.5%, local methods by 10.1%, injectables by 7.9%, traditional methods by 7.0%, the pill by 5.8%, female condom by 0.9%, male condom by 1.5%, implants by 1.5%, contraceptive patches by 1.5%, the emergency pill by 0.4% and male surgical sterilization by 3.1%.[199]

In Nicaragua in 2006/2007 only 48.8% of all women interviewed by ENDESA said they were "currently using" a contraceptive method, which means that 51.2% were not. When the data is reported for currently married women and women in union in the same survey it reported 72.4% contraceptive prevalence for any contraceptive method and 69.8% for any modern method. Nonetheless, the same survey reports that 70% of the women "at some time" in their life used contraceptives.

The methods most used currently are female surgical sterilization 35.86%, injectables 30.53%, pill 17.42%, male condom 5.53%, IUD 5.12%, rhythm/Billings 3.89%, breastfeeding 1.23% and male surgical sterilization 0.41%.[200] The Survey reports that "the use of contraception in Nicaragua is relatively high, as 70% of all women of fertile age have used a family planning method "at some time" in their life.[201]

In 1999 official MINSA information stated that 40% of sexually active adolescents had never used contraceptive methods.[202] There is no disaggregated official information on the percentage of methods used by male adolescents at the rural or urban level. In 2009, according to a USAID study on the contraceptive market in Nicaragua, it was concluded that "the use of contraceptives is particularly low among adolescent women between 15 and 19 years old in both groups and also among young married women between 20 and 24 years old. Only 58.9% of sexually active women between 15 and 19 years old not in a union and 61.1% of women currently in a union use contraceptive methods."[203] It adds that responding to the unmet need of these women is particularly critical, as adolescents between 15 and 19 years old have twice the probabilities of dying from causes related to pregnancy and delivery than women of older ages, given that many adolescents are physically immature, which increases their risks of suffering obstetric complications such as have been mentioned in the report "Family Planning Saves Lives".[204]

In the Dominican Republic the Contraceptive Prevalence Rate (TPA) increased for modern methods from 46.5% in 1986 to 70% in 2007, with increased use of contraceptives in women in unions from 49.8% to 72.9% between those same years for any contraceptive method. With respect to traditional methods, they dropped from 3.3% to 2.8%, while non-use of contraceptives fell from 50.2% to 27.1%.[205]

Table 11

Contraceptive Prevalence Rates and method selection

Updated Table on Contraception Prevalence Rates (CPR) taken from Demographic and Health Surveys (where available) and World Contraceptive Use 2011

COUNTRY	ANY METHOD	ANY MODERN METHOD	PILL	IUD	INJECTION	CONDOM	FEMALE STERALISATION	MALE STERLISATION	IMPLANT	LACTATIONAL AMENORREA	FOAM AND JELLY	OTHER MODERN METHODS	ANY TRADITIONAL METHIOD AND FOLK METHOD	NOT CURRENTLY USING
Argentina (2001)	65.3	63.8	46.5	14.5	7.65	34.1							20.3	
Brazil (2006)	80.3	77.1	30.7	2.36	4.98	15.1	36.1	6.35	0.1				3.98	
Colombia DHS 2010	79.1	72.9	9.6	9.48	11.6	8.8	44.1	4.29	3.9	0.25	0.1		7.7	20.9
Mexico (2006)	70.9	66.5	6.6	16.3	7.0	9.0						*54.1	6.2	
Nicaragua 2006-07 RHS	72.4	69.8	17.9	4.69	32.3	5.24	33.5	0.5					3.5	27.6
Dominican Republic	72.9	70.0	18.3	2.8	5.76	2.6	65.0		0.8	0.68			3.8	27.1

Source: World Contraceptive Use 2011- Argentina, Brazil and Mexico. Latest DHS data for Colombia, Nicaragua and Dominican Republic

Table 12

Male contraception as percentage of total contraception

Male contraception as percentage of total contraception		
Name of the Country	**Condom users as proportion of all contraceptive users**	**Male sterilisation as proportion of all contraceptive users**
Argentina	34.1	
Brazil	15.1	6.35
Colombia	8.8	4.29
Mexico	9.0	
Nicaragua	5.2	0.5
Dominican Republic	2.6	

Source: World Contraceptive Use 2011- Argentina, Brazil and Mexico. Latest DHS data for Colombia, Nicaragua and Dominican Republic

Mexico reported 54.1% for both male and female sterilisation and this number is grouped under other modern methods. This data is not disaggregated and hence exact data is not available.

Condoms are one of the most used contraceptive methods in the six countries under review. In the six countries under review, Argentina reports the highest use of condoms followed by Brazil. Condom use as a proportion of all contraceptive use ranges between 9.0 in Mexico and 2.6 in Dominican Republic.

Data on male sterilisation as proportion of all contraceptive users is available for three countries under review and ranges between 0.5 (Nicaragua) to 6.35 (Brazil).

Table 13

Unmet need for family planning 1995/ 2003/ Latest (2008-2010)

The unmet need for contraceptive methods is not available in all countries. The official data generally do not reveal the true situation, because, despite the offer of a variety of methods by the services, they are not always available at the moment of consultation due to problems of supply or of the organization of the services.

Based on the next table, the unmet need for family planning for the six countries under review ranged between 6% (Brazil) and 12% in Mexico between 2008 and 2010.

Country	Unmet need for family planning		
	1995	2003	Latest (2008-2010)
Argentina	NA	NA	NA
Brazil	7.3 (1996)	NA	6 (2006)
Colombia	7.7	5.8 (2005)	7
Mexico	16.1	9.9	12
Nicaragua	14.7 (1997)	14.6 (2001)	7.5 (2006)
Dominican Republic	12.5 (1996)	10.9 (2002)	11.4 (2007)

Source: Argentina: No DHS. Data is also not available in the World Contraceptive Use 2010.
Source: Brazil: Pesquisa Nacional sobre Demografia e Saude 2006.
Source: Colombia: Measure DHS Country Quick Stats.
Source: Mexico: Encuesta Nacional de la Dinámica Demográfica 1995, 2003, 2006.
Source: Nicaragua: RHS, cited in World Contraceptive Use 2010.
Source: Dominican Republic: Has no source.

Table 14

Reasons for non-use of Contraception

Information on the reasons for non-use of contraception is only available in four of the six countries. In addition, this information results from the perception of the service providers; only very rarely is it obtained from the users themselves. The opposition from factors having to do with the Catholic religious influence, the moral condemnation actively publicized by Protestant sects prevails over the opposition of the partner or husband.

Country	Fatalism	Husband opposed	Others opposed	Health concerns	Inconvenient to use
Argentina	NA	NA	NA	NA	NA
Brazil	0.7 (1996)	1.3 (1996)	15.6 (1996)	2.6 (1996)	3.2 (1996)
Colombia	0.9 (1995)	1.9 (1995)	4.5 (1995)	5.4 (1995)	7.1 (1995)
Mexico	NA	NA	NA	NA	NA
Nicaragua	0.3 (1998)	1.9 (1998)	10 (1998)	9.5 (1998)	2.5 (1998)
Dominican Republic	0.1 (1996)	4.7 (1996)	12.7 (1996)	3.6 (1996)	3.1 (1996)

Source: Macro International Inc, 2011. Measure DHS Stat compiler. http://www.measurehs.com. August 18 2011.

Supplies distributed by the health services. Access to a broad array of safe birth control methods

Sexual health and reproductive health services are essential for the health and survival of communities, particularly women and adolescents. When women are healthy, their benefits influence other areas of human development, such as for example poverty reduction, education, population and sustainability of the natural resources.

Argentina, Colombia, Mexico and the Dominican Republic have programmes to distribute safe birth control methods: hormonal methods, tablets, injectable hormones and sub-dermal implants, as well as condoms for men and emergency contraception. Since 2006 Argentina has included free coverage of female and male surgical sterilization and the following year included emergency contraception in the Obligatory Medical Programme.[206]

In Mexico in 2010 the people newly accepting contraceptive methods reached 2,457,057 women. The methods accepted were hormonal (944,467), IUDs (657,231), surgical methods (429,595) and other methods (425,764).[207] Of the 424,668 surgical interventions done that same year, 384,510 were on women (90.5%) and 40,158 on men (9.4%), demonstrating that surgical birth control in women continues to prevail, given that the conception still exists that reproduction is a "women's issue." With respect to the use of birth control methods after obstetric care, 184,803 women are reported to be using hormonal methods, 552,990 IUD applications and 325,955 female surgical sterilizations.

In the Dominican Republic there are certain limitations to access to contraceptive methods, especially emergency contraception. The unmet need for contraceptives is 11%. The public sector provides 80% of the injections, 67% of the implants and 8% of the surgical sterilizations. The private sector provides 58% of the pills and 56% of the condoms.[208]

Access to safe abortion

The ICPD Programme of Action makes special mention of the fact that abortion must be accessible where it is legal and that the quality of abortion treatment must be guaranteed in all services, including in countries where it is not permitted by law. The treatment of its complications must be provided in the framework of respect for women's human rights.

Given that the total prohibition of abortion brings health dangers or the loss of women's life as a consequence, access to safe abortion is the guarantee of the respect for human rights, and reflects the national legislative advances after Cairo.

Circumstances in which access to abortion is not criminalized

In none of the countries studies is abortion totally permitted; penalties are established that differ in their magnitude when it has to do with women or health professionals, which can go as high as 20 years in prison. The severity of the sentences include reclusion, prison, forced labour, the closure of clinics or consultancies and disbarring from the practice of medicine, thus revealing the patriarchal bias of the legislation. Nicaragua and the Dominican Republic do not permit abortion under any circumstances, even when the life of the women is in danger or for rape.

Exceptions exist, however, that can be applied in four of the countries. Although abortion is decriminalized in some circumstances, the possibilities of women's access are hindered by multiple barriers. In Mexico's capital, it is decriminalized when the pregnancy is not greater than 12 weeks; and in Colombia it is permitted for three causes, including if the pregnancy is in the third trimester of gestation.

According to the reports of the countries studied, the abortion rate is shown as persistently high given that the prohibitions never succeeded in reducing it. It varies by country between 33 and 60 per 1,000 women, which is evidence that abortion, in addition to being a social justice problem, continues to be an enormous public health problem.

Despite reported under-recording, the number of deaths from abortion varies in the six countries between 9% and 33% of their total maternal mortality. Preventing these avoidable deaths of women would represent important progress. The annual number of deaths due to complications from unsafe abortions varies between 70 and 697, although this figure was not available in all countries. One country estimates the annual loss of a total of 17,184 years of life of women who have died due to abortion complications.

In Argentina abortion is decriminalized when it is practiced by a licensed doctor with the consent of the pregnant women, if it has been done to avoid danger to the life or health of the mother, if this danger could not be avoided by other means or if the pregnancy comes from a rape or attempt against decency committed against a mentally retarded or demented woman.[209]

Abortion in general has a punishment of 3-10 years of confinement or imprisonment if it was done without the woman's consent and could increase to 15 years if the act was followed by the woman's death. Confinement or prison would be 1-4 years if it was done with the woman's consent and would rise to a maximum sentence of six years if the abortion was followed by the woman's death. Special barring is added, doubling the time of the sentence for doctors, surgeons, midwives or druggists who abuse their science or art to cause the abortion or cooperate to cause it.

In Argentina the general abortion rate per 1,000 women from 15 to 19 years old is 60.8, according to reports of 2004-2005.[210]

In Brazil, the abortion rate is 40.8 per 1,000 women, with approximately 31% of all pregnancies ending in abortion. According to the Single Health System, it was reported that 243,988 women received post-abortion attention in 2004 alone.[211] Approximately 1,054,253 abortions occurred in Brazil in 2005.[212]

The Guttmacher Institute estimates that Colombia has 400,400 induced abortions annually, which translates into an annual rate of 39 abortions per 1,000 women between 15 and 44 years old. In 1991 there were 25.1 abortions per 1,000 women of reproductive rate, while in 2006 that rose to 33 per 1,000 women.

In Brazil abortion is permitted to save the life of the pregnant women or if the pregnancy is the result of rape, and is performed with the consent of the woman or her legal representative.[213]

In Colombia, the Constitutional Court decriminalized abortion in May 2006 for three causes: when the continuation of the pregnancy endangers the woman's life or health as certified by a doctor; when there is a grave malformation of the foetus that makes its life unviable, also as certified by a doctor; and when the pregnancy is the result of duly denounced conduct constituting abusive sexual intercourse or a sexual act without consent, artificial insemination or transfer of a fertilized egg without consent or incest.[214]

In Mexico's system of competencies, penal legislation corresponds to its 32 federated entities. Abortion is permitted in all 32 states due to rape, in 30 states when it is reckless or culpable, in 29 states when there is danger of the death of the pregnant women, in 14 states when there are grave genetic or congenital malformations in the foetus, in 12 states due to serious damage to the health of the pregnant woman, in 11 states when there is non-consensual artificial insemination, in 1 state for economic reasons when the woman already has three children and in 1 state at the woman's will during the first 12 weeks of pregnancy.

In Nicaragua therapeutic abortion was legal since 1871, although the causes were not specified. In 2006 that was abolished, leaving abortion absolutely criminalised, even when the life or health of the pregnant woman is in grave danger. Attention to obstetric emergencies whose resolution was previously done under basic criteria of urgent medicine is now restricted due to the absolution penalization of abortion.

In February 2003 the pregnancy of a nine-year-old Nicaraguan girl who was living with her parents in Costa Rica and was raped and ended up pregnant showed the Episcopal Conference to be the final health authority, creating a major crisis of MINSA's credibility with the citizenry as it tried to force the raped little girl to give birth. In response to the demand of both parents and the girl herself to interrupt the forced pregnancy via therapeutic abortion—at that time still accepted in national legislation—MINSA responded by forming a mega-commission of 15 members to define "whether the girl was at any risk." They said they could not rule because she could be in danger either way. In the end the procedure was performed by three specialists outside of the health system and the girl suffered no complications. Groups called "pro-life" filed charges with the Public Prosecutor's Office against the mother, the father and leaders of the women's movement, but the prosecutor general found that there had been no crime; the abortion was performed according to law. The cardinal, however, excommunicated the mother, father, girl, feminist leaders and the three doctors who had applied Article 148 of the Penal Code to save the girl's life.

The Dominican Republic also absolutely penalizes the interruption of a pregnancy, even when the woman's life is in danger, in cases of rape and incest, and in pregnancies in which the foetus will not survive, such as those that are anencephalic.[215] Article 317 of the Penal Code punishes women who intentionally abort with from 5 to 20 years of prison, a sanction also applied to health professionals who cooperate in or perform an abortion, with no extenuating circumstances.[216]

Changes in the abortion laws, clauses of conscience, rights of the foetus

In Argentina there were no changes in the abortion laws after the ICPD, although there were various projects to expand decriminalization for causes never dealt with in the Congress. The 1922 Penal Code remained in effect, with one modification in 1988 aimed at promoting the most restrictive interpretation of point 2 of article 86, which limited it to raped women only when they were mentally retarded or demented.

The Supreme Court ruling of March 2012 indicated the least restrictive interpretation of that article, leaving it that abortion must be permitted in all rape cases, as well as attempts against the decency of mentally retarded or demented women, in which the Court specified that no charge must be mediated; the sworn declaration of the women or her legal guardian, if applicable, is enough. With respect to conscientious objection, the Court made explicit that access to the right to non-punishable abortion cannot be compromised, including the need to avoid delays or consequences, and that the jurisdictions or provinces, as well as the national government, must draw up treatment protocols to concretise this attention.

There are no significant legislative changes in Brazil. The cause of anencephaly was introduced in 2012, and was approved by the Supreme Tribunal.[217] Abortion is a crime punishable by between one and four years of prison in Brazil, although it is permitted if the woman's life is in danger or the pregnancy is the product of rape. Different projects to decriminalize abortion have been rejected over the past 16 years.[218]

Abortion was completely decriminalized in Colombia before the Constitutional Court sentence C-355 of 2006; despite that sentence, however, multiple barriers and disinformation have persisted that limit access to this right for some women. Through a protection sentence, the Constitutional Court has facilitated the regulation of the abortion procedure, after the Council of State, in October 2009, dismantled Ministry of Health Decree 4444, which regulated its practice.

In Mexico between 2008 and 2011, after abortion in the first 12 weeks of pregnancy was decriminalized in Mexico City, 16 federated entities reformed their Constitutions to protect life "starting from conception." They are Baja California, Chiapas, Colima, Durango, Guanajuato, Jalisco, Morelos, Nayarit, Oaxaca, Puebla, Querétaro, Quintana Roo, San Luis Potosí, Sonora, Tamaulipas and Yucatán. That brings the total to 17, given that Chihuahua had already reformed its Constitution in October 1994. Laws exist in 6 states that anticipate conscientious objection: Aguascalientes, Colima, Distrito Federal, Jalisco, Querétaro and Tlaxcala.

In Nicaragua the old Penal Code article that permitted therapeutic abortion was abolished via Law 603, passed in 2006 in concordance with the religious hierarchies. In September 2007, with the FSLN again in power, article 143.1 on therapeutic abortion was eliminated from the new Penal Code. The criminalization of all abortion was maintained in the Penal Code and protection of the "unborn" was incorporated, granting the foetus legal supremacy over women's rights. Article 148 prohibits any "lesions to the unborn" and punishes any medical personnel who cause them to 2-5 years in prison, special debarring from practising medicine for 2-8 years and the closing of their clinics or consultancy offices for the same amount of time.

In the Dominican Republic article 37 of the Political Constitution, proclaimed in 2010, establishes the right to life as "... inviolable from conception to death. The death penalty may not be established, called for or applied in any case." This article is used in practice as if it were an absolute prohibition of abortion and sets up the rights of the foetus or embryo against the rights of women.[219]

Table 15

Grounds on which abortion is permitted

Country	Grounds on which abortion is permitted						
	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Argentina	Yes	No	No	Yes	No	No	No
Brazil	Yes	No	No	Yes	No	No	No
Colombia	Yes	Yes	Yes	Yes	Yes	No	No
Mexico Federal District	until 12 weeks						
Mexico other states	Yes (16)	Yes (12)*	Yes (12)*	Yes (32)*	Yes (14)*	Yes (1)*	Yes (1)*
Nicaragua	No	No	No	No	No	No	No
Dominican Republic	No	No	No	No	No	No	No

Source: World Abortion Policies 2011

http://www.un.org/esa/population/publications/2011abortion/2011abortionwallchart.

* Numbers of states in Mexico where it is allowed.

Degree to which the abortion law is known, accepted and applied by health professionals and the general public

In Argentina knowledge and application of the law by health personnel are disparate, especially among doctors who do not know how to proceed. The Ministry of Health approved the National Technical Guide for Comprehensive Treatment of Abortions in 2010, following the legal interpretation of article 86 by the Supreme Court, but it did not adopt it by ministerial resolution and although it was uploaded onto the web page, there has been no training on it or any solution offered to make this practice uniform as a public policy. As a consequence, women exercise their rights according to where they live, without all receiving the same benefits.[220]

In Brazil the Penal Code establishes three cases in which abortion is not criminalized: when it puts the woman's life at risk, which is widely known and practiced by health professionals; in case of sexual violence; and in the case of anencephaly, which was practiced over time and now has become normal. In 23 states of the federation and in the federal district itself, there is evidence of major ignorance about the documentation needed to perform the interruption of the pregnancy in cases considered legal.

According to estimates of the Guttmacher Institute in Colombia, 400,400 women abort annually in that country; after five years of implementation of the sentence decriminalizing abortion, the Ministry of Social Protection reports that only 996 women turned to the voluntary procedure to interrupt the pregnancy, referred to as IVE for its acronym in Spanish, between May 2006 and December 2010.[221] Many barriers and a lot of ignorance still persists about IVE; for example, the Attorney General of the Nation openly opposes it due to personal and religious convictions and has incited doctors, both male and female, to become conscientious objectors, harassing and persecuting officials and organizations working on the issue.

In Mexico health professionals and the general public know little about abortion legislation. Women have little knowledge of the legal causes for abortion in their states. Although abortion due to rape is legal all over the country, statistics indicate that there is little or no access to this cause. Because of the reforms to the local Constitutions that protect life from conception, a climate of persecution toward women and of confusion has been generated in public officials with respect to their obligations related to providing reproductive health services.

In Nicaragua the legislation with respect to the absolute prohibition of abortion is known, although when therapeutic abortion existed, that possibility was not generally known. Health

professionals are completely unaware of the article "on lesions to the unborn" which would punish them with a prison sentence, special debarring from practicing medicine and the closure of their clinics or consultancies.

In the Dominican Republic article 317 of the Penal Code, which absolutely criminalizes abortion, is known by the population and by health professionals, who apply it under a double moral standard as if they did not know the law.

Estimated rate of unsafe abortion over the years

Among the six countries studied, the existence is revealed of a total of nearly three million abortions per year. The estimates of recent years show more than a million annually in Brazil,[222] more than 800,000 in Mexico,[223] between 400,000 and 600,000 in Argentina,[224] more than 400,000 in Colombia[225] and 90,000 in the Dominican Republic.[226] These figures are barely a reflection of the multitude of cases that are initiated outside of the public system and come to the health establishments only when there are serious complications.

In Nicaragua's 1996 national population policy document, two years after ICPD, the government published abortion estimates of "between 27,000 and 36,000 induced abortions per year. Since then no more official figures have been made available.

In the Dominican Republic, according to the Allan Guttmacher Institute, the latest estimate is 82,500 annual abortions in 1992, which is equivalent to a rate of 43.7 per 1,000 women of fertile age.[227]

Percentage of unsafe abortion within total maternal mortality

In the six countries analysed approximately 700 deaths of women from unsafe abortion occur annually, ranging between 300 in Argentina[228] and 150 in the Dominican Republic[229] to 70 in Colombia.[230] In Nicaragua there are no data on the number of abortions or of deaths from this cause.

In Argentina, the percentage of unsafe abortions within total maternal mortality ranges between 25 and 33, but is always one of the first three causes. In 2010, it was 20.5%.[231]

In Brazil, there were 697 deaths as a result of pregnancies ending in abortion between 2000 and 2004; women between 20 and 29 years old accounted for 323 of those deaths. While the figure varies from region to region in Brazil, abortion was responsible for 11.4% of all maternal deaths in that country.[232]

According to a WHO estimate of some 780 maternal deaths in 2008, it can be concluded that approximately 70 women die each year due to unsafe abortions.[233]

In Mexico in 2010, unsafe abortions accounted for 9.3% of total maternal mortality.[234]

In Nicaragua the government recognised in 1996 that induced abortion was one of the main causes of maternal death in 1990 and 1991, causing 24% of the intra- and extra-hospital maternal deaths.[235] Between 1993 and 1996 the percentage of deaths from abortion in a single hospital was 19.23% and the reported hospitalized maternal mortality rate was 20% of total maternal mortality.[236] No official data are known about the percentage of abortion within the total maternal mortality since those years.

In the Dominican Republic official statistics from the 2007 Demography and Health Survey[237] put induced abortion as the fourth cause of maternal mortality, attributing 13% of the total to it in 2006, while the Dominican Gynaecological and Obstetric Society estimates the real 2007 figure at 20%.[238]

Quality of public health care in safe/unsafe abortion situations

The quality of abortion treatment is very uneven in the public services, given that not all requisites are included in the legislation, the norms are not met when they do exist, mistreatment and stigmatization are frequent, the professionals have low training levels or limited use of AMEU due to lack of receptiveness by the medical personnel, their own high rotation and the conscientious objection that plays a role generally associated with double moral standards.

Where abortion is permitted by law, the information provided is usually skewed to dissuade women, although in one country (Mexico D.F) services have been opened that are of very good quality, with professionals who respect women's decision and resources that are adequate to the needs. In two countries the regulations stipulate time periods for the steps needed to authorize the interruption of the pregnancy, include pre- and post-abortion counselling and oblige public establishments to have personnel who do not have conscientious objection.

At the other extreme, women are denounced to the police, interrogated at length or left unattended until they reveal how they got the abortion, are made to pay steep fines to avoid being detained, and are persecuted and/or jailed and sometimes tried even in cases of spontaneous miscarriages, which by any definition is considered "poor" treatment. One or various of these violations of women's human rights or those of their relatives occur in some states of Mexico, in Nicaragua and in the Dominican Republic.

The care is uneven in cases of non-punishable abortion as the only legal possibility of safe abortion in Argentina, including variants in the requisites for access to non-punishable abortion such as a minimum age or prior denunciation of rape. There is no evidence of state efforts to publicise or implement the National Technical Guide for Comprehensive Attention to Non-publishable Abortions, which the health minister made clear he

did not agree with.[239] The first version was prepared in 2006 and updated in 2010.

In Colombia stigmatization of the abortion issue persists at the national level and translates into abusive interventions for many women. Nonetheless, the Ministry of Health has made efforts to sensitize and train the personnel so they provide quality services with human warmth. The ministry has also tried to encourage the use of manual endo-uterine aspiration (known by its Spanish acronym AMEU), with little receptivity by many doctors. Another obstacle is high rotation in the health sector and thus difficulty in making these formative processes systematic.

This problem also shows up in basic technical aspects such as training in safe abortion techniques such as AMEU, which the WHO recommends as the most appropriate for this procedure up to 14 weeks of pregnancy. In many cases, doctors and other health personnel misuse conscientious objection or, worse yet, provide biased and erroneous information to women to convince them not to interrupt their pregnancy.[240]

In the case of Mexico City, where abortion is legal during the first 12 weeks of pregnancy, 84,159 legal interruptions of the pregnancy (ILE) have been performed as of 31 July 2012, with a repeat rate of 2.09%.[241] The Federal District's health services have responded very favourably to the decriminalization of abortion during the first 12 weeks of pregnancy. Qualified and sensitized personnel exist to perform these procedures. One of the most successful parts of the ILE programme has been the establishment of specialized reproductive health clinics that provide this service with more trained personnel. In the case of other federated entities, deficiencies have been detected in access to legal abortion for the victims of rape.[242] The norm for attention to victims of sexual violence is not totally met as in many cases the women do not have information or services on emergency contraception methods, HIV and STI prophylaxis, or ILE.

In the case of unsafe abortions, cases have been documented of women who turn to the health services with incomplete abortions and are denounced by doctors or social workers in the hospital. On occasions they are obliged to confess that they took pills to provoke the abortion and some have to pay bail, sometimes very high, to stay out of prison during the criminal processing of the case against them. Women who are sentenced sometimes have to go to prison but in most cases are sentenced to community work or psychological treatment.[243]

In states that have reforms protecting life from conception it is observed that the persecution and denunciation of women with incomplete abortions has increased. Cases have even been documented of women with miscarriages who are charged and tried.

In Nicaragua in 1997, when therapeutic abortion was still legal, a national study concluded that "among upper-level officials there is major ignorance of the Norms of Attention to Abortion, as no training sessions are organized at all levels for gynaecology and obstetrics specialists."[244]

The quality of abortion attention in the public services is very closely linked to its illegality. Since 2008 Nicaraguan Ministry of Health personnel frequently denounce women who come seeking treatment for complications from abortion. They are interrogated or are left without doing curettage "until they remember" who provided them the medications or attention before entering the hospital. The National Police and special Police Stations for Women and Children recorded 79 women who were charged with the crime of abortion and 38 men detained for the same crime in its diverse manifestations.[245] At the end of 2011, 15 women were charged, bringing the total to 94 since the new Penal Code was approved, and if men are included, a total of 132 people have been prosecuted, charged or detained for the crime of abortion. It has not been learned whether judicial processes were opened against them.

In the Dominican Republic, the quality of attention is generally poor, although a protocol exists for Emergency Obstetric Care.

Post-abortion care

In Argentina post-abortion treatment is very uneven. The national Guide or Protocol, which insists on good practices and counselling, was beneficial, but its use is not massive in that it was not approved by ministerial resolution nor was it adopted as public policy in the Federal Health Council together with the provinces. For example, it is not used in Mendoza, Córdoba, La Pampa, Entre Ríos and Salta.[246] There are other provinces where it is also not applied; in some it is only applied in some hospitals, which generates serious diversity, going against the effectiveness of and respect for this right for all women equally.

In Brazil post-abortion care in public hospitals is done in accord with the Technical Norm of Humanized Treatment of Abortion prepared by the Department of Programmatic Strategic Health Actions for Women. These regulations include post-abortion contraception as a right of women that must be offered in all centres that treat women in this situation.[247]

Each year, Colombia's health system offers post-abortion treatment to 93,000 women whose avoidable complications use scarce available resources. The highest treatment rate and greatest burden of care in the health system occurs in the Pacific region, where each year 16 out of every 1,000 women receive post-abortion treatment.[248] The Guttmacher report recognises that a fifth of all women with complications resulting from abortion end up untreated.

Some women who avoid seeking medical attention due to fear of mistreatment even though Colombia, which has adopted clear directives to provide services for the voluntary interruption of a pregnancy (IVE) and the treatment of miscarriages, lacks similar guidelines for treating complications derived from unsafe abortions.[249] Nonetheless, the existence of some private health entities that provide comprehensive services for the legal and voluntary interruption of a pregnancy, including contraception and post-abortion care, should be highlighted. They offer comprehensive counselling on IVE or safe abortion and if the women decide to go ahead, they do the procedure when the pregnancy is no greater than 12 weeks.[250]

In Mexico, post-abortion care provided in the specialized ILE clinics in the Federal District can truly be considered of good quality.

In Nicaragua the 1989 standards for attention to abortion established preferential endo-uterine aspiration but did not include counselling on contraception or multidisciplinary post-abortion counselling.[251] According to a 2003 report, 3.95% of the health units in the country had post-abortion care services, covering 26 health centres with bed in the first tier, 20 general hospitals in the second tier and 1 national referral hospital in the third tier. Within these services, 82% of the women with abortion complications were treated with an instrumental uterine curettage and 18% with an AMEU.[252] This means that for each AMEU there were 4.55 curettages. It has not been possible to get updated figures given the official policy of complete secrecy regarding public health statistics, especially on abortion.

In the Dominican Republic, an evaluation done in 2002 in 17 hospitals found flaws that affect the quality of care; long waits due to the high number of women who go for abortion complications, exceeding the installed capacity for this service; lack of privacy; violation of the norms and protocols; no hospital that performs AMEU; absenteeism of medical personnel; and lack of appropriate training and counselling or family planning methods. In 2007 the national emergency obstetric care strategy got underway and in 2006 the national regulations for managing the main obstetric urgencies were modified, including AMEU as a national policy for post-abortion cases in the first trimester.

Number of OBS/GYN patients admitted for complications from unsafe abortions

In Argentina 55,798 women left public hospitals due to abortions across the country in 2008, the last year of Health Ministry data.[253] In Brazil the sequential Single Health System statistic on hospital abortions in Brazil shows a reduction in the past 20 years from 344,956 cases reported in 1992 to 250,000 in 2005.

In Mexico approximately 149,000 women were hospitalized in 2006 for abortion complications.[254]

In Nicaragua the abortion records in just one Managua hospital was 5,640 between 1993 and 1996.

In the Dominican Republic there were some 122,790 induced abortions.

Number of hospital admissions due to miscarriages

In Argentina the Ministry of Health report does not distinguish between hospital releases of patients for unsafe abortions vs. miscarriages. Whether voluntary or spontaneous, they are simply listed as abortions.

Nor in Brazil does the Single Health System's Databank, which records hospital admissions for abortion, disaggregate the information on miscarriages. All women who arrive in the process of aborting are treated by gynaecologists/obstetricians as an abortion procedure; at times it is very difficult to separate the information on abortion and miscarriage unless the signs indicate an infection from induced abortion.[255]

In Mexico it is calculated that 46,097 women were hospitalized for spontaneous abortion in 2006.[256] In the Dominican Republic in 2004 hospitals and clinics treated 23,438 abortion complications, a third of them concentrated in the national maternity unit. The number of abortions recorded in the public health institutions for 2011 is 24,167.

Access to public information about abortion

Argentina does not have a federal law on access to information that is applied all over the country. Although Decree 1172/2003 of the national executive branch exists, state institutions are reticent to provide information on this and other issues.[257]

In Colombia there are no massive publicity campaigns in the media about abortion. The Ministry of Health and Social Protection has prepared videos on sexual and reproductive rights and attention to victims of sexual violence that detail aspects related to access to voluntary interruption of a pregnancy, but their circulation is restricted to health personnel training sites or to those who access the ministry's internet page. The women's organizations working on the issue have disseminated the information through printed material: folders, posters, booklets and their web pages.[258]

In countries such as Mexico, where abortion is restricted by legislation, obtaining faithful data is a challenge.[259] The Federal Health Secretariat periodically publishes statistical information

concentrating on hospitalizations due to specific maternal causes and maternal deaths due to groups of causes, including abortion.

In Nicaragua, although MINSA has Epidemiological Surveillance System that can be viewed on its Internet portal, the information is completely out of date. And when there is information on maternal death due to abortion, its magnitude is minimized via multiple disaggregations that do not allow its real causes to be known. There is no published information on maternal mortality due to abortion complications disaggregated by age groups and no official report that states the proportion of abortions treated in health installations relative to the total estimate of abortions practiced in the same defined period.

In the Dominican Republic information on miscarriages that occur in the public health institutions exists and is accessible in both the Statistics Department and the General Division of Epidemiology.

SUMMARY

Abortion

Abortion is illegal in four of the countries analyzed and the punishments range from 1 to 20 years for women who abort and from 3 to 20 years for health professionals. The punishments include reclusion, prison, forced work, closure of clinics or consultancy offices and disbarring from the practice of medicine, which reveals the patriarchal skew of the legislation.

In five countries there are circumstances in which access to abortion is not criminalized in the national legislation. When it is permitted, conditions exist on how women will be treated by doctors or licensed personnel. In four countries abortion is permitted when the woman's life is in danger; in three when her health is in danger or when rape was involved, in two when there are grave congenital malformations, in one due to non-consensual artificial insemination, in another for economic reasons and in yet another when the women is no more than 12 weeks pregnant.

In no country are the health personnel obliged to denounce a punishable abortion, although it is in the emergency wards of public hospitals where women suffer mistreatment and delays that increase the risk to their health and their life.

Twenty years after ICPD the persistence of the illegality of abortion shows that the States have not applied its recommendations. Nonetheless, it is important to mention the favourable changes in four of the six countries, such as the expansion to three causes in Colombia, where it was previously totally illegal; the decriminalization of abortion within the first 12 weeks of pregnancy in one state of Mexico and for anencephaly in Brazil. In addition, high-level resolutions have been issued in Argentina to interpret abortion due to rape positively and treat it without delays or prior denunciations, requiring protocols for its treatment.

Negative changes occurred through abolishment of therapeutic abortion in Nicaragua and the reform of the Constitution in the Dominican Republic, recognising life as commencing "from conception," which is applied as an absolute prohibition of abortion.

The positive legislation is known very unevenly by the personnel that must apply it and by women themselves. The negative attitude of officials in high posts also acts as a barrier in that they influence other professionals in the official institutions.

It is well known where it is totally prohibited by legislation and, while the double moral standard prevails, an ignorance of laws gravely and specifically affects professionals for presumed harm to "the unborn." This occurs in Nicaragua, where the legislation has granted the foetus and embryo legal recognition above women's rights.

Where abortion is permitted by law, the information provided is usually skewed to dissuade women, although in one country (Mexico D.F) services have been opened that are of very good quality, with professionals who respect women's decision and resources that are adequate to the needs. In two countries the regulations stipulate time periods for the steps needed to authorize the interruption of the pregnancy, include pre- and post-abortion counselling and oblige public establishments to have personnel who do not have conscientious objection.

Maternal Mortality

Maternal Mortality Ratio

Maternal mortality represents the degree to which the countries have made progress toward development, and specifically the recognition of women as citizens and whether they have achieved the full exercise of their human rights. It reveals the concern of the States and the legislative and programmatic development aimed at preventing and avoiding the death of women as a consequence of the reproductive process. It requires the conjunction of all state institutions coordinating with the civil society organizations to detect and deal with the risk factors of the women and of the surroundings in which they live. In Latin America the disparities in the legislation, its application and the knowledge of it by the women themselves as well as by the health personnel is insufficient and is often influenced by the religious hierarchies.

The figures officially reported by each country differ according to the sources and significant differences are even found in the same years. In general, the information on maternal mortality is

not efficient; the classification is not very reliable and comparison is difficult among the diverse countries.

In Argentina the maternal mortality rate/ratio in 2010 was 43 per 100,000 live births.[260] In the WHO reports, however, it is 77 x 100,000 live births that same year. According to the Brazilian Ministry of Health the estimated maternal mortality rate in 2010 was 56 per 100,000 live births,[261] which represents about 1,700 deaths a year.[262] Between 1990 and 2010 Brazil registered a 51% reduction in maternal deaths but it was still insufficient to reach the target set by Millennium Development Goal (MDG) 5. The maternal death ratio reported for 1990 was 140 per 100,000 live births, while in 2007 it dropped to 75 per 100,000 live births; however UNDP reports 19 points more than the Ministry of Health.[263]

The reported figures on maternal mortality in Colombia vary according to the sources consulted: the maternal mortality ratio in 2011 was 85 per 100,000 live births,[264] the lowest of all the national reports; in the WHO reports it reached 92 x 100,000 live births that same year.

The National System for Monitoring Public Health (SIVIGILA) reported 437 maternal deaths in 2011, an increase of 22 deaths (5%) compared to 2010 when 415 cases were reported. Maternal deaths in the indigenous and Afro-descendant populations reflect women's unequal opportunities for exercising control over their reproductive process.

In Mexico, according to data from the Maternal Mortality Observatory, the national maternal mortality ratio in 2010 was 51.5 for every 100,000 live births; in the WHO reports it is 50 x 100,000 live births that same year. According to the same source, the highest maternal mortality ratios were found in the following states between 2002 and 2010: Oaxaca with 88.7, Guerrero with 85.5 and Chiapas with 73.2.

In 2010[265] ECLAC published the maternal mortality rate in Nicaragua as 100 per 100,000 live births; in the WHO reports it is 95 x 100,000 live births that same year. According to the Nicaraguan Ministry of Health (MINSA), maternal mortality dropped to 71.9 per 100,000 live births in 2010.

In this report, four Local Comprehensive Health Care System (SILAIS) had a maternal mortality rate of over 100 per 100,000 live births: in the South Atlantic Autonomous Region it rose to 180.6, in Jinotega to 145.3, in León to 118.2 and in Chinandega to 100.8.[266] According to the North Atlantic Autonomous Region's SILAIS, maternal mortality had dropped to 104.8 per 100,000 live births in 2010;[267] but it then reported that maternal mortality increased to 221.7 per 100,000 live births in 2011, as the number of deaths rose from 9 to 20 in one year, more than twice the national rate reported by the government.[268]

In the Dominican Republic the maternal mortality rate of 159 per 100,000 live births, estimated by the 2007 National Demography and Health (NDH) Survey, is disproportionately high and has not significantly decreased in the last decade; undoubtedly the illegality of abortion has significantly contributed; in the WHO reports it is 220 x 100,000 live births that same year.

Confirmed maternal deaths were 190 in 2008, 215 in 2009, 201 in 2010 and 175 in 2011.[269] Since there were 201 maternal deaths in 2011, the Ministry of Public Health estimated the rate at 100 deaths per 100,000 live births.

Table 16

Maternal Mortality Ratio per 100,000 live births

Country	1990	1995	2000	2005	2010	Lifetime risk of maternal death: 1 in ...2010	ICPD Target for 2015 met*
Argentina	71	60	63	69	77	560	No
Brazil	120	96	81	67	56	910	Yes
Colombia	170	130	130	100	92	430	No
Mexico	92	85	82	54	50	790	Yes
Nicaragua	170	150	130	110	95	350	No
Dominican Republic	220	170	130	130	150	240	No

Source: WHO; UNICEF; UNFPA; The World Bank. (2012). Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. Geneva, Switzerland: WHO

Main causes of maternal mortality

Argentina is one of the Southern Cone countries that reports unsafe abortion as the main cause of maternal death and that it continues to add a significant percentage to the total number of maternal deaths. Complications from unsafe abortion have been the leading cause of maternal mortality in Argentina for more than twenty years. Its percentage in relation to the total causes of death ranges between 25% and 35%, depending on the year.[270]

For 2010, the main causes of maternal mortality in Argentina were unsafe abortion 20.5%, hypertensive disorders 11.2%, infections 10.9%, haemorrhages 12.7% and other direct causes 15.7%.[271]

In Brazil, according to Ministry of Health reports for 2009, the causes of maternal mortality were abortion 9.5%, indirect obstetrical reasons 24.5% and direct obstetrical reasons 64.1%.[272]

In Colombia, it is very difficult to apply the international classification. Numerous unclassified, disaggregated causes are reported, which we managed to recompile according to international parameters for this research. It was concluded that 52.7% of maternal deaths in Colombia occur through direct obstetrical causes:[273] hypertensive disorders 21.5%, haemorrhagic complications 18.1%, sepsis in obstetrics/gynaecology 5.9%, abortion 3%, ruptured ectopic pregnancy 2.1%, and amniotic fluid embolism 1.1%. And the rest, 48.3%, are from indirect obstetrical causes or causes unrelated to the pregnancy or childbirth or are "under study."

The National Health Institute provided other figures for 2001. The first five causes of maternal deaths were classified as hypertensive disorders 37%, haemorrhagic complications 31%, respiratory infections 12%, sepsis in obstetrics/gynaecology11%, and sepsis not in obstetrics/gynaecology 9%.[274]

In Mexico, maternal deaths are classified as hypertensive disease in pregnancy 25%; haemorrhage in pregnancy, childbirth and post-partum 19.6 %; other complications, mainly from pregnancy and childbirth 12.9%; abortion 9.3%; other complications, mainly post-partum 3.2%; sepsis and other post-partum infections 1.8%; venous complications in pregnancy, childbirth and post-partum 1.5%; obstetrical death from unspecified cause 0.4%; and indirect obstetrical causes 25.1%.[275]

In Nicaragua the national register for maternal mortality does not provide reliable data.[276] Between 1997 and 2005 the Pan-American Health Organization (PAHO) analysed 1,113 maternal deaths but reached no conclusions about the causes of maternal mortality as 41% were not classified or misclassified, among them 23% were allegedly infections and 18% completely unclassified.[277] The only thing that was clear in the study is that 33% of the deaths occurred from haemorrhages; 19% gestational hypertension; 7% unsafe abortion complications; and in the remaining 41%the causes were not defined.

Between 2007 and 2011, the real causes of maternal mortality cannot be determined from MINSA's national report as the international classification was only applied in 53.9% of cases.[278] Of the registered deaths, 46% do not correspond to international classification.[279]

In the Dominican Republic the main causes of maternal mortality are identified as hypertension induced by the pregnancy, haemorrhages, abortions and post-partum complications.[280] Between 1997 and 2007 the ratio of maternal mortality was 159 per 100,000 live births.

In 2010 the direct obstetrical causes were oedema, proteinuria and hypertensive disorders 23.2%; haemorrhage 14.6%; pregnancy terminated in abortion 11.7%; other post-partum complications 10.1%; sepsis and other post-partum infections 5.1%; other complications of pregnancy and childbirth 6.2%; obstetrical death from unspecified cause 5.1%.[281] Although official statistics place unsafe abortion as the fourth cause of maternal mortality, with 13% of the total, in the situation analysis of unsafe abortion in 2009, the real figure is estimated to be 20%.[282]

Violent maternal deaths

In Nicaragua maternal deaths are also caused from violence by spouses. Ten pregnant women were reported murdered between 1997 and 2009: three by deep gunshot wounds, three by deep knife wounds, three from traumatic cranial injury and one from hepatic trauma. None of them were entered into the maternal mortality rate as they were considered to be "indirect" deaths.[283] In just in the first eight months of 2009, the media reported 6 cases of maternal death through medical negligence in state institutions or private clinics.

In 2008, 18 maternal deaths were analysed,[284] all were considered avoidable and associated with a lack of blood, multiple shortcomings in the diagnosis and treatment of gestational hypertensive syndrome, unexpected vaginal tearing during childbirth, tearing during caesarean section through malpractice, uterine inversion through untimely manoeuvres followed by hypovolemic shock, uterine rupture by manoeuvre performed by midwife, lack of referral to more complex units, care by "traditional doctor," complications from home childbirth in areas where there are Maternity Houses, etc.[285]

Were the MDGs goals of reducing maternal deaths by 75% between 1990 and 2015 met?

The ICPD Program of Action establishes that all countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by

one half of the 1990 levels by the year 2000 and a further one half by 2015. According to WHO estimates, however, only two of the six countries analyzed will reach the ICPD goal in 2015: Brazil and Mexico.[286]

Given that the figures reported both in 1990 and in 2010 have important variations and that not all countries record and share their figures with the ICPD goals but rather with the MDG goals, it is difficult to establish with exactitude the strict fulfilment of the goals of reducing maternal mortality.

Since 1990, maternal mortality in Argentina went from 52 per 100,000 live births to a projected 38.2 per 100,000 live births for 2015. This means it will only have dropped 26.5% and not the 75% target set by the MDGs of reaching 13 per 100,000 live births. These estimates do not coincide with the maternal mortality rate in Argentina in 1999 reported by the WHO, which was 71 x 100,000 live births.

In 2010, according to the 4th Monitoring Report of the MDGs in Brazil, maternal mortality has fallen by almost 50% since 1990. The maternal death ratio reported for 1990 was 140 deaths per 100,000 live births, whereas in 2007 it decreased to 75 per 100,000 live births.[287] These estimates do not coincide with the maternal mortality rate in Brazil in 1990 reported by the WHO, which was 120 x 100,000 live births.

In Colombia, maternal mortality fell 27% between 1998 and 2009, according to vital statistics reported by the National Administrative Department of Statistics. In the last 5 years there have been no changes and the mean for this period was 74 for every 100,000 live births. The WHO estimates report 85 x 100 live births in 2010.

In 1990, the maternal mortality rate in Colombia was 170.[288] One expert stated: "The country must redouble efforts if it wants to meet the goal of 45 per 100,000 live births in 2015."[289]

According to the MDGs information system in Mexico, the maternal mortality ratio in 1990 was 89 per 100,000 live births. These estimates do not coincide with the maternal mortality rate in Mexico in 1990 reported by the WHO, which was 92 x 100,000 live births.

In 2010, it decreased to 51.5 per 100,000 live births. Between 2010 and 2015 it would be very hard for Mexico to meet the goal and reduce maternal deaths by 75%, since up to 2010 it has only managed to reduce them 42.1%. The estimated target is for 22.22 per 100,000 live births.

In 1996 the Nicaraguan government stated that "it accepts the Cairo commitment of reducing this indicator with maternal mortality estimated at 160 per 100,000 live births in 1990, to reduce this rate to 80 by 2000 and to 40 in 2015." These estimates do not coincide with the maternal mortality rate in Nicaragua in 1990 reported by the WHO, which was 170 x 100,000 live births.

Official propaganda in 2011 announced that maternal mortality had already dropped to 63 per 100,000 live births although there are no known documents to substantiate these figures. Furthermore it said that the goal is 27 per 100,000 live births for 2015, contradicting what the government itself said in 2006.[290] Assuming that official estimates can be met, Nicaragua would only have reduced maternal mortality by 39.35% in 2011, not reaching the 75% envisaged by the MDG.

In the Dominican Republic, the Ministry of Public Health estimated a rate of 159 deaths per 100,000 live births for 2010. In the 2010 MDG report it says that it is unlikely to meet the goal of 46.9 per 100,000 live births in 2014 and that trend analysis suggests that in 2015 maternal mortality will be triple the level set as a goal, given that the projection is for 141 per 100,000 live births.

Table 17

Skilled health attendants at births

In Argentina, Colombia and the Dominican Republic the percentages of skilled personnel attending births have not made significant advances between 1995 and 2003. Only Nicaragua reports important progress in that period, but it is known that this country's statistics are not reliable, as analyzed throughout the document.

Country	Skilled health attendants at births			ICPD/ICPD+5 targets for 2005 met? (by 2005, 80% of births should be assisted by skilled attendants)
	1995	2003	Latest (2008-2010)	
Argentina	97.2 (1997)	98.7	94.8 (2008)	Yes
Brazil	87.7 (1996)	NA	NA	Yes
Colombia	84.5	86.4 (2000) 90.7 (2005)	94.8	Yes
Mexico	85.7 (1997)	95.3 (2004)	93.7 (2007	Yes
Nicaragua	64.6 (1997)	89.7 (2001)	NA	Yes
Dominican Republic	95.3 (1996)	97.8 (2002)	94.8 (2007)	Yes

Source: Millennium Development Goals Indicators. http:/unstats.un.org/unsd/mdg/Data.aspx

Prenatal care

To learn the possibilities of successfully terminating a pregnancy, it is necessary for prenatal care of the women to be provided by skilled personnel who offer high quality services that include a wide range of diagnostic and therapeutic possibilities when complications are noted

Table 18

Prenatal care coverage in 6 countries in LAC

For prenatal care to be considered adequate and timely, it must be developed from the state of the pregnancy and involve at least four consultancies. All countries report coverage of at least one visit near or greater than 90%, but that is totally insufficient. When the four minimum visits are measured, the percentages drop to nearly 80% or further.

Country	Prenatal care coverage in 6 countries in LAC (%)			
	1995	2000	2003-2005	2008-2010
Argentina				
At least 1 visit, %	95 (1992)	97.5 (2001)	99.2 (2005)	NA
At least 4 visits, %	NA	NA	NA	89.3 (2006)
Brazil				
At least 1 visit, %	85.7 (1996)	NA	97.4 (2005)	96.7 (2007)
At least 4 visits, %	75.9 (1996)	NA	87 (2005)	88.7 (2007)
Colombia				
At least 1 visit, %	82.6 (1995)	90.8 (2000)	93.5 (2005)	NA
At least 4 visits, %	NA	81 (2000)	83.1 (2005)	NA
Mexico				
At least 1 visit, %	86.1 (1995)	NA	NA	97.7 (2006)
At least 4 visits, %	NA	NA	NA	88.3 (2006)
Nicaragua				

continues

Country	Prenatal care coverage in 6 countries in LAC (%)			
	1995	2000	2003-2005	2008-2010
At least 1 visit, %	71.5 (1993)	85.5 (2001)	NA	90.2 (2006)
At least 4 visits, %	61.6 (1998)	71.6 (2000)	NA	77.7 (2007)
Dominican Republic				
At least 1 visit, %	98.3 (1995)	98.5 (2001)	97 (2006)	98.9 (2007)
At least 4 visits, %	87.6 (1996)	93.5 (2001)	NA	94.5 (2007)

Source: Millennium Development Goals Indicators: The Official United Nations Site for the MDG Indicators, http://unstats.un.org/unsd/mdg/Data.aspx

Pregnancy rate and % of teenage pregnancies in total number of pregnancies

With respect to adolescent pregnancy rates, there is also a lack of reliable reports, given that there is a significantly high variation of figures from one source to another.

The adolescent fertility rate is a parameter that continues to be persistently high or has increased in recent years; it increases when the education levels are lower, when the adolescents live in rural areas and when they are poor. Shortcomings in sex education through the influence of religious hierarchies result in adolescent girls failing to prevent unplanned pregnancies, to which is added the obviously very limited involvement of adolescent boys in the prevention of pregnancy.

Analyzing the figures reported by the countries studied, estimates of the percentage of 15-19 year old pregnant adolescents or those who are already mothers in 2011 were, in decreasing order: 41% for Nicaragua, although the government reported 25%; 27.6% for Mexico; 23% for Brazil; 20.6% for the Dominican Republic and the lowest for Argentina, 15.1%.

In Argentina, according to data from the Centre for Population Studies, the early adolescent fertility rate for 10-14 year olds between 1960 and 2004 was 1.6 per 1,000.[291] According to the UN Population Division, the fertility rate for 15-19 year old adolescents in Argentina only varied from 57 to 55 between 2007 and 2010.[292] However, according to data from the National Ministry of Health the adolescent fertility rate in 2007 was 32.5‰. In 2011 the percentage of 15-19 year old adolescents who were already mothers was 15.14% of the total number of women in the same age group.[293]

In Brazil, the 2006 National Demographic and Health and Children Survey showed that 23% of the 15-19 year old girls interviewed were pregnant at that time and 12% had been pregnant but had had no live births.[294]

In Colombia, according to the 2010 NDH Survey, 19.5% of adolescent girls had been pregnant at some time. In rural areas 26.7% had been pregnant at some time compared to 17.3% in urban areas. The highest percentages of teenage pregnancies occur in girls without education, 55%, and those with only primary education, 46.5%.[295]

In Mexico, according to the 2009 National Demographic Dynamic Survey, the specific fertility rate in 15-19 year old women is 69.5 per 1,000 women. The percentage of adolescents who have already been mothers in Mexico is 27.6%.

In Nicaragua, MINSA reports that between 1998 and 2007the fertility rate in 15-19 year old adolescents dropped 23.74% in 9 years, from 139 per 1,000 adolescents in 1998 to 106 in 2007.[296] In 2010, an independent investigation totally contrasted with the official figures. Lion, Prata and Stewart reported that the adolescent fertility rate in Nicaragua is the highest in the world, with the exception of Africa, and is higher than the overall Sub-Saharan rate: 127 births for every 1,000 adolescents.[297]

According to the United Nations Population Fund (UNFPA), the teenage pregnancy rate dropped 33% between 1993 (101.1) and 2006 (99.9), and that this rate only dropped 1.2 points in the last six years. Up to July 2012,[298] 41% of Nicaraguan pregnancies occurred in adolescents and young adults.[299] UNFPA reported that to July 2012, pregnancies in 10-14 year old girls increased 47% in 9 years, from 1,066 in 2000 to 1,477 in 2009.

In the Dominican Republic, the percentage of 15-19 year old adolescents who were already mothers or pregnant for the first time in 2007 was 20.6%.[300] In women from rural areas this percentage was 20.4%. In adolescents without education it was 42.2% compared to 3.6% in women with higher education; 30.5% for those in the lowest wealth quintile compared to 5.7 % for those in the highest quintile.

SUMMARY

Existence of Sexual Reproductive Health Services

The impact of the Programme of Action agreements is evident in the countries of the region that were studied. The institutionality and regulations have been strengthened, although unequally. In only one country is there a specific law on sexual and reproductive health, while there are national policies in three; national programmes in three; models, guides or national norms of attention in six; and national strategies in two, which reflects the progress on the issue after the ICPD.

The services included in the public health system vary by country, with the provision of contraceptives in three, teenage pregnancy in three including friendly services, reproductive health for men in one, and safe maternity or maternity health in six, including prenatal attention, institutional attention to birth, puerperium, emergency obstetrics, abortion and post-abortion.

One country and one state in another country include attention to the voluntary interruption of a pregnancy, while all six countries provide attention to STI, HIV and AIDS, with different provisions; one country addresses lesbians in a specific programme, three countries refer to having health attention in violence against women and two have programmes and protocols. Cervical cancer is mentioned in four countries and breast cancer in two with specific programmes, while only one country offers attention to male cancer. None have post-reproductive health services and two provide infertility and sterility services, one with a specific law and other with a policy on the issue.

Women's organizations and other NGOs exist in two of the six countries studied that provide comprehensive health care services and have specific programmes for the coverage of all target populations, especially directed to women and adolescents.

Maternal Mortality

There are enormous statistical difficulties in analysing maternal mortality by cause due to the international classification being misapplied or to disaggregation, which creates tremendous confusion and demonstrates the poor quality of national registers.

Only Argentina reports the five causes established in the international classification; the Dominican Republic reports seven different causes; Colombia and Mexico report eight causes and Nicaragua reports nine different causes.

Only two of the six countries studied can achieve the ICPD of reducing the number of maternal deaths in 1990 by 75% by 2015: Brazil and Mexico; followed by Colombia 43.5%; Nicaragua 37.5%; Argentina 26.5%; and the Dominican Republic 25%. However, if official estimations alone are taken in account then Nicaragua has reduced maternal mortality by 55% and the Dominican Republic by 46.8%.

The adolescent fertility rate is a parameter that continues to be persistently high or has increased in recent years and raises when the education levels are lower, when the adolescents live in rural areas and when they are poor. Shortcomings in sex education through the influence of the religious hierarchies results in adolescent girls failing to prevent unplanned pregnancies, to which is added the obviously very limited involvement of adolescent boys in the prevention of pregnancy.

Cancer of the Reproductive System

The available information on cancer of the reproductive system in the reports of the six countries of Latin America and the Caribbean is not fully organized. On occasions some type of information is found, but not on all countries and not necessarily presented the same way.

Incidence of breast and cervical cancer

Cervical cancer is currently the malign neoplasm with the highest incidence in women from underdeveloped countries. It has become a serious public health problem, and is the second cause of death at a world level, producing around 300,000 deaths a year.[301]

Lesbian women may run a greater risk than heterosexual women of developing breast cancer because on a small percentage of them have gotten pregnant compared to heterosexual women.

According to the reports of the six countries studied in Latin America, it can be deduced with regard to breast cancer that Argentina has an incidence of 35.7% in women over 15 years old and the figure in Nicaragua is 14.6%.

In Brazil there are an estimated 52,680 new cases of breast cancer per year in 2012.

In Colombia breast cancer occupies first place with nearly 7,000 new cases each year, followed by cervical cancer with 5,600 cases per year. The incidence of breast cancer is estimated at 31.2 and of cervical cancer at 21.5 new cases per 100,000 women.

In Mexico breast cancer is one of women's main health problems. It has had a 30% increase in the past 20 years, going from a rate of 13.1 per 100,000 women of 25 and older in 1990 to 17 in 2010.

In Nicaragua the cervical cancer rate in 2002 was 13.9 per 100,000 women over 15 years old. In that year, 6.8% of the women with this type of cancer were between 15 and 34 years

old; 30% occurred between 35 and 49 years old and 63.2% were over 50 years old.

Access to prevention PAP tests and treatments

Argentina, Brazil, Mexico, Nicaragua and the Dominican Republic report that the diagnosis, treatment and follow-up of women with cervical and breast cancer are provided by public hospitals and through social security, private insurance and the welfare medical clinics. Despite the fact that the services are free, women face inequalities in access to them.

In Brazil the proposed PAP coverage must be 100% but there are no data of the effective coverage in any of the three subsystems: public, union-financed *Obras Sociales* or private.

In the context of oncology services, 85% of the supply in Colombia is in the private sector, despite the fact that since 2007 the requirements for approval of oncology services have become more stringent. In recent years a proliferation of services has occurred that are generally dedicated only to a therapeutic modality and do not respond to a comprehensive treatment process for users with cancer.

In 2000 the available information shows that 76.6% of Colombian women between 25 and 69 years old have had a cytology in the past three years and 50% in the past year. A study in four departments showed that 49% of the cytologies were false negatives, which confirms the low sensitivity of this test as well as the need to make efforts with respect to quality. As regards the follow-up to women with abnormalities in their cytology the same study showed that six months after the report of their cytology, 27% of the women with detected intraepithelial lesions of a high degree has still not had a definitive diagnosis via a colposcopy or biopsy, or if they had, they had not received treatment.

In Colombia the recommendations for the early detection of breast cancer include a biannual mammogram check-up in women between 50 and 69 years, an annual clinical breast examination and self-examination as a test that permits women's greater knowledge of their breasts and the possibility of consulting with respect to changes in them.[302]

In Nicaragua the percentage of women who have had PAP tests in the last year is not known, but the PAP coverage has gone from 6.25% in 1995 to 11% in 1999, then dropped to 9.3% in 2009; 6 of the 17 SILAIS in the country have lower coverage than the national. Of the women interviewed, 47% have had a PAP test in the past 12 months, and 98.4% of the women in the urban area and 94.9% of those in the rural area said they know about PAP.[303] In the Social Security system, 11,300 PAP smears were reported in 1995 and 28,700 in 2002, although it is not known what percentage of the total number of insured women is covered by this examination.

En Nicaragua the Social Security Institute in 2011 reported having done 62,257 Papanicolaou smears, finding 1,155 with alterations (1.85%).[304]

In the Dominican Republic, the Papanicolaou coverage among women of fertile age does not reach 10% and was concentrated in those under 25 years old. They also indicate that the loss of detected cases before being adequately treated is very high.[305]

Cervical cancer and the vaccine against the Human Papillomavirus

The greatest repercussion for public health of the vaccine against Human Papillomavirus (HPV) will be recorded in the low and medium income countries where a large proportion of the population has limited or no access to screening and early treatment of precancerous lesion and where the treatment of cancer and the palliative care continue to be insufficient. With respect to the medium income countries, Mexico has been one of the first to present a public vaccination programme against HPV.[306]

Of the six countries studied, three of them do not have vaccines against HPV. Brazil, Nicaragua and the Dominican Republic do not have specific norms due to the high costs and still do not have a defined position by their national health system.

In Argentina in 2011, the vaccine against HPV was added to the vaccination calendar to immunize all girls of 11 years old for free. It is financed with funds from the National Vaccination Programme and the National Programme to Control Cervical Cancer.

Recently, Colombia's Ministry of Health and Social Protection has included the vaccine against HPV within its Expanded Vaccination Programme. This vaccine is to be introduced in two phases; the first will start in August 2012, exclusively for school girls in public and private educational institutions who are in fourth grade of primary schools and at the time of the vaccination will have turned nine years old. The second phase is to begin in February 2013 for girls not in school who live in urban and rural zones in populated and rural centres of difficult access. The Ministry will make an investment of close to US$26 million in the introductory phase of the vaccine.[307]

In Mexico the HPV vaccine was added to the vaccination calendar in 2011 and was initiated by the Ministry of Health to also vaccinate for free. There are different types of vaccines to prevent cervical cancer and these vary by age. For 9-year-old girls three doses of a vaccine are applied against infection by the Papillomavirus with six-month spacing between each of the three. For women of 25 to 34 years old the Pap smear is done. The Papillomavirus is done on women from 35 to 64. In addition, the informative material provided is translated into eight languages.

In Nicaragua the vaccine is not found at the Health Ministry level. It exists in the country privately and has a high cost so is not accessible to the entire population. In 2010, at the initiative of Ixchen, an alternative women's centre, the Sectoral Programme of Cervical Cancer Prevention and Treatment, made up initially by 23 authorities of the State and civil society. Attention was provided to 4,437 women in 15 clinics, with a Pap smear done on 68,550 women over three years in 12 departments of the country. They found 4,437 early lesions and 201 users with carcinomas. The diagnosis was confirmed for 2,643 (60%) through biopsy, finding low and high grade lesions, invasive and relapsing carcinoma of the vaginal vault. Of those, 44% (1,154) presented HPV, 24% (624) NICI-HPV, 14% (375) had NICIII-HPV, 11% (288) NICII and 7% (201) carcinoma of invasive scaly cells.

The Dominican Republic does not have the vaccine for the Human Papillomavirus. In the Women's Hospital in 2009, of 853 biopsies done up to October 13 cases of cervical cancer and 396 cases of HPV were found. In a study done in the Luis Eduardo Aybar Hospital between January 2003 and January 2004 the incidence of infection by HPV was 52%; by civil status single women presented the greatest incidence with 46%, followed by married women with 30.48% and women in a free union with 16%. The age group with the greatest incidence was from 29-35 with 25%, followed by the 36-42 group with 20% and that of 43-49 with 19%. This study also found that the younger the first sexual relationship the greater the incidence of HPV, with 42% corresponding to women who had their first relationship between 13 and 16 years old.[308]

Mortality from cervical cancer

In Brazil the gross mortality rate from cervical cancer in 2003 was 4.7 per 100,000 women. Between 1980 and 2003 the risk of death tendency remained stable for women between 30 and 59 years old and increased significantly for those of 60 and older. The analysis of mortality from cervical cancer presents a limiting factor, which is the high number of cases of cervical tumours codified as not from a specified part, which was 29% and in some States up to 50% of the cases of cervical cancer. With respect to cervical cancer according to the record of the Secretariat of Health between 2000 and 2010, the deaths have dropped from 4,514 to 3,869 in all ages. The distribution by age among young women between 10 and 29 years of age was 63 deaths in 2010.[309]

The death rate from cervical cancer in Nicaragua is 17.8 per 100,000 women; 8 of the 17 departments of the country report a rate of 47 greater than the national rate.[310] The age group most affected is 50 and older, followed by the 35-49 age group. It is important to underscore the presence of deaths from this cause in the 15-34 age group.[311] The main cancer treatment services in Nicaragua are centralized in the capital and few have been implemented in the departments. Chemotherapy treatments are scarce and many women do not have access to them. Over 65% of women with cancer come from hard to reach communities.

In 2000, at least 76,000 cases of cervical cancer and 30,000 deaths are estimated for the region in general, which represents 16% and 13% of the world total, respectively. Therefore the countries of Latin America are found in a geographic area with some of the highest incidence rates in the world.[312]

In Argentina cervical cancer generates 3,000 new cases per year and annually causes more than 2,000 deaths, although it is totally preventable if detected early and the lesions are treated.[313]

In Brazil, 4,800 deaths from cervical cancer and 18,430 new cases were presented in one year. The county's capacity to do early diagnoses has advanced; in the nineties 70% of the cases were diagnosed as invasive illness; currently 44% of cervical cancer is diagnosed in the in situ or non-invasive stage. Women diagnosed on time receive adequate treatment, and have a virtually 100% possibility of cure.

Mortality from cervical cancer in Mexico has maintained a falling tendency in the past 15 years, with a rate of 25.3 deaths per 100,000 women of 25 years and older in 1990 and 14.6 in 2006, which represents a 45% drop.

At the level of the Americas, Nicaragua is in second place for the highest levels of morbi-mortality from cervical cancer after Haiti, and with a tendency to increase. In 2005, 2,227 women were diagnosed with cervical cancer compared to 1,688 in 2000. Nonetheless, it is estimated that the dimension of the problem is much greater, becoming the main cause of death in Nicaraguan women as a product of a complex causal structure.[314] Mortality from cervical cancer in women over 15 years of age rose from 17.6%[315] to 75% in 2000 and 61% in 2001.[316] Mortality data from PAHO between 1996 and 2001 indicate a persistently high mortality from cervical cancer standardized by ages in Nicaragua of up to 26 deaths per 100,000 women. In Nicaragua 45% of mortality from cervical cancer occurs in women between 20 and 34 years old.

Table 19

Cervical cancer risk, mortality and incidence in 6 countries in LAC - 2008

Country	Incidence			Mortality			5-year prevalence		
	No.	%	ASR (W)	No.	%	ASR (W)	No.	%	ASR (W)
Argentina	3,996	7.6	17.5	1,809	6.3	7.4	13,241	9.6	86.3
Brazil	24,562	15.3	24.5	11,055	12.6	10.9	80,309	18.9	110.7
Colombia	4,736	15.3	21.5	2,154	12.5	10.0	15,347	19.2	94.0
Mexico	10,186	15.5	19.2	5,061	12.8	9.7	34,294	20.5	86.7
Nicaragua	869	27.2	39.9	414	21.8	20.6	2,956	35.6	158.4
Dominican Republic	1,299	20.0	29.7	591	15.6	13.7	4,279	25.5	126.0

Incidence and mortality data for all ages. 5-year prevalence for adult population only. ASR (W) and proportions per 100,000

Source: GLOBOCAN 2008, International Agency for Research on Cancer.http://globocan.iarc.fr/

Mortality from breast cancer

In Argentina, Brazil, Mexico and the Dominican Republic, breast cancer represents the first cause of death by cancer in women.

Argentina records a mortality rate from breast cancer of 20.1% and Nicaragua of 9.1%. Brazil, Colombia and Mexico range between 12% and 14%. The Dominican Republic recognizes that this type of cancer causes 35% of the deaths from malignant tumours.

In Colombia the mortality rate adjusted by age for both cancers is 10 per 100,000 women. The recent information on mortality from cervical cancer shows a reduction in the mortality rates in general and mainly affects the most outlying and poor populations. The tendency for mortality from breast cancer at the national level is clearly increasing, with 60% of the cases diagnosed in advanced states, while a slight drop is beginning to be observed in cervical cancers.[318] Breast cancer presents its greatest incidence in the urban areas and cervical cancer in the outlying departments, border zones and banks of the major rivers.

In Brazil, according to data of the Health Secretariat, 35,823 women died from cancer during 2010; 5,062 from breast cancer and 3,959 from cervical cancer.

The gross mortality rate from breast cancer in Brazil in 2003 was 10.4 per 100,000 women. The mortality risk tendency from this cause in the 1990-2003 period showed a significant increase in all age groups, with the exception of the group from 60 to 69 years old. The Southern region presents the highest rates.[319]

In Mexico the number of deaths from breast cancer in women 25 and older has increased year after year, from 3,468 in 2000 to 5,062 in 2010. Of the total number of women who died in 2010, 44 are women within the 20-29 age group. The greatest number of deaths per year occurred between the ages of 50 and 59, reaching 622 women.[320]

In Nicaragua breast cancer rose to 5.8 per 100,000 women above 15 years of age in 2002, with 53% of the mortality between ages 20 and 34 occurring from breast cancer.

Breast cancer in the Dominican Republic has become a serious health problem and the number of women who turn to medical consultations is alarming. During 2005 breast cancer causes 17% of the deaths from cancer among Dominican women. The mortality rate of 6 per 100,000 women is the main cause of deaths among the population of 15 to 49 years old.[321] Nonetheless, other sources report other data: between 2002 and 2005 the mortality rate from breast cancer in the Dominican Republic was 12.1 and cervical cancer was 13.3 per 100,000 women of all ages.[322]

Table 20

Estimated breast cancer incidence and mortality in 2008

Country	Estimated Incidence Age-standardized incidence rates per 100,000	Mortality Age-standardized mortality rates per 100,000
Argentina	74 (18,712 cases)	20.1 (5,873 deaths)
Brazil	42.3 (42,566 cases)	12.3 (12,573 deaths)
Colombia	31.2 (6,655 cases)	10 (2,120 deaths)
Mexico	27.2 (13,939 cases)	10.1 (5,217 deaths)
Nicaragua	22.9 (468 cases)	8.6 (173 deaths)
Dominican Republic	32.7 (1,422 cases)	12.1 (522 deaths)

Source: GLOBOCAN 2008, International Agency for Research on Cancer http://globocan.iarc.fr/factsheet.asp

Prevention of prostate cancer

Although health promotion activities aimed at the early detection and monitoring of prostate cancer have increased in recent years, they have been more focused on the practical aspects of the manifestations, signs, symptoms and treatment than on prevention. Educational activities mostly disregard cultural forces and beliefs that form attitudes and the decision to take part in certain diagnostic tests, such as the digital rectal examination (DRE), which compromises the traditional concept of masculinity and other elements of Latin American machismo. This problem creates communication barriers that affect both health sector activities as well as access to the services from people at risk for prostate cancer.[323]

In Argentina, the Ministry of Health does not publicise prevention campaigns or specific programmes for prostate cancer. These services are provided through the Adult Care Programme. Certain organizations and both *Obras Sociales* and private insurance companies carry out campaigns for the prevention of prostate cancer. In Brazil, the second cause of death is prostate cancer (12%) and that of the stomach (11%).[324]

In Colombia prostate cancer is the second only to gastric cancer as the cause of death by cancer in men. Although one in every twenty men contract prostate cancer in his lifetime, only one in 100 men will die from this disease. The mortality rate from prostate cancer is increasing in Colombia and has tripled in the last 30 years.[325]

Currently there are no possibilities in the near future of checking for a decrease in its incidence or expand the chance of its cure; to do so would stress the need for early diagnosis and timely treatment. The 2009 statistics show the probability of 1 in every 6 men suffering from prostate cancer, proportionally much greater than for breast cancer, which is estimated 1 in every 9 women.

Timely detection though the Prostatic Specific Antigen[326] and the DRE are the primary resources for an asymptomatic population. The best way to diagnose prostate cancer is a combination of these two tests, since the first fails to diagnose 30-40% cases when used exclusively and the second, if it is the only test, fails by 20%, while the two combined only loses 5% of positive cases. In Colombia, according to the technical standard for early detection of changes in adults, the DRE is part of the physical examination for men over 45 years of age. Despite having the option of having diagnostic tests for prostate cancer, not all men do it.

Among Mexico's current health programmes, there are none specifically dedicated to the prevention of prostate cancer. However, the 2001-2006 National Health Programme contained an action programme for the prevention and monitoring of prostate cancer whose strategy was "To address emerging problems through the explicit definition of priorities," among which was promoting healthy lifestyles and preventing specific risks among the most exposed sectors of the population, as well as the timely detection of cases and early care of the sick.

According to the Nicaraguan Ministry of Health, prostate cancer is a disease that mainly affects old men, 75% of the new cases diagnosed are in men aged over 65. Nevertheless, incidence in men aged 50 to 59 has increased. In Nicaragua

prostate cancer ranked as the fourth leading cause of death by cancer in 2007, 2008 and 2009. Nicaragua has a limited number of people trained to manage this disease and few material resources to address this increasing health problem.

In the Dominican Republic there are no official statistics on prostate cancer, neither is there an early detection programme for the disease and the only studies and research we found were by surgeons specialized in urology.

The highest cancer mortality rates are recorded among the population aged over 65 years of age, the main cause of death being a malignant tumour of the prostate, with 122 deaths for every 100,000 people aged 65 and over. The age group with the least number of deaths from cancer is under 15 years of age, leukaemia being the main cause of death from cancer in this group. The main actions for preventing and monitoring cancer in the Dominican Republic are contained in the Strategic Plan for Comprehensive Prevention and Monitoring of Non-Communicable Chronic Diseases 2008-2015.[327]

SUMMARY

Cancer of the reproductive system

Genital and mammary cancers have become the malignant neoplasm with the greatest incidence in women from underdeveloped countries.

The reports of the six countries studied are uneven due to the lack of organized information and of a recording system that is applied in a common manner.

The greatest incidence of cervical cancer is reported in Nicaragua with 27.2% and the lowest in Argentina with 7.6% in women older than 15 years old. Brazil, Colombia and Mexico range around 15%.

Nicaragua reports the highest mortality rate with 21.6% and Argentina the lowest with 6.3% but this varies according to whether the source is official or independent. Also in Nicaragua the percentage of deaths by from this type of cancer is 75% of the malignant tumours in women. Brazil, Colombia and Mexico range around 12.5%.

Both cancers are progressively affecting increasingly younger women. New cases are frequently reported among those between 20 and 25 and at times younger.

The quality of the Papanicolaou cytologies is mentioned as low in two countries, with the percentage of false negatives high, and the supply of oncology services is usually centralized in urban areas.

With respect to cervical cancer, its prevention is reported as 76.6% of women with Pap smears in Colombia versus 10% in Nicaragua, which results in the late detection and high mortality this country reports. Brazil shows important advances in early diagnosis of these growths.

ENDNOTES

[162] Ibid.
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CHAPTER 4

sexual health and sexual rights

CHAPTER IV. SEXUAL HEALTH AND SEXUAL RIGHTS

This chapter monitors the status of the AIDS pandemic in the six countries of the region, including the legislation, policies and programmes to combat it under sexual health. It also reports on the sexual rights of adolescents and young adults, with emphasis on sex education, an issue that causes no few controversies, especially in the field of legislation or access to services, as occurred during the Cairo Conference. In addition, sexual rights and respect for sexual diversity are taken up, as well as sexual violence against women.

STI / HIV and AIDS

Legal framework on HIV and AIDS: Does the legislation protect the human rights of people living with HIV/AIDS and is it complied with?

Women are the visible face of the speed with which the HIV and AIDS pandemic spread through the region is embedded in the global crisis that also struck the countries studied—and also obeys women's lack of power in the patriarchal society. It is subject to factors such as sexual behaviour patterns and insufficient access to information, the lack of formal and informal sexual education, limited use of condoms and, to complicate the scenario further, restrictions imposed by the religious hierarchies in all the countries.

The law in Argentina makes no substantive statements about the rights of people with HIV.[328] An HIV detection test is often compulsory when applying for a job.

A new constitution was established in Brazil in 1988 with a strong human rights focus, including articles that guaranteed legal protection against discrimination and defended rights related to free health care, including the legal opinion CFM No.14/88 that sets non-discriminatory ethical standards.[329] In 1996 the law was passed about the free distribution of medicines to people living with HIV and those with AIDS.[330] Subsequently, a decree was issued about alternative breastfeeding methods for HIV+ women,[331] as well as the decree for the rapid testing of women for HIV so as to give counselling on breastfeeding.

Since 2001, there has been an agreement in Brazil that includes making most HIV medicines available and also infant formula for children exposed to HIV for their first six months. In addition, Resolution 3443, from 2006, also provides guidelines for HIV care.

The Penal Code in Colombia contains an article that specifies that a person who knows he/she has been diagnosed as HIV+ and behaves in such a way to put another person at risk of infection is committing a crime punishable by a prison sentence of 8 to 12 years. There is a Sexual and Reproductive Health Policy, the programme management model, Decree 1,543, and Law 972 which bans laboratory testing to determine HIV infection as a mandatory requirement in different situations.[332]

In the Mexican Constitution there is a federal law since 2003 preventing and eliminating discrimination and the Official Mexican Standard for HIV Prevention and Care that guarantees the specific rights of people living with HIV. Since 2012, there has been an HIV law in Mexico City with a gender perspective, the Law for HIV/AIDS Prevention and Comprehensive Care.

In 1996, Law 238 was approved in Nicaragua for the promotion, protection and defence of human rights in relation to AIDS, and in 1999 its regulations were passed. Law 238 recognises and emphasises the human rights of those living with HIV and their families.[333] The Law for the Comprehensive Promotion of Young Adults establishes that "information should be provided about sexual and reproductive health, especially about teenage pregnancy, unwanted pregnancies, unsafe abortions, STDs and HIV/AIDS.[334]

The Nicaraguan AIDS Commission created by Law 238 includes the representation of nine State institutions and three civil society organizations, but since 2010 it no longer summons the civil society representatives from the National Commission for the Fight against AIDS.

At national level the Dominican Republic guarantees the effective protection of human rights referred to in Article 8 of the Constitution through Law 135/11 about AIDS and other related laws such as 24-97 about Intra-family Violence that punishes discrimination; the General Health Law 42-01 and the Law creating the Dominican Social Security System.

Since 1999, the National Programme for Reducing the Vertical Transmission of HIV and AIDS and in 2004 the National Programme for Comprehensive Care coordinated by the National Directorate for Sexually Transmitted Infections and AIDS, which is a dependency of the Ministry of Health and Social Attention, and is additionally the regulatory body for HIV and AIDS programmes.[335]

Do laws and policies exist against HIV and AIDS stigmatization and discrimination?

In three countries the legislation focuses on protecting the human rights of people living with HIV and AIDS, and three countries also have laws against discrimination.

In Argentina the Law and Programme for Sexual Health and Responsible Parenthood include anti-discriminatory policies.[336] In the workplace there is a refusal to accept people who live with HIV. Discrimination was reduced in schools but there are still problems with families of classmates accepting boys and girls with HIV.

Brazil signed UNAIDS' Declaration of Commitment about HIV/AIDS that establishes the goal of eliminating all forms of discrimination against people living with HIV/AIDS.

In November 2011, Colombia passed Law 1,482 which modifies the Penal Code and establishes that people who commit acts of discrimination based on race, ethnicity, nationality, sex and sexual orientation will incur extremely severe penalties, both criminal and economic. This recently proclaimed law has still not been regulated but it is a breakthrough in the conditioning of the legal framework protecting the sexual and reproductive rights of the LGBTI community and of people living with HIV.[337]

Despite the fact that Mexico has anti-discrimination legislation, most human rights violations of people living with HIV are related to the workplace, where diagnostic tests are required for recruitment. Furthermore, health services violate the confidentiality of diagnosis and discriminate against people at all levels of care for their serological status, even resulting in death which frequently occurs as a consequence of services being denied or delayed.

Although the primary goal of Nicaragua's Law 238 is to promote and protect the human rights of people living with AIDS, it does not ensure non-discrimination in health care in terms of sexual orientation, modes of transmission, nationality, age and sexual activity.

In the Dominican Republic stigma and discrimination are punishable under Law 135-11. It guarantees non-discrimination and fair treatment, penalising discriminatory or stigmatising practices in both public and private arenas against people living with HIV and AIDS, their family members and close associates.

Reproductive rights of HIV+ women

Women's sexual and reproductive health is inherently linked to HIV; good quality, non-discriminatory reproductive and sexual health services are a fundamental component of successful programmes for HIV prevention and treatment. In practice, however, HIV+ women frequently face discrimination in the reproductive health services including delays in care, verbal abuse, pressure not to have children, forced or non-consensual sterilization, or they are denied the care they seek, so violating their rights.

In Argentina the Law for Sexual and Reproductive Health does not explicitly deal with the sexual rights of HIV+ women, but obviously incorporates them.[338] In Brazil, according to the provisions in decree No. 766, the recommendation of the Ministry of Health is that HIV testing be offered to all pregnant women, regardless of risk factor identification. Abortion in Brazil is only legal if the pregnancy results from a rape or if the pregnancy endangers the women's life,[339] however, HIV/AIDS is not considered life threatening.

In Colombia there are no specific references to the reproductive rights of women with HIV; their right to have children is protected through effective prevention of perinatal HIV transmission.

In Mexico the reproductive rights of women with HIV are protected in the Official Regulations and in the 2012 Guidelines on the Antiretroviral Management of CONASIDA, which includes the provision of contraceptives to women with HIV. Despite advances, there are three main abuses of HIV+ pregnant women's human rights such as the right to non-discrimination: it is very common for HIV+ women to have to wait to the last for a gynaecological consultation, take their own disposable supplies or pay an extra fee for them and endure delays on entering the operating room, even for Caesarean sections, once the health staff becomes aware of her diagnosis.

In Mexico there are problems with the right to relevant information and informed consent about health procedures. Women with HIV are under pressure to end their pregnancy, or they are coerced to accept surgical sterilization because they live with HIV. There is misinformation and pressure so that women with HIV adopt the contraceptive methods the staff consider suitable for them, without their wishes being even considered.

Women with HIV in Nicaragua cannot ask for their pregnancy to be terminated since the National Assembly repealed therapeutic abortion in 2006, which means they are forced to remain pregnant despite having expressed their decision to discontinue it.

In the Dominican Republic, article 17 of the HIV and AIDS Law No. 135/11 protects the reproductive rights of people living with HIV, however in practice this article's implementation is affected and these rights violated by the absolute criminalization of abortion provided for in the Penal Code and by certain constitutional constraints, such as article 37, which establishes the inviolability of life from conception until death. The National Programme for the Reduction of Vertical Transmission only prioritizes their care and that of the newborn. Furthermore, contraceptive provision and counselling and gynaecological care are not listed among the services of specialized units caring for people living with HIV.

Estimated number of people living with HIV

With respect to HIV, not all countries have equal statistical information, making it difficult to make comparisons as they vary in the criteria for collecting information, the indicators applied and the consolidation of the information. The number of people living with HIV or AIDS shows the institutional capacity to prevent and stop the pandemic in different groups and both sexes, as well as the extent of its advance. In recent years, the total estimated number of people in the six countries of the region ranges between 1.46 million and 1.1 million.

Of the six countries, only Colombia, Mexico and Nicaragua mention their country's official statistics under-reporting information. The only statistics Nicaragua has are from the Ministry of Health, which are difficult to interpret as they are not published regularly and in a timely manner and do not include a qualitative analysis incorporating gender, generational, multiethnic and multicultural indicators.

In Argentina there were an estimated 130,000 people living with HIV[340] in 2010. From 1980 until June 2011, a total of 608,200 AIDS cases were identified in Brazil: 397,662 (65.4%) men and 210,538 (34.6%) women. However this difference has decreased over the years which can be seen by checking the man/woman ratio.

In Colombia, despite declared under-reporting, an estimated 500,000 people are living with HIV.[341] Some reports total HIV, AIDS and deaths at 78,683 people from 1983 until 2010. In 2010 alone 7,174 were reported, of whom 5,070 were people living with HIV and 1,344 had already developed AIDS, 743 had died and 17 were unclassified: 76% men and 23.3% women. More than 18,000 people have already died.[342]

The National Centre for the Prevention and Control of HIV/AIDS in Mexico (CENSIDA), reports 157,529 cases of AIDS up to June, 2012: 17.9% women and 82.1% men.[343]

From 1987 until 2011, Nicaragua reported 6,864 people affected by the epidemic: 177 living with HIV, 695 having already developed AIDS and 941 have died. In the Dominican Republic the number of people living with HIV was 57,000 in 2009.[344]

Table 21

HIV and AIDS Estimates and Data, 2009 and 2001

The spread of the AIDS epidemic in the countries analysed is unequal and reflects the responsibility with which the States have responded to control the propagation of its transmission. With respect to the total population, the figures in the Dominican Republic indicate the least growth, with 5.5% between 2001 and 2009, while Nicaragua had the greatest growth with 86.4%.

With respect to women living with HIV, the Dominican Republic had an increase of 10.3%, while the increase in Brazil was 112.4% and in Nicaragua was 90%. In all countries the velocity of the increase of the epidemic in women exceeded that of the increase in the general population.

Colombia is the only country that reports both a smaller total population and fewer women living with HIV in 2009 than in 2001. Among the countries under review the estimated people living with HIV has declined only in Columbia (210,000 in 2001to 160,000 in 2009). The same trend is seen in the number of women (15+) living with HIV where this has declined from 65,000 in 2001 to 50,000 in 2009. Under-reporting is so great that national estimates brought this figure up to more than 500,000 individuals in 2010.

Estimated People Living with HIV- Adults and Children and Women (15+) living with HIV

Country	Estimated People Living with HIV (PLHIV), Adults + Children		Women Living with HIV (WLHIV) (15+) (Estimate)	
	2001	Latest (2009)	2001	Latest
Argentina	80,000	110,000	25,000	36,000
Brazil	(380,000- 560,000	460,000-810,000	(80,000 – 330,000	140,000 – 210,000
Colombia	210,000	160,000	65,000	50,000
México	180,000	220,000	41,000	59,000
Nicaragua	3,700	6,900	1,100	2,100
Dominican Republic	54,000	57,000	29,000	32,000

Source: Informe Global sobre VIH/SIDA 2010 de ONUSIDA.

Feminization of the epidemic. Ratio of HIV+ men/ women

According to the reports of the countries analyzed, the feminization of the epidemic is manifest and sustained: the Dominican Republic has the highest percentage of women living with HIV or AIDS, 56.1%; Mexico has the least with 26.8%.

The epidemic's feminization is notable in the six countries studied in Latin America. The man/woman ratio is almost equal in all countries with the exception of Mexico which has a ratio of 4.6 men to one woman.

In Argentina the man/woman ratio in new infections was 7 to 1 in 2010.[345] In women aged 15-24 years it was 1 to 0.9, while in those aged 15-19 years it was 1 to 0.8.[346] The man/woman ratio in Brazil in 1989 was 6:1; changing in 2010 to 1.7 to 1.

Overall, the epidemic in Colombia has involved 74.0% men and 26.0% women; the man/woman ratio went from 10 to 1 in the 1990s to 2.6 to 1 in 2011.[347] The HIV epidemic by sex shows a growing involvement of women; for every HIV+ woman in 1988 there were 13 men and by 2008, it is estimated that for every infected woman there are two men, according to data from the National HIV Observatory.[348]

According to the 2012 national progress report in the fight against AIDS from CENSIDA in Mexico, the man/woman ratio is 4.6 men to one woman.

In 2011, of the 1,171 people newly diagnosed as HIV+, 61.94% were men and 38.05% women, giving a man/woman ratio of 1.62: 1. In 1997, the ratio was 16 men for every woman, making the feminization of the epidemic unquestionable in Nicaragua. In mid-2011, 66.5% of those newly reported aged 15-19 years were women. Also 61.5% of new HIV+ cases in the 20-24 year age group were women.

In the Dominican Republic the male/female ratio has been equalizing and in 2003 was calculated at 16 a 1. In 2007 the relationship was 7 to 1, however current HIV prevalence in the general population is the same for men and women: 0.8%.[349]

Estimated number of women living with HIV

If the total estimated number of women living with HIV in the six countries studied in the region, it ranges between 300,000 and 370,000, which shows how greatly the pandemic has affected women

In Argentina, the overall number of women affected is 54.418, which is 37.5% of the total; there were 20,407 HIV+ women in 2010. It is estimated that there are 6.7 HIV+ women per 100,000 women.[350]

In Brazil some 210,000 women are living with HIV: 0.4% in women and 0.8% in men.[351] The percentage of Colombian women aged 15 and older living with HIV in 2009 was 33%.[352] The number of women aged 15 or older in 2009 was 50,000, ranging between 38,000 and 65,000.[353]

Mexico reports 220,000 people living with HIV, of whom 59,000 are women. There were 28,163 reported cases of AIDS in women up until June 30, 2012[354] which amounted to 27% of the total.[355] In the Dominican Republic, there were 24,245 women aged between 15 and 49 years living with HIV and AIDS in 2007 and this dropped to 22,765 in 2011.[356]

The estimated number of women living with HIV in the Dominican Republic ranges between 32,000 and 34,630, which is between 56.1% and 60% of the total.[357]

Are antiretroviral services available in the health system? Social security coverage

The six countries studied mention that regulations and protocols are established for access to antiretroviral services in the health system, however users are subjected to a slow and tedious process in order to receive them, which results in their preferring not to attend because of the many inconveniences.

In Argentina national law requires free HIV and drug coverage by all three segments of the health care system: the union-managed and financed public health care known as *Obras Sociales*; voluntary private insurance and the mandatory social security insurance. Since 1996, Brazil decided to provide free antiretroviral treatment to all people living with AIDS,[358] regulated in the National Policy on Sexually Transmitted Diseases, HIV and AIDS. In Colombia, antiretroviral treatments are included in the Mandatory Health Plan.[359]

UNAIDS estimates that Mexico has 57% antiretroviral coverage for people with HIV; sex disaggregated data has not been obtained. By the end of 2011, of the 1,686 people in therapy 1,595 were adults and 91 children. It is estimated that 2,730 people—both adults and children—need antiretroviral therapy but they can only manage 62% coverage.[360]

In the Dominican Republic, Law 135-11 on HIV and AIDS guarantees access to antiretroviral treatment but Regulation 002 of the National Social Security Council explicitly excludes antiretroviral treatment from social security.

Number or percentage of women receiving antiviral treatment over the total of female HIV carriers

It has not been possible to reliably estimate the extent of people's antiretroviral treatment coverage, nor that of women with

advanced HIV infection who need treatment. Nor is information available on the coverage of social security attention.

In 2011, the National AIDS programme in Argentina found that approximately 30,000 people were receiving treatment provided by the Ministry of Health; 41% were women.[361] In 1996, Brazil passed the law on free distribution of medicines to people living with HIV and those with AIDS.[362]

The Ministry of Health in Mexico reports 11,027 women receiving antiretroviral treatment in the second quarter of 2012.[363] In Nicaragua, the precise national figure of women requiring antiretroviral treatment or of those who are effectively receiving it is not known. In 2011, of the 106 pregnant women with HIV registered, 100 (94%) received prophylaxis to diminish mother to child transmission. In Nicaragua, 34.6% of the people who receive antiretroviral treatment are women.

Although all countries contemplate the provision of antiretroviral treatment for pregnant women, in the Dominican Republic it is not included in social security. Almost all the antiretroviral medicines in the Dominican Republic are being covered by the Global Fund for HIV and AIDS, Tuberculosis and Malaria, which funding will end in 2015. At this time, through a process that should begin in June 2013, the government will assume 100% responsibility for the drugs whose cost amounts to U$1,550,000.[364] According to PAHO's estimates, dependency on international cooperation for antiretroviral treatment is high, representing 75% to 100%.[365]

It was estimated that in 2009 there were 19,410 people with advanced HIV infection, of whom 7,820 were men and 11,590 women; there were 12,912 adults and 873 children receiving antiretroviral treatment, with coverage of 71.02%.[366] Coverage of pregnant women with HIV with antiretroviral therapy was 46.98% of the estimated total.

Sexual and reproductive health care exists for people living with HIV

According to the existing laws, policies and programmes in the countries studied, there should be sexual and reproductive health care available to people living with HIV, however the countries do not comply with providing all forms of care, and most do not provide comprehensive care, which causes problems affecting the quality of care that is provided.

Almost all the countries stipulate counselling before and after testing; confirmatory diagnostic testing is almost always available. There are almost no monitoring systems for women at risk. Efforts are made to culturally influence young people of both sexes with the most risk of exposure to HIV, promoting actions and public campaigns. This takes place in all the countries, especially through the efforts of civil society organizations.

In Argentina there is sexual and reproductive health care for people living with HIV but it is not easy.[367] Women living with HIV or AIDS are often not attended to because it is believed that they should not have children. In other cases professionals from the Sexual Health and Responsible Parenthood Programme believe they should just use condoms, refusing to inform them about other methods.

Since 1997, with Brazil's inauguration of the first HIV Testing and Advisory Centre (CTA) and the consolidation of counselling as a decisive practice in the prevention of STIs, research into the testing service has indicated that the CTA is very relevant through its informative capability and attention to users.

In Colombia sexual and reproductive health care is included in the Mandatory Health Plan, as is the provision of condoms to people with HIV or AIDS. Also included are prompt testing for syphilis, the relocation of HIV screening tests in first level care and confirmatory tests in secondary level care, the purchase of supplies to implement the strategy of eliminating mother-to-child HIV transmission, aimed at pregnant women not affiliated into the system.[368]

In the specific programmes for HIV and sexual and reproductive health in Mexico, there is no mention of the reproductive health of women with HIV, their integration reduced to promoting condoms and limited support so that women with HIV can exercise their right to decide about having children. They are not offered contraceptives or comprehensive advice on safe pregnancy in all levels of public services.

Sex workers living with HIV

HIV+ sex workers face many difficulties in getting their clients to use condoms and receive various forms of physical and psychological abuse from the health services. HIV prevalence among sex workers is highest in Argentina at 6% and lowest in Mexico at 0.6%.

In Argentina, the prevalence of HIV+ sex workers was 6% in 2010.[369] In Brazil, sex workers still face many barriers to condom use, such as being victims to violence, increased payment for unprotected sex and competition for clients. A 2009 study found that although 90% of sex workers reported having used a condom with their last client, only 55% reported having used one with all their clients. HIV prevalence among sex workers in Brazil is 4.9%.[370]

A 2008 study of sex workers in Colombia showed prevalence to be higher than the national average. In Medellin it was 1.2%, in Cali 1.7%, in Bucaramanga 3.8% and in Barranquilla 4.5%.[371] A 2011 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report in Mexico showed 0.6% prevalence in female sex workers.

In 2011, HIV prevalence among female sex workers in Managua was 1.8%; 2.4% in Chinandega and one incidence of 0.8% was found. Of those interviewed, 76.9% in Managua and 91.5% in Chinandega referred to consistent use of condoms with frequent clients and 94.8% in Managua and 91.9% in Chinandega consistently used condoms with new clients, both during the last 30 days. Condom use with their steady partner during their last sexual encounter was reported by 72.6% men and 49.4% women in general.

In the Dominican Republic, in 2008, the first surveillance survey on behaviour in vulnerable populations with serological connections—gays, transsexuals and other MSM, sex workers and drug users—reported that HIV prevalence was 4.8%.[372] This information is not disaggregated by affected population.

Prevalence of STIs

The same types of statistics from a single comparable source are not found in all countries, which makes it impossible to make comparisons from one country to another. In Argentina, a 2010 study of syphilis and HIV in postpartum women reported the estimated prevalence of syphilis among women throughout the country at 1.32%.[373] In Brazil, according to estimations from the World Health Organization, the annual numbers of sexually transmitted infections are as follows: syphilis 937,000; gonorrhoea 1,541,800; chlamydia 1,967,200; genital herpes 640,900; and HPV 685,400. Between 1999 and 2011, 343,853 cases of viral hepatitis were reported.[374]

In Colombia, the 2010 NDH Survey reported that of 43,966 women interviewed who had had sexual relationships in the last 12 months, 9% had problems allegedly related to STI.

In Nicaragua, 2,400 STI events were reported in 2011 making a national incidence rate of 40.8 per 100,000 showing an increase of 5% compared to 2010. The most common sexually transmitted infections are: Condyloma acuminata 46%; gonorrhoea 35.4%; acquired syphilis 14.5 % and one case of congenital syphilis. Gonorrhoea and Condyloma acuminate account for 81% of the STIs. There is low notification and search for congenital syphilis.

In the Dominican Republic, according to the NDH Survey, 9% of the sexually active women interviewed suffered some STI in the last year. Prevalence was higher among adolescents and young people aged 15 to 29 years, in the rural population and in women with fifth to eighth grade primary education.[375]

SUMMARY

STI / HIV and AIDS

Legal progress in the care of people affected by HIV-AIDS is universal; all the countries have specific laws protecting various rights. In three countries legislation is focused on protecting the human rights of people living with HIV or AIDS; there are also three countries with laws against discrimination. Progress has been made in formulating national strategies for the prevention and protection of affected people's human rights, ensuring voluntary and confidential testing, prohibiting tests being required in order to start or keep a job. Discrimination in health services and elsewhere is punishable. Public services are required to provide comprehensive care to people living with HIV. In one country, the provision of infant formula is legally established. Antiretroviral treatment is free in all countries although it does not cover all those who need it.

However, these important formal breakthroughs are not complied with to the same degree or comprehensively in all the countries. Many violations of human rights are reported; laws are not complied with; HIV tests are requested in order to enter employment; there is discrimination against people for their sexual choice or gender identity, whether male or female, etc. Furthermore, people do not always know about facilities for complaints about discrimination—or they are not always functioning—and neither do they ensure a satisfactory resolution in all cases.

Training for public service personnel is adhered to in most countries but is insufficient. Civil society organizations are not incorporated into programmatic policy decision-making bodies in all countries, although there are various levels of involvement.

There is increasingly more sensitivity about undertaking actions from a perspective of equality of gender and recognising and incorporating gender specifics into the standards and protocols for HIV+ people.

Legislation in three countries establishes the rights of women living with HIV or AIDS to reproduction and to receiving comprehensive sexual and reproductive health care.

The quality of the public care services for women is only considered to be good in Brazil and complete in Colombia. Different

problems are reported in Argentina, Mexico, Nicaragua and the Dominican Republic. Women often suffer the worst kinds of abuse of their human rights in that they are forced to wait until the last for medical consultation; their surgical operations are delayed, even caesarean sections; they have to bring disposable supplies; there is verbal abuse and pressure to terminate their pregnancies; there is no contraception or an imposition of contraceptive methods chosen by the provider; priority is given to the foetus or newly born infant and their needs ignored; requests for pregnancy termination are denied in three countries, all of which demonstrates that women's reproductive process is a further opportunity for oppression by the patriarchal system.

The number of people living with HIV or AIDS shows the institutional capacity to prevent and stop the pandemic, in different groups and both sexes, as well as the extent of its advance. In recent years the total number of people living with HIV or AIDS in the six countries of the region ranges between 1.46 million and 1.1 million.

The total estimated number of women living with HIV in the six countries studied ranges between 400,000 and 420,000 showing how greatly the pandemic has affected women; in Brazil alone, there are 240,000 women, which is 60% of the total.

Although all countries contemplate the provision of antiretroviral treatment for pregnant women, in the Dominican Republic it is excluded from social security. It has not been possible to reliably estimate the extent of people's antiretroviral treatment coverage, nor that of women with advanced HIV infection that need treatment.

HIV+ sex workers face many difficulties in getting their clients to use condoms, in addition to various forms of physical and psychological abuse from the health services. HIV prevalence among sex workers is highest in Argentina, 6%, and lowest in Mexico at 0.6%. This information contradicts the high use of condoms in Argentina and their low use in Mexico.

Adolescents' Sexual Rights – Sex Education

Does sex education legislation exist?

The Cairo Conference was a singular scenario in the debate about the rights of adolescents and young women; the contradictions of that moment are reflected in the Latin American and Caribbean region, especially in the countries where the religious hierarchies exercise major control over the authorities of almost all branches of government. Nonetheless, the advances are significant and the positive influence of the Programme of Action is totally demonstrable.

Sex education is legally regulated by legislation in Argentina,[376] Brazil,[377] Colombia[378] and Nicaragua.[379] Each one has particular features that depend on the progress and importance with which the States and governments are committed to this obligation.

The approaches and levels contained in these laws are adopted in different ways by the educational establishments in each country. The law has not been fully implemented in Argentina, which is a problem. The national Ministry of Education has prepared materials for staff training and also those to be used in direct activities with the students at each level from preschool to third year. In Brazil sex education is a mainstream subject throughout basic education covering many different dimensions and identities, so that it brings together scientific information and promotes ethical principles ensuring the subjective comprehension of identity and giving guidance in sexual and emotional choices.

In Colombia the law in the regional decentralization and autonomy framework establishes competencies for each educational institution, accompanied by the respective Secretariat of Education, to formulate its own projects in accord with the regional characteristics and needs.

In Mexico, although various laws have been proposed, it has not been possible for adolescent and young peoples' sex education to be upheld in the Political Constitution.

The General Education Law and the National Law for the Protection of Children and Adolescents which are based on international treaties such as ICCPR, ICESCR, CCR and the CEDAW.

In addition, it is recognized in three international documents; the ICPD's Programme of Action, the Declaration of Commitments in the Fight against HIV/AIDS and the Declaration "Prevent with Education."

In Nicaragua, the Children and Adolescents Code establishes that, since 1998, "girls, boys and adolescents are entitled to receive a comprehensive, objective, guiding, scientific, progressive and formative sex education that develops their self-esteem and personal respect for responsible sexuality, the State will ensure sex education programmes through schools and the educational community."[380] It has not been respected by any government and furthermore adolescent women suffer the consequences of not having sex education with very high percentages of HIV and unplanned pregnancies.

The National Policy for the Comprehensive Care of Children and Adolescents was passed in 1996 and reformed in 2001[381] but it does not mention that there must be specific regulations and protocols in the health services for these age groups with attention to quality. The Policy for Special Protection of Children and Adolescents, passed in 2006, contains the principles, objectives and strategies that state institutions and society in

general must incorporate in order to safeguard and restore the enjoyment of children and adolescents' rights against threats or abuses of the same. The existence of both policies has not meant recognition or respect for the rights of adolescents in Nicaragua, especially in the area of sexuality, reproduction and non-violence. The Dominican Republic has no legislation regulating or establishing sex education.

Conflicts in the implementation of the legal framework: With which sectors?

All countries report the religious interference—especially that of the Catholic hierarchy—as conflictive as it negatively influences enabling adolescents and young people access to information about issues of sexual and reproductive health, which is why teenage pregnancies, STIs, HIV and AIDS continue without effective prevention measures, as well as why male adolescents and young adults do not exercise their sexuality responsibly.

In Argentina 2010-2011, this right is not guaranteed in schools, not even in the provinces that have their own laws about sex education and have a more progressive debate on the issue. This is mainly due to conflict with the Catholic Church[382] and other conservative religious and/or political sectors. The exceptions are the provinces of Santa Fe—which has advanced the most—and La Pampa, which has advanced but not so far. The deferment is very considerable and there are exceptions according to the schools' directors.

In Brazil there is a lot of conflict through the implementation of sex education policies in schools. The government has already made several attempts to put these policies into practice, but they are always blocked by the Catholic Church which does not accept the Ministry of Health progressing in this area. Even considering that the 1988 Federal Constitution declared Brazil to be a secular country, the Church's hierarchies always continue to be a controlling element, pressuring and reversing the implementation of any policy related to these issues.

There are many academic studies about sex education in Brazil and the formation of educators that emphasise the importance of teacher training. The Ministry of Education says that of 989 universities, 41 offer 68 courses in pedagogy in which the subject of sexuality is present in some discipline. However, in most of the universities it is offered as an "option," so that it is not compulsory to take the course. Their contents include gender, body/corporality, sexual diversity, biology/education, health/education and not just "sex education" or "sexuality."[383]

In Colombia there are difficulties in ensuring that teachers are qualified in all the subjects that have been defined having a cross-disciplinary focus in terms of education, including the issue of sex education. Furthermore, there are difficulties in each educational institution with articulating these projects with other programmes that address the subject such as Healthy Schools and the good treatment network. One of the big problems is the opposition in religiously affiliated schools to implementing sex education programmes in an appropriate manner.

In Mexico there is direct conflict with the Ministry of Education; pressure had to be asserted for the subjects of sex education and sexual rights not to be removed from the formal curriculum. In addition, very little is invested in training teachers—especially female teachers—with a gender and sexual rights focus which are novel and the teaching staff do not understand them. In 2007 and 2008 the Ministry of Education bought books opposed to the legal framework, with religious instead of scientific values about contraceptive methods and the effectiveness of condoms, and distributed them alongside the official textbook.

In Nicaragua—after ICPD—during the 1990s, successive governments expressed their opposition to sex education for adolescents and young people in state institutions on the grounds that parents should not "cede" to the state an issue that pertains exclusively "to the family." Regarding which, in the decree that creates the Ministry of the Family it states "that the State recognises that parents are the primary and principal educators...."[384]

In February 2002, the National Programme for Sexual and Reproductive Health was withdrawn from MINSA through pressure from ecclesiastical hierarchies; Nicaragua spent four years without any programme on sexuality and reproduction. Also in 2003, the Ministry of Education withdrew the "Manual for Life," a sex education text for teachers, by order of the Catholic hierarchy. The "Pro Life" Catholic groups, evangelical groups and the Archbishopric mounted an intense campaign against the manual accusing the Ministry of Education of "promoting abortion and homosexuality and trying to break up families".[385] The Cardinal celebrated the withdrawal of the manual announcing that he counted on "a commission of moralists and theologians to makeover the document."

In the Dominican Republic the difficulties in adopting a legal framework for sex education are the result of interference from the Catholic Church hierarchy in public policy decision-making in the area of health, sexuality and reproduction, based on the existence of the Concordat between the Vatican and the Dominican Republic signed in 1954 during Rafael Leonidas Trujillo's dictatorship.

Is sex education from a human rights perspective included in formal education?

There is no fundamental similarity among the countries regarding sex education from a human rights perspective being included into formal education as part of the official education

programmes. It is noticeable that the countries are gradually taking steps to abandon a paternalistic, risk perception approach for one focusing on rights that acknowledge adolescents and young people as individuals with rights and is aimed at ensuring their freedom, responsible decision-making and promoting their citizenship as social participants.

In Brazil the human rights perspective is included but not complied with because of conflicts with religion; the programmes realized include aspects of equity and non-discrimination.

In Mexico they are regulated through the civics and ethics curriculum that explicitly addresses adolescents as individuals with rights, promotes gender equality and sexual rights awareness.

In Nicaragua during the 1990s pressure groups lobbied on behalf of the State against sexual and reproductive health services for adolescents and young people in all international forums because "they violate parental authority," as parents should know what kind of enquires their children are making and what kind of care they receive; violating the confidentiality and respect due to the young people. They refused to acknowledge the magnitude of the HIV/AIDS epidemic and its impact on adolescents and young people. For more than a decade they argued that Nicaragua was the country in Central America with the least number of HIV+ people and publicly opposed the use of condoms for protection against HIV/AIDS. Various consultants, speaking on behalf of the government, published newspaper articles attacking the use of condoms and modern, scientific, sex education, the use of modern contraceptive methods and the citizens' rights of adolescents and young adults.

Public budget allocated to sex education

Colombia is the only country that specifically includes sex education as a separate entry in its budget.

Legal status of adolescents regarding access to sexual and reproductive health services

Some countries have enacted new laws incorporating the focus of reproductive rights and sexual and reproductive health rights. In all the countries the Convention on the Rights of the Child, which has constitutional status, is accepted as the legal basis for the right of adolescents and young people to information, education and services, however, the laws, regulations, standards, plans and programmes do not reflect the real needs and interests of adolescents and young adults.

So, in Argentina there is the Law for the Comprehensive Protection of the Rights of Children and Adolescents[386] that guarantees the right to comprehensive health; the Law for Sexual Health and Responsible Parenthood;[387] and the Law for Patients' Rights, Medical History and Informed Consent.[388]

Before 1998, Nicaragua did not have legal regulations to promote the right of adolescents to sexual and reproductive health information and services; however the Children and Adolescents Code did not establish provisions for sexual and reproductive health services. Since 2002, the Law for the Promotion of Comprehensive Young People's Development[389] establishes that the health institutions must ensure services for young people, which are unknown to most of the population and therefore to adolescents and young people.

The Dominican Republic's Code for the System of Protection of the Fundamental Human Rights of Children establishes that "All children and adolescents are entitled to be attended on issues of health, nutrition, early stimulation, physical development, sexual and reproductive health, hygiene, a clean environment and accidents. Likewise, both they and their immediate family members have the right to be informed, in a truthful and timely manner, about their state of health, according to their stage and level of development."

Reproductive rights of young adults

The right to decide on the number of children and the spacing between the births, as well as access to information and the means to exercise this right is, to a greater or less extent, in the constitutions of Argentina, Brazil, Colombia and Mexico.

In Mexico, as in Nicaragua, the principles underlying processes promoting the full exercise of reproductive rights and guaranteeing access to family planning and reproductive health services are recognised in the National Population Policy.

In 2006, the Brazilian government drafted a conceptual framework of the sexual and reproductive rights of adolescents and young adults, which is contained in the Ministry of Health's publication "Sexual rights, reproductive rights and contraception."[390] This document envisaged respect for these rights within the framework of human rights and the right to care, free from prejudices and coercion.[391]

In Mexico, existing legislation is instrumental in the creation of the National Youth Institute. This has involved legal loopholes on the direct recognition of reproductive and sexual health rights of young people, mainly in the latitude of those over- and under-age and their entitlement to rights in the exercise of their sexuality.

In this respect the reproductive rights of young people are linked to general laws which make specific mention of this part of population. The General Education Law and the General Health Law only refer to responsible exercise of sexuality, family planning and information about the inappropriateness of pregnancy before the age of 20.

With regard to sexual and reproductive rights in Nicaragua, Law 392 for the Promotion of Comprehensive Development of Young Adults establishes "that it should contribute to a healthy and responsible education promoting respect for sexual and reproductive rights, responsible and safe paternity and maternity, as well the prevention of sexually transmitted diseases." The right to continuity of education for girls, pregnant adolescents and mothers has been established in the Children's Code since 1998 and in Law 392 which defines the guaranteed provision of free primary and secondary education as well as that young adults should not be excluded from the state educational system for reasons of sex and that adolescent girls in particular should not be excluded because of pregnancy or breastfeeding.[392] Both laws are not complied with and adolescent girls are frequently separated from the educational system by pregnancy.

Meanwhile in the Dominican Republic, although reproductive rights are provided for in the Youth Law, the Law on HIV and AIDS and the Code on the fundamental rights of Children and Adolescents, in practice they are not implemented, primarily affecting women. For example, the strategic plan for the prevention of pregnancy in adolescents states that in the case of school drop-out, the main reason mentioned by the male population was associated to factors within the system while a significant proportion of girls left school to get married and 37.2% because of pregnancy.

The educational sector continues to discriminate against pregnant adolescents, despite Law 136-03.[393] On the other hand the media needs regulating in terms of its handling of adolescents and sexuality and using the image of women as a sex object. Therefore, in general terms, the sexual rights and reproductive rights are not incorporated or specified in public policies.

Adolescent-friendly services with national coverage

Range of services for adolescents

In Argentina, the Programme promotes and disseminates the rights of adolescents to independent access the health system, without the mandatory presence of an adult, and within a framework of respect and confidentiality. Regarding differentiated services, the Ministry of Health created and distributed a guide with recommendations for comprehensive adolescent-friendly care in quality arenas.

In Brazil, the Adolescent Health Programme was established in 1989 in order to promote comprehensive health, regulate actions in priority areas including sexuality and reproductive health.[394] In addition a National Comprehensive Health Programme for Adolescents was created to implement comprehensive care adaptable to local conditions in each of the country's regions.[395]

In Colombia there have been many initiatives, programmes and projects on the subject of sexual and reproductive health, most of them only aimed at prevention and with a sectoral vision focussed on a biological perspective, implemented by promoting and distributing contraceptive methods to population groups and by campaigns to control sexually transmitted infections. However, they have not always classified the population groups by age, gender and sexual orientation and have overlooked fundamental aspects of how promoting rights and the diverse socio-cultural characteristics of the Colombian population will end up affecting sexual behaviour.[396]

In terms of public health care services, Mexico has the National Centre for Gender Equity and Reproductive Health; the Sexual and Reproductive Health Programme for Adolescents, and also, at national level, the Ministry of Public Education's adolescent-friendly services. Programmes for adolescents aim to promote information, education and communication activities in order to raise awareness among different audiences about the importance of prevention, adoption of healthy behaviour in sexual and reproductive health so as to reduce the risks of unprotected sex and to promote the benefits of exercising their sexual and reproductive rights responsibly.

In Nicaragua a Comprehensive Attention Model for Women, Children and Adolescents was defined in 1995. Services were integrated and a National Plan of Attention to Adolescents defined. Clinics for adolescents were set up in municipal centres and in Managua's Bertha Calderón Hospital. Despite this extensive set of rules and regulations, most of the public health services do not have differentiated care for adolescents, who should be the priority group. The National Strategic Plans for the Prevention of HIV/AIDS do not establish special provisions for dealing with adolescents, despite the blatant feminization of the epidemic among teenage women.

Programmes in the Dominican Republic do not have national coverage, which is consistent with the fact that there is no legislation establishing mandatory services for adolescents and young people. There are actions that are basically aimed at preventing and treating HIV and AIDS. Meanwhile, the National Programme for the Comprehensive Health of Adolescents considers that comprehensive care should be provided in a continuous, humane and timely manner through the promotion, protection and maintenance of physical, mental and social health in order to help reduce adolescent morbidity and mortality.

Access to information, education and services for unmarried young people

Throughout the region, the 15-29 year old age group comprises about 28% of the total population, a significant percentage that

indicates that health care and services have important competition from unmet demand due, among other causes, to social differences, high fertility rates, poverty and incomplete coverage.

Adolescents and young adults of both sexes are accessing information, education and services, not through the will of governments but because women's organizations develop programmes for prevention, care and training and through concern about the teenage pregnancy situation, feminization of the HIV and AIDS pandemic and the high incidence rate in violence against women at all stages of their lives.

While there is a clear need to increase the dissemination of information on sexual and reproductive health, starting with the very young, as well as to expand services for adolescents and young adults so as to ensure them access to comprehensive health, a timely, scientific, quality education and a decent life, there are inequalities in how this commitment is adopted by the countries being studied. The situation of adolescents and young adults is not resolved just by the existence of these services, but by their being adapted to their needs and accepted by the users and made geographically, economically and conceptually accessible.

In Argentina, adolescents and young adults in Argentina have access to information, education and services, however it is not determined whether this is a consequence of their marital status. These activities almost always result from the personal initiative of those involved rather than institutional programming.[397] More than as a consequence of their being married or not, the problem is if they are already pregnant and/or have children, from that moment on they are cared for.

In Brazil, specific, differentiated, services for young people are part of the comprehensive health care for children and adolescents. The Ministry of Health develops information campaigns on the right to sexual and reproductive health, activities for young people and finances activities in the States and municipalities; civil society organizations also develop similar activities.

Brazil makes available a wide range of contraceptives and it has specific programmes to deal with adolescents and young adults of both sexes, with special emphasis on providing services about HIV and AIDS. Access to contraceptive methods is through the primary health care system and although there are no formal barriers to access, or to emergency contraceptives, there is interference from religiously motivated or conservative health authorities. Condoms are liberally distributed, even in schools, despite actions by conservative and fundamentalist groups against these measures.

Colombia has made significant progress in its care for adolescents since it has individual services providing general medical advice and consultation, sexual and reproductive health, sexual rights and reproductive rights, contraceptive methods, prevention and treatment of violence, HIV and AIDS. It also provides collective services that include talks, group learning and peer group interaction, as well as a reference and cross-reference system linked to other health services and other public, private or outreach organizations that enable follow-up in specific cases.

For 28 years the Comprehensive Services for Women Foundation (SI Mujer) has been providing sexual and reproductive health services in the south western part of Colombia. It is a pioneer in the provision of comprehensive care to the victims of sexual violence. The services offered ensure comprehensive care for adolescents and young adults of both sexes. Similarly it offers a free, comprehensive care service to survivors of rape and sexual abuse. The service includes medical and psychological care and basic legal advice for cases where the victims decide to report the abuse.

Since the decriminalization of voluntarily terminating a pregnancy on three grounds, in 2006, the Foundation also offers support to women requesting abortions so that the health authorities respect their rights.

In Mexico services include prevention, information and use of contraceptive methods for adolescents. The Mexican Social Security Institute has rural care centres for adolescents and the Ministry of Health has adolescent-friendly services. The General Division for Indigenous Education grants scholarships for adolescent mothers through its PROMAJOVEN programme.

In Managua, Nicaragua, the Reproductive Health Centre for Adolescents is run within the Bertha Calderón Hospital facilities. In 2011 it reported having attended to 10,240 users of whom 98.46% were women; of these 6.14% were aged 10 to 14 years and 93.85% aged between 15 and 19 years.[398] Nine of the girls aged 10 to 14 years were reported as "married." They attended to 155 pregnant girls in this same age range and to 3,887 pregnant adolescents aged 15 to 19 years.

In Nicaragua, although they opened municipal adolescent houses and a care service for adolescents specializing in sexual and reproductive health in Managua, the adult focus seriously limited the influx of the target population, making the initiative unsuccessful.

Simultaneously the women's organizations created centres for education and attention to adolescents from the gender and generational perspective that survived with the exclusive efforts of its members given that international cooperation has almost completely withdrawn from Nicaragua and the lack of governmental support has been constant since the early nineties.[399]

In the Dominican Republic the services provided through the different institutions are contraceptives, sexual violence, sexual exploitation, sexually transmitted infections, HIV/AIDS; domestic violence, responsible sexual behaviour, prenatal care, counselling, health promotion and education, gynaecology and early detection of cervical and breast cancer, monitoring growth, development and sexual maturity. According to the Ministry of Public Health only 50% of the country's provincial health directorates have incorporated differentiated care for adolescents in at least one of their services' network of establishments and of these only 17% are working properly. The programmes aimed at young people are not classified according to their marital status.

SUMMARY

Sexual Rights of Adolescents. Sex Education

In all the countries there are legal regulations governing the sexual rights and the reproductive rights of adolescents. The right to sexual education is established in four of the six countries analysed, as is the stipulation that continuity of education is guaranteed to pregnant adolescent girls. Brazil is the only country that reports having a mainstream focus for sexual education in the public curriculum that addresses many distinct dimensions and identities; two countries have healthy schools and adolescent-friendly services which seek to address their needs comprehensively. In only three of the countries being monitored does the public middle-school curriculum incorporate the perspective of gender and human rights so as to facilitate adolescents' access to information and sexual and reproductive health services.

Others reported obstacles by the permanent interference of the Catholic religious hierarchy. Conflicts come from the church authorities, although the Constitution in two countries establishes the secular character of the State, powerful sectors within the governments themselves also oppose the implementation of national legislation on sex education, supported by like-minded conservative and political groups. To stop the spread of religious fundamentalism, women's organizations maintain a tenacious defence of adolescents' and young peoples' rights as citizens, creating specialised centres in three countries for comprehensive health care, education and disseminating information in the communities, ensuring access to the very youngest groups of sexual diversity, indigenous and Afro-descendent peoples.

Legal regulations concerning adolescents' access to information and sexual and reproductive health services has made significant progress: the six countries of the region promote them as the rights of adolescents and there are few legal constraints to their being exercised; regulations and protocols are adopted into the public health system that include quality care for adolescents in matters of counselling on: the prevention of violence and sexual exploitation, responsible sexual behaviour, sexual development, contraception, pregnancy, childbirth, post-partum, sexuality, sexual violence and HIV-AIDS, including the free distribution of condoms and, in two countries, the legal termination of a pregnancy.

Although there are sexual health and reproductive health programmes aimed at adolescents, considered to be of good quality, their differentiated needs are not always taken into account, they are not well known, centralised in urban areas, and the care depends on the criteria of the staff providing it.

Sexual Rights

With respect to the information contained in the title of this chapter, it includes what is available by country in the following order: Right to choose one's partner, early marriage, child marriage, forced and arranged marriage, average and legal age to marry. Not all that information exists in all countries, so it is impossible to make comparisons between countries on each issue.

Information is not available on early sexual initiation, early marriage and child marriage in all countries. The information on sexual rights is not recorded in the same way in all countries and some do not have it available at all.

Right to choose one's partner

In Brazil it is common practice to choose one's partner freely, especially since the country underwent intense urbanization

In Mexico there are advances in the Federal Civil Code on the issue of marriage. Free choice of marriage is recognized in article 162 for men and women without distinction, eliminating coercion or arrangements. A sexist, adultist approach continues to be applied in the distribution of matrimonial obligations between men and women as well as between adults and minors.

Median age for first sexual relationship

In Brazil, in contrast to what common sense assumes, among young men the median age for their first sexual relationship occurs at 16.2 years and among girls at 17.9 years. The age of initiation of men's sexual activity does not change as a function of social variables such as education, income, religion and race/colour and is fairly homogeneous. This is not so in the case of women who present significant variations according to limitations of this type. Women from lower classes usually have a sexual relationship earlier than the rest. Nevertheless, girls of all social strata who are committed to their education tend to postpone the start of sexual relationships, which is not the case with boys in the same situation. In Nicaragua the average age to initiate sexual relations for women is 17.8 years old while in Colombia and the Dominican Republic it is 18.1.

Forced marriage

There is no evidence of child marriage or arranged or forced marriages, but it has been denounced that at least 65,000 girls of 11 years old are united in matrimony in Brazil, including with older men.[400]

With respect to the freedom to choose a partner, Mexico is the only country where it is reported that the Federal penal Code specifically recognizes protection against forced marriage.

Mean and legal age for marriage

Only in Brazil is it known that the mean marrying age is 16.2 among males and 17.9 among women.[401]

In Argentina, in accordance with the Law on legal age[402] one is considered an adult at 18 years old, the age at which men and women can marry. So-called "minor adults" between 14 and 18 years old may marry with a dispensation from the courts, in other words, not with their parents' permission, and are irrevocably emancipated from the moment of marriage and beyond its duration.[403]

In Brazil, the legal age for contracting marriage is 18. Marriages of minors require the consent of the father or tutor, and are admitted by justice in exceptional cases.

The legal age for marriage in Colombia is 18, the age determined to cease being a minor. In general heterosexual couples have no impediments to marry after age 18. There is no known documentation on systematic practices of forced marriage or child marriage.[404]

In Mexico in 2009 adulthood was set at 18 via Law 26,579, the Civil Code was modified and the minimum legal age for contracting marriage for both sexes was lowered from 21 to 18 years old. Article 148 determines that young women can marry at the age of 14 and men at the age of 16 with the consent of parents or grandparents. Despite not having full citizenship rights they acquire binding responsibilities. There is more discretion given to young women's rights if these relate to marital duties, in contrast to their political rights. Only from the moment they get married can they achieve the emancipation of civil rights, according to article 641.

According to the law in Nicaragua, the minimum age for marriage is 14 for women and 15 for men, giving girls of that age responsibility to assume the obligations marriage holds in store for women in a patriarchal society.[405] It does not explicitly recognise the right of women and men to make free and informed choices about their sexuality and reproduction.

In the Dominican Republic the minimum age for marriage without the consent of parents or guardians is 18. However, girls can get married at 15 and men at 16 with their parents' consent.[406] It was determined that 38% of women between 25 and 29 had been married before they turned 18.[407]

Table 22

Legal age and median age at marriage

In five countries men and women have legal authorization to contract marriage at the same age, whereas in Nicaragua it is 18 for the woman and 21 for the man. The only country that protects women up to 21 years of age before no longer requiring consent before marriage is Brazil. Colombia permits the marriage of girls from 12 years old with the consent of adults, whereas in Argentina and Nicaragua it is required until age 14. The mean age for initiating sexual relations is lower in Brazil than in Colombia or the Dominican Republic.

Country	Women	Men	Median age of at first sex for women age 25-49 years (Measure DHS)
Argentina	18, exception 14 but requires parental consent	18, exception 14 but requires parental consent	NA
Brazil	21, exception 16 but requires parental consent	21, exception 16 but requires parental consent	16.2
Colombia	18, Exception 12 requires parental consent	18, Exception 14 requires parental consent	18.1 (2010)
Mexico	18, Exception 16 but requires parental consent	18, exception 16 but requires parental consent	NA
Nicaragua	18, Exception 14 requires parental consent	21, Exception 15 requires parental consent	17.8 (2001)
Dominican Republic	18, Exception 15 requires parental consent	18, Exception 16 requires parental consent	18.1 (2007)

Source: Indicators on Women and Men / United Nations Statistics Division http://data.un.org/DocumentData.aspx?q=legal+age+of+marriage&id=294

Women's rights to physical integrity. Traditional practices harmful to women

In Argentina the Law for Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women[408] notes obstetric violence among the forms of violence against women such as caesarean sections and obstetric abuse, although there are no statistics for either. The Beijing+15 study mentions complaints on the basis of individual cases not registered officially. The study conducted in the City of Rosario in 2003 on Human Rights in reproductive health care in public hospitals by the Latin American and Caribbean Committee for the Defence of Women's Rights (CLADEM) Argentina,[409] concerns a wide casuistry on obstetric violence.

Brazil is a signatory to all the international women's human rights documents: CEDAW, ICPD, Beijing Platform, Declaration of Human Rights in Vienna, Convention of Belem do Para, which prohibit traditional practices that are dangerous to women. However, there are serious allegations in the country on the existence of 65.000 girls from age 11 upwards living as married, after having been victims of statutory rape by people known or unknown to them and subsequently surrendered by their parents to adults, as evidenced by reports recently published in the Brazilian press.[410]

In Colombia, female genital mutilation is practised in the Indigenous Emberá Chamí community located in the Risaralda and Choco departments. Starting with a project undertaken by the Ministry of Health and Social Protection, UNFPA and UN Women in 2011, it was agreed in consultation with male and female community leaders to eliminate this practice. However, there are still reports of isolated cases in communities of the same ethnic group who live in the rain forest of the Colombian Pacific. Also in some areas of the Pacific coast of Colombia populated by Afro-descendant communities, the SI Mujer Foundation has received testimonies from women who report the traditional use of herbs, or candle wax, which are applied to the clitoris of newly born girls to partially inhibit sexual pleasure during their adult life. However, this practice has not been systematically documented and there are no known academic or institutional sources that might certify its existence as a form of female genital mutilation.[411]

In Nicaragua, in addition to forcing women to renounce their own lives through the total criminalization of abortion, girls are forced to give birth to products of rape. This reflects the desperate situation of victims of violence when it results in forced pregnancies, high risk pregnancies and new pregnancies as a result of impunity, given that all these women return to the same environment where they became pregnant and

continue to be at risk from their attackers. In 2010 the Maternal Centre (prenatal care home) in Bilwi looked after 24 pregnant girls between 10 and 14 years old without the problem being reported to the police or judicial authorities. Women leaders convened by SI Mujer in October 2010 stated "We know that their relatives, fathers, grandfathers, are the ones who got the girls pregnant, but they don't report them. When they get out of hospital they go back to live at the same place again and with the same people, they might come back two or three times more, pregnant again..."[412]

In the Dominican Republic the Law on Domestic Violence[413] provides for personal integrity, as does the Constitution, but in practice this proposition is violated, for example, by the absolute penalization of the interruption of pregnancy.

The status of diverse sexual and gender identities and recognition of their rights. Legal situation regarding sexual preference and relationships with same-sex partners

The legal status of lesbians, gays, bisexuals and transsexuals varies greatly throughout the world without them enjoying equal rights with heterosexuals. Both criminalization and the legal invisibility of sexual relationships affect the right of gays and lesbians to equal treatment and opportunities and access to areas such as employment, housing, public services, pensions and health benefits, among others.

In Argentina the equal marriage and gender identity laws grant legal recognition to sexual diversity.[414] All these laws were discussed at length and were highly controversial.

The Autonomous City of Buenos Aires in Argentina through its Constitution recognises non-discrimination on the basis of sexual orientation, likewise in the city of Rosario since 1996 and in the province of Rio Negro since 1966 the Municipal Ordinance that ensures and recognises the right to be different was adopted. In December 2002 law 2004 on Civil Union was enacted in the City of Buenos Aires. In the same year the province of Rio Negro approved the homosexual Coexistence law that grants same-sex couples the same rights guaranteed by the province to de facto unions as "cohabiting couples", except for the possibility of marrying and adopting children. In 2010 in Argentina Law 26,618, known as the Law of Egalitarian Marriage, was enacted; by modifying the Civil Code same-sex couples are awarded the same rights and obligations as heterosexual couples.

In Brazil case law called homo affective unions is being created regarding the Right of Union of People of the Same Sex; for its part, the Maria da Penha Act recognises violence between women living together as a couple. In Brazil a National Plan for Promoting LGBT Citizenship and Human Rights has come into effect; in 2011 the Federal Supreme Court recognised homosexual unions as family entities with binding effect, this being the most important conquest in the history of the LGBT movement.

In Colombia Decree 100 of 1980 decriminalized homosexuality, which had previously been prohibited as a "crime" in the 1936 Criminal Code in which it had ceased to be regarded as a "disease." Colombian legislation on the rights of the Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) community has varied expressions. In 1992 the Constitutional Court stated that "the concept of autonomy of the personality includes any decision that affects the evolution of the person during the stages of life in which they have sufficient elements of judgement to be able to take it. In 1993 the Constitutional Court ruled that a person born as a man could change his name to a feminine one as an expression of individuality and uniqueness.

In 1994 the Constitutional Court protected the rights of a student in a military training school who was sanctioned for carrying out "homosexual acts" on considering that the condition of being gay cannot in itself be grounds for exclusion from an armed force. In 1998 the Constitutional Court ordered the reintegration of two students who were not allowed to enrol in a public school run by a religious community on the grounds of their sexual orientation, because this conduct was considered discriminatory and because educators have the function of teaching tolerance and respect and not imposing certain ways of life. In 2000 the Constitutional Court declared that sexual diversity and its public expression are protected by the Constitution.

Faced with sexual diversity, the Constitutional Court of Colombia has recognised the property rights of same-sex couples and requested Congress to legislate on the subject. However, Congress has not yet legislated on the subject.

The Civil Chamber of the Supreme Court of Justice in 2001 recognised the right to an intimate visit in jail of a same-sex partner and in 2003 extended this right to all same-sex couples. Judgement C-075 of 2007 defined the property regime of permanent partners in homosexual couples, protection against infringement of human dignity and the free development of personality. In 2007 the Constitutional Court recognised the right of health registration of same-sex couples under the same terms and conditions as heterosexual couples.

In 2008, the Court reaffirmed that the Constitution prohibits all forms of discrimination on the basis of an individual's sexual orientation and recognised pension rights of survivors in same-sex couples. In 2008 the Constitutional Court recognised maintenance obligations in same-sex couples under the same terms

and conditions as heterosexual couples. In 2009 it extended the rights and obligations of same-sex couples in different regulatory areas contained in 26 laws. In 2011 the Court requested the enforceability of article 113 of the Civil Code that defines marriage and urged Congress to legislate systematically and in an organised way on the rights of same-sex couples.

The Colombian government enacted law 1,482 of 2011 against discrimination; it includes sanctions against discriminatory acts against the LGBTI community, punishes those who infringe the rights of people due to their race, nationality, sex, religion or sexual orientation; it includes penalties of more than three years in prison but has not yet been regulated.[415]

Until 2008 in Nicaragua legislation condemning sodomy was still in force under Article 204 of the Penal Code.[416] In the new adopted in 2008 this article disappeared; however, Nicaraguan law does not explicitly recognise the rights of people according to their sexual orientation or gender identity. Article 36 of the Penal Code sets out circumstances that exacerbate criminal liability when an offence is committed on the grounds of race or any other type of discrimination pertaining to the ideology or political or religious choice or beliefs of the victim, ethnicity, race, or nation to which they belong, sex or sexual orientation, or any illness or disability they might suffer.[417] It also recognises the labour rights of individuals without discrimination for sexual option.[418]

In the Dominican Republic the national legislation, beginning with the Dominican Constitution and its adjective laws, does not recognise sexual diversity and as a consequence does not foresee services of that order.

Respect for cultural and sexual diversity in the Sexual and Reproductive Health Services

With regard to cultural and sexual diversity in the Sexual and Reproductive Health Services, Argentina reports the existence of Friendly Services; Colombia multiple favourable resolutions by the Constitutional Court; Nicaragua a Ministerial Resolution ordering non-discrimination in health services. In Brazil there are important initiatives in the field of health, education and security, prioritizing the creation of a less LGBT-phobic political culture and social environment, however, patriarchal and sexist culture still prevails in the health services.

In Argentina the Sexual and Reproductive Health Law proclaims non-discrimination in sexual health services. In 2010 the AIDS and STI Office at the Ministry of Health began a project of Friendly Services for sexual diversity. The Office creates and disseminates materials on the issue and also displays on its web page the addresses and opening hours of the services, which only exist in the province of San Juan, the province of Salta, several in the province of Buenos Aires, the city of Mar del Plata, the District of Lanús, the District of San Martín and the District of La Matanza, these last three districts are located in the first ring of the Buenos Aires conurbation.[419]

In Brazil there are important initiatives in the field of health, education and security, prioritizing the creation of a less LGBT-phobic political culture and social environment, basically by promoting training courses for professionals and valuing the secular nature of the State, as well as monitoring allegations of violence and discrimination against LGBT people. Nevertheless, it is a recognised fact that the policies are still somewhat nascent and limited in scope, lacking budgetary resources and facing strong institutional and State homophobia, they do not have explicit legal support and are not monitored or validated in their implementation.

The patriarchal and sexist culture still prevails in the health services, although policies do exist that were developed for afro-descendant, indigenous and rural women and also for the LGBT community. Lesbians are not respected in their sexual preference and their health care is not considered a right. Among health professionals a racist and sexist culture predominates where there is a greater level of acceptance and inclusion for whites, heterosexuals and those belonging to social classes with greater purchasing power. While at the level of municipalities there are laws, decrees and some ordinances, these do not constitute a coherent set of effectively guaranteed rights for the LGBT community. In spite of the fact that at the administrative level there have been specific victories on access to the transexualizing procedure, sex-change operations and the conjugal rights of same-sex couples, there are no legal regulations in this respect.

The Ministry of Health conducts sex change surgeries, transexualization and ensures health care for lesbians, bisexuals, gays, transsexuals and transgender people. This does not mean that it happens throughout the health system, since a political priority has not been established that might be implemented later in the more than 5,000 municipalities; anyway, there is a lack of training for professionals to put it into practice without prejudice and stigma. In some states of Brazil, including Rio Grande do Sul, a "social name" is legally accepted for people who wish to adopt a name usually associated with people of the opposite sex.

Brazil is a signatory to the Cairo Programme of Action; in the Ministry of Health a National Policy on Sexual and Reproductive Rights has been adopted. Nonetheless, the III National Plan for Human Rights did not include sexual rights.

In Nicaragua under Ministerial Resolution 249 of 2009, the Ministry of Health mandated that all establishments providing

public and private health services should promote actions aimed at eradicating discrimination on the basis of sexual orientation. This resolution is little known by the staff that provides the services and there are frequent complaints from LGBT people who receive care from the services. Transgender people do not find care in the health services and the medical staff has not been trained to understand the specific features and problems to be dealt with in these consultations.

National legislation in the Dominican Republic does not recognise sexual diversity and consequently does not provide services along these lines.

Situation of lesbians

A specific section on the situation of lesbians in the Latin American and Caribbean region is found in Chapter V, and is called "Women in all their diversity."

Situation of transgender individuals

In Argentina in 2012 the Law of Gender Identity on the rights of transgender individuals was adopted, which gives people the freedom to change their legal and physical gender without the approval of a judge or doctor. The law passed by the Argentine Senate, despite strong opposition from the Catholic Church, has removed all barriers that prohibited transgender people changing their sex. Argentina has a transgender community of more than 22,000 people.

According to the shadow report of the Diverse Colombia Foundation published in 2010, the murder of at least 17 transvestites was reported, showing that the main victims of violence due to prejudice are transvestites working as prostitutes. Likewise, it was established that the main victims of police abuse were transvestites along with members of the community that makes its sexual orientation or gender identity visible in the public domain. To date, according to data consolidated by Diverse Colombia, at least 57 LGBT people were killed in 2008 while up to September 2009 at least 39 have been reported. For its part, the official representative of Medellin reported that between 2007 and 2009 at least 49 LGBT people have been killed in that department. For its part, the Sectional Prosecutors' Offices do not record LGBT people as victims because they believe it is not possible ask about sexual orientation or gender identity because "this does not constitute a category of people."[420]

SUMMARY

Sexual rights

Only two countries report the existence of total freedom on the issue of the right to select a partner.

On forced marriage, two countries have established legislation to avoid it. There are no differences between adolescent men and women in the six countries with respect to the legal age to marry except for one country, and exceptions are included when a judicial dispensation or the parents mediate to contract marriage before 18 years old; in these cases the authorized age is always lower for women than for men, socially legitimizing greater responsibilities for women when faced with maternity and family burdens than men, given the patriarchal culture; these so-called rights for women do not correspond with their civil and political rights at the same age.

Violations of women's physical integrity such as obstetric violence is legislated for in Argentina; traditional practices harmful to women such as female genital mutilation has been denounced in indigenous tribes of Colombia, also by testimonies of women who are aware of the traditional use of herbs or candle wax applied to the clitoris of newly born girls in order to partially inhibit sexual pleasure during their adult life. However this practice has not been systematically documented.

In Nicaragua in addition to forcing women to renounce their own lives through criminalizing abortion, girls are forced to deliver the products of rape. This reflects the desperate situation of victims of violence when it results in forced pregnancies, high risk pregnancies and new pregnancies as a result of impunity, given that all these women return to the same environment where they became pregnant and continue to be at risk from their attackers.

The legal situation regarding sexual preference and same-sex relationships has seen significant steps forward.

Non-discrimination has been established for sexual option in all countries except in the Dominican Republic. In Colombia adoption, intimate visits to jail and pension for survivors of same sex couples are beginning to be legislated.

Argentina is the first country in the region to pass a law of egalitarian marriage that allows same-sex marriage; in Brazil, legislation recognises violence among women living together as a couple, allows sex changes, called transexualization, and homo affective unions as family entities.

Colombia decriminalized homosexuality; its legislation on the rights of the LGBTI community has varied and important expressions such as the autonomy of personality, non-exclusion from an armed institution on the basis of being gay; it stated that sexual diversity and its public expression are protected by the Constitution and has recognised the property rights of same-sex couples, among other positive measures; Nicaragua has removed the crime of sodomy from the Penal Code; meanwhile in the Dominican Republic there is no legal recognition of

sexual rights, nor have measures been established so that the LGBT community can access health services.

In Argentina frequent attacks are reported against transsexuals; in Brazil, there are 3.4 complaints a day about violence against homosexuals; in Colombia threats, attacks, shootings and raids against human rights defenders are reported; in Nicaragua murders occur of people in the LGBT community in the form of hate crimes that have gone unpunished, direct attacks by the hierarchies of the Catholic and evangelical Churches accusing them of promoting crime, practising paedophilia and incest, using drugs and promoting abortion; in the Dominican Republic there are frequent threats, taunts, harassment and blackmail against activists working on violence against women. In relation to transgender people there are serious verbal and workplace violence and hate crimes.

With regard to cultural and sexual diversity in the Sexual and Reproductive Health Services, Argentina reports the existence of Friendly Services; Colombia multiple favourable resolutions by the Constitutional Court; Nicaragua a Ministerial Resolution ordering non-discrimination in health services.

In relation to the legal recognition of transgender people, Argentina possesses the first law on gender identity that gives people the freedom to change their legal and physical gender without approval from judges or doctors. In Brazil there are important initiatives in the field of health, education and security, prioritizing the creation of a less LGBT-phobic political culture and social environment, however, patriarchal and sexist culture still prevails in the health services.

Sexual violence against women

Legal framework: Is there legislation that prevents and punishes sexual violence against women?

In relation to the legal framework in the six countries analysed, there are specific laws addressing this issue to achieve a life free of violence that include different types of violence. These include laws against: physical, psychological, sexual, economic, domestic, institutional and labour violence; violence against reproductive, obstetric and media freedom; and exploitation, cruelty and oppression. There are also laws that protect women against forced displacement due to internal armed conflicts or non-consensual insemination, or that decriminalize abortion in certain cases or at certain stages of pregnancy.

In Argentina, Law 26,485 of 2009 includes different types of violence against women: physical, psychological, sexual and economic. It defines different modalities of violence: domestic, institutional and labour; and against reproductive, obstetric and media freedom. The crime of femicide has not yet been classified, although a draft bill has been approved by the Chamber of Deputies and is currently being processed in the Senate where there is a majority to approve it.[421]

In Colombia, pressure from citizens' movements and women's organizations has led to modifications to the legal framework. Law 1,257 of 2008 stands out in this respect, bringing together the contents of the CEDAW and Belém do Pará international agreements against discrimination and violence against women. In the framework of this law, sexual harassment is classified as a crime. In addition, since 2008 the Constitutional Court has particularly protected women who are victims of forced displacement as a result of the internal armed conflict. Law 1,146 of 2007 establishes forms of prevention and punishment for sexual violence against children and adolescents. The crime of femicide is not typified in the Penal Code, although a draft bill to that effect is being analysed by the Congress.

In Nicaragua the comprehensive law against violence toward women was approved in February 2012, which includes the sexual crimes of rape and sexual harassment.

Table 23

Anti-Rape Laws in 6 countries in LAC

In 1997, three years after the ICPD, the Dominican Republic was the first country to pass legislation on violence against women. The most recent legislation is that of Nicaragua, in 2012. The majority of the legislation in Latin America and the Caribbean is not specific about sexual violence; generally the laws on violence include the majority of sexual crimes. An exclusive law on rape has been promulgated in Argentina.

Country	Anti-Rape Laws
Argentina	Law 25,087"Crimesagainst sexual integrity". 1999. Alpha Comprehensive Protection Act to prevent, punish and eradicate violence against women in areas where they develop their interpersonal relationships. 2009.
Brazil	Compulsory notification of cases of violence against women who are treated through health care services. Law No. 10,778/2003. Amendments to the Penal Code. 2005.
Colombia	Law 742 of 2002 approving the Rome Statute of the International Criminal Court of 1998. Law 882 of 2004. Law 975 of 2005 (Law of Justice and Peace). Law 1,146 of 2007. Law 1,257 of 2008, which establishes standards for the sensitization, prevention and punishment of forms of violence and discrimination against women, reforming the Penal Codes, the Penal Procedure, Law 294 of 1996, and other regulations. Integral Programme against Gender Based Violence. 2008.
Mexico	General Law on Women's Access to a Life Free of Violence. 2007. Decree to reform the Civil Code and Penal Code with reference to domestic violence and sexual violence. 1997.
Nicaragua	National Plan for the Prevention of Domestic and Sexual Violence2001-2006.
Dominican Republic	Law 24-97on domestic violence. 1997. Penal Code as amended by Law No. 24-97 of 28 January 1997.

Source: Political Constitution and Penal Code of the six countries studied

Incidence of sexual violence

In terms of the incidence of sexual violence, the registers are not unified and are difficult to compare among countries. Argentina records over 10,000 sexual crimes a year; in Colombia over 50% of sexual crimes involve girls under the age of 15; in Mexico over 3,000 disappearances of women and girls are documented, which are linked to organized crime groups, drug trafficking and trafficking networks for sexual exploitation.

In the vast majority of cases of forced sex and sexual abuse, the aggressors are known to the victims, including fathers or stepfathers. Births among 10-to 14-year-old girls have increased notably as a result of sexual violence, with the aggressors frequently going unpunished. The rape of women who are no longer virgins is rarely reported and often not even recognised as such, particularly when the aggressor is known to the woman and much less when he is the husband or former husband.

In 2008 in Argentina, 10,604 crimes against sexual integrity were registered, representing 26.68 per 100,000 inhabitants.[422]

In Brazil, the Sangari Institute has revealed that 19,440 murders of women were reported between 2003 and 2007. The data show around 4,000 homicides a year. This is the equivalent of a national average of 4.2 homicides per 100,000 women.

According to its records, the Women's Assistance Centre has provided assistance 1,266,941 times, ranging from requests for information on the current legislation to where to go if you are a victim of violence. Threats and bodily injuries from former boyfriends and former partners persist. A total of 69.7% do not financially depend on the aggressor, while 68.1% say that their children witness the violence and 16.2% that they suffer violence along with their mothers.[423]

In terms of alleged sexual crimes in Colombia, the rate of medical examinations performed on women in 2011 was 81.42 x 100,000. A total of 22,597 examinations were performed in the whole country, representing an increase in relation to 2010. Meanwhile, 24% of female victims of sexual violence were between 5 and 10 years old and 36% were between 10 and 15, indicating that girls and female adolescents are predominantly affected.[424] With respect to the crime of sexual abuse among minors, data from the National Institute of Legal Medicine and Forensic Sciences show that out of 20,142 medico-legal examinations performed in 2010, 85.97% corresponded to minors, with 6,219 corresponding to the 10- to 14-year-old age group.[425]

In Mexico, it has been documented that between January 2010 and June 2011 [426] there were over 3,149 cases of disappeared

women and girls in nine of the country's states, which could be linked to organized crime groups, as well as drug trafficking and trafficking networks for sexual exploitation.

In 79% of the cases of forced sex and 87% of those of sexual abuse in Nicaragua, the aggressors were known to their victims. Fathers or stepfathers were identified as responsible for 3% of the forced sex cases and 9% of the sexual abuse cases.[427]

According to the Police Stations for Women and Children, the comparative statistics on domestic and sexual violence for 2010 and 2011 show 3,660 sexual crimes, including 1,827 rapes, 260 attempted rapes, 877 cases of sexual abuse, 479 cases of *estupro* (an adult's rape of a person aged 16 to 18), 27 cases of sexual exploitation, 184 cases of sexual harassment and 6 cases of incest. The 5,086 examinations reported by the Institute of Legal Medicine for sexual violence only represent 9% of all of the medico-legal examinations performed on living people at the national level.[428]

Through its Observatory for Secular Awareness, Catholics for the Right to Decide in Nicaragua has presented an analysis of the cases of sexual violence denounced by the different written media in 2011, highlighting that 338 victims of sexual violence were reported, of which 85.5% were women and 14.5% men.[429]

Births among girls between the ages of 10 and 14 have increased notably, with the UNFPA reporting a rise of 46% in 9 years up to July 2012, according to official figures (from 1,066 in 2000 to 1,477 in 2009). Both before and after therapeutic abortion was repealed in Nicaragua girls have been forced to give birth to children resulting from what is basically rape, as nobody can deny that at their age they are unable to have consensual sexual relations, given their emotional immaturity. None of the institutions responsible for providing care and follow up for victims and survivors of sexual violence keep a record of the girls, adolescents and women who become pregnant following rape.

According to the Dominican Republic's ENDESA 2007 (2007 Demographic and Health Survey), the number of women between 15 and 49 that had experienced sexual violence at some time was 10.1% in 2007.[430] During 2010, a total of 64,022 denunciations were recorded, of which 5,488 corresponded to sexual crimes, revealing a great reticence on the part of adult women to report rape and sexual harassment. The breakdown of the cases by age shows that around three quarters of the denunciations corresponded to minors, particularly girls. The rape of adult women or female youths that have lost their virginity is rarely reported and often not even recognised as such, particularly when the aggressor is known and much less when the aggressor is the husband or ex-husband.[431] The low denunciation rates are partly due to cultural prejudices that tend to blame the victim, morally shaming her in front of the family and the community.

Table 24

Anti-sexual harassment laws in 6 countries in LAC

Legislation against sexual harassment is present in all six countries studied, however at least in half of them it is included within the laws on violence against women.

Country	Anti-sexual harassment laws in 6 countries in LAC
Argentina	Decree on sexual harassment in public, 2,385. 1993
Brazil	Law 10,224. 2001.
Colombia	Law 360 on Sexual Offences. 1997.
Mexico	Federal Penal CodeArticle259. 2012.
Nicaragua	Law 779, Law against violence towards women. 2012.
Dominican Republic	Law 24-97 on Domestic Violence. 1997.

Source: Political Constitution and Penal Code of the six countries studied.

Violence against lesbians and transgender women

In Argentina the Law for Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women protects all women from all kinds of violence. However, there is plenty of violence against transgender women, about whom there is only partial data as it is not reported by official sources.

In Brazil in 2011, the Secretariat of Human Rights of the federal government registered on average 3.4 complaints a day about violence against homosexuals. These facts are gaining greater publicity in recent years since the Secretariat began to receive complaints by means of a telephone line set up especially for this purpose. It is worth noting that acts of violence are aimed at people with a sexual orientation considered outside of the norm, not against the activists. Currently in the Senate there is a bill that criminalizes acts of discrimination against homosexuals. The bill makes all forms of prejudice related to sexual orientation or gender identity occurring in the labour market, consumer relations and the public services a criminal offence.[432]

There are some studies that document violence against lesbians, including the Dossier of Lesbian Health drawn up by the Feminist Health Network.[433] In Brazil homophobia and discrimination is still alarming and there are still frequent brutal murders of gay people and transvestites in addition to a diffuse homophobia that is manifested in all social spheres and particularly in the areas of family, work and education, health and safety services. This continues to happen despite the fact that over the past 30 years there have been significant changes in the social images of these communities and there is greater commitment from various actors to gender equity and the guarantee of rights for society in general.

In June 2000, for the first time in Nicaraguan history, a jury convicted the murderers of a 33 year-old lesbian, whose body was found at the bottom of a latrine, after confirming during the trial that the victim's sexual preference had been the motive for the crime. She earned her living by raising pigs and chickens and from her youth suffered discrimination in her neighbourhood because she never tried to hide her sexual option; a neighbour knocked her over with his pick-up truck simply because she was a lesbian, after which she suffered problems in one leg.[434] One year before the murder, the murderer had accused her of the crime of sodomy and for this the young woman went to prison for two months.[435] Two men were found guilty of the crime of aggravated murder; however, in August 2001 the judges of the Court of Appeal declared the process null and void meaning that her attackers went unpunished.[436]

In May 2012 twenty LGBT organizations demanded justice "For the high levels of violence against transgender people, gays, lesbians and bisexuals in Nicaragua," organizations and activists stated their demands for justice for the victims, punishment for the criminals and repudiation of all discrimination on the basis of sexual identity." In May 2012 in Managua a young finalist in the Miss Gay Nicaragua 2012 contest was shot in the chest, two other transgender citizens were shot and three activists were threatened with firearms by individuals on motorbikes wearing balaclavas.

In the Dominican Republic, there is extensive discrimination towards homosexuals, lesbians, gays, transgender and transsexual people, which is manifested through insults in the streets, the refusal to enrol them in public schools, the arrest of transvestites and job dismissals from private and public agencies such as the National Police. The homosexual and transgender community is the victim of verbal and work-related violence, discrimination and hate crimes.

Laws against human trafficking

All of the countries have laws against human trafficking to eliminate this practice aimed at sexual exploitation and forced labour in the countries of origin, transit and destination. In Mexico, the magnitude of trafficking has turned it into the second most profitable illicit business for organized crime, ranking it above arms trafficking and only below drug trafficking.

In Argentina the Law for the Prevention and Punishment of Trafficking in Persons was passed in 2008. The national programme to prevent this crime and particularly to assist the victims has its origin in the struggle initiated by Susana Trimarco, mother of Marita Verón, a girl who was disappeared and sold to a brothel in La Rioja. Argentina is a country of origin, transit and destination for men, women and children who are victims of human trafficking for the purposes of sexual exploitation and forced labour. Many of the victims come from rural areas or northern provinces and are forced to practise prostitution in urban centres or more prosperous provinces of the country's central and southern regions. A large number of foreign women and children are forced into prostitution in Argentina. The last Report on Trafficking in Persons ranks Argentina second among 186 countries in terms of the origin, transit and destination of victims of this social scourge.

In Brazil, the 2005 Penal Code refers to the crime of international trafficking of persons for purposes of sexual exploitation, stipulating imprisonment and fines for anyone who "promotes, intermediates or facilitates the entry into national territory of a person who comes to exercise prostitution or the departure of a person to exercise it abroad."The immensity of Brazil's territory and its poverty levels and social inequality demand an increase in judicial actions against human trafficking and sexual exploitation, while at the same time making it even more difficult to fight against such crimes.

Since 1960 there have been legislative advances in Colombia related to human trafficking, notably Law 74, Law 470, Law 704, Law 679, Law 747, Law 800, Law 985, Law 1,257 and Law 1,336,which adds to and strengthens Law 679 by adding connected aspects such as pornography and sexual exploitation of children and adolescents.[437] Based on Law 985 of 2005, prevention, protection and assistance measures against human trafficking were adopted, while the President of the Republic issued decree 4,786 of 2008 adopting the National Comprehensive Strategy against Trafficking in Persons.

According to the Report on Trafficking in Persons of June 2012,[438] Mexico is a Tier 2 country, which corresponds to countries whose governments do not comply with the minimum prevention standards but are making significant efforts to comply with them. In 2007, around 14% of the total victims identified during the year in the United States were of Mexican origin.[439] In June 2012, the President signed the decree for the General Law to Prevent, Punish and Eradicate Crimes related to Trafficking in Persons and for the Protection and Assistance of the Victims of Those Crimes. According to the Assessment of the Conditions of Vulnerability that Favour Human Trafficking in Mexico,[440] this is the second most profitable illicit business for organized crime, ranking above arms trafficking and only below drug trafficking. Twenty-eight of the 31 states and the Federal District have legal provisions that consider trafficking in people to be a crime.

In Nicaragua, the new Penal Code[441] establishes trafficking in persons as a crime and prohibits the submission, detention or forced recruitment of a person for the purposes of slavery, forced labour, servitude, or participation in armed conflicts. Most of the victims are young women between the ages of 19 and 25, although it is increasingly frequent for the networks dedicated to this crime to target minors.[442] During 2011, the police investigated 26 potential cases of human trafficking, including two cases of forced labour. The authorities initiated 21 judicial proceedings. Nine people accused of trafficking were found guilty and sentenced to prison sentences of between 7 and 11 years.

The Office of Human Rights Ombudsperson presented a study[443] that highlights as one of the big deficiencies the lack of a single system to record the statistics of cases of trafficking with indicators that measure the impact of this crime and that register the statistics in a disaggregated way.[444] One of the advances has been the creation of the 24-hour 133 phone line run by the Ministry of the Family, which between 2009 and 2011 registered around 20,000 calls requesting information about human trafficking, mainly on border points. Other positive aspects have been the actions of the National Coalition against Human Trafficking, led by the Ministry of Government, as well as the attention provided to victims and a legal, regulatory and procedural framework that classifies the crime and is oriented toward protecting and helping the victims and their families.

At the legislative level, the Dominican Republic has adopted different instruments to prevent and punish human trafficking, which is specifically prohibited in the Constitution of 2010, although Law 137-03 on the Illicit Trafficking of Migrants and Trafficking in Persons was passed in 2003. In 2002, the Interinstitutional Committee for the Protection of Migrant Women developed programmes for sensitization and education on the crime and its dangers, as well as the implementation of assistance services for the victims and the conducting of judicial proceedings against the traffickers. The work on human trafficking in the Dominican Republic has been closely linked to the migration control policies and in line with the plans of the United States. Sometimes human trafficking and trafficking in general are treated as if they were the same thing.[445] It is estimated that 50,000 Dominicans work in the sex industry, mainly in Europe.

Table 25

Anti-Trafficking Laws

Five of the six countries have specific legislation against human trafficking, which is an important regional advance. Nicaragua contains the crime of human trafficking in its Penal Code.

Country	Anti-Trafficking Laws
Argentina	National Law 26,364. Prevention and Punishment of Trafficking and Victim Assistance. 2008.
Brazil	Ordinance 2,167 establishing the implementation of the Action Plan to Combat Trafficking in Persons among Member States of MERCOSUR and Associated States(MERCOSUR/RMI/AGREEMENT. 2006.
Colombia	Law 747 of reforms and additions to the Penal Code elaborating the offence of trafficking in persons. 2002.
Mexico	Law to prevent and sanction trafficking in persons 2005.
Nicaragua	Law 641, Article 16, paragraph f) Penal Code2007.
Dominican Republic	Law 137-03 on Illicit Trafficking of Migrants and Trafficking in Persons. 2003.

Source: Political Constitution and Penal Code of the six countries studied.

Sex work

In the Dominican Republic, most of the women that practice sex work and/or transactional sex are young people between 15 and 25, most of them single mothers, 70% of them with an average of 2 or 3 children, and with a history of physical and verbal maltreatment and other forms of domestic violence. The aim of practicing sex work and/or transactional sex is to economically maintain their children, parents or relatives. In other words, they practice sex work due to a situation of social inequality, extreme poverty and low education levels.

Most of them are exposed by their clients to the use of drugs and alcohol, the transmission of sexual infections, violence and noise, according to a study in 4 provinces. The same study refers to the fact that through the client's incitement, 50% of sex workers used marihuana or crack, while the HIV prevalence among them is approximately 5% and the syphilis prevalence approximately 11%. A draft bill is currently under discussion that is considered discriminatory by the United Women's Movement (*Movimiento de Mujeres Unidas*) as it blames women who practice sex work.[446]

SUMMARY

Sexual violence

With respect to the legal framework in the six countries analyzed, laws a gainst violence exist that specifically incorporate sexual violence against women among their articles. The legislation relates different situations of violence that could result in sexual violence as well as physical, psychological, economic, domestic, institutional and labour violence, violence against reproductive freedom, exploitation, forced displacement due to armed conflicts and others.

Colombia includes care for sexual violence as a medical emergency. There are women's centres with specialized individual and group attention in the area of violence in three countries.

In terms of the incidence of sexual violence, the records are not unified and it is hard to make comparisons among countries; Mexico has documented over 3,000 disappearances of women and girls that are linked to organized crime groups, drug trafficking and trafficking networks for sexual exploitation.

In the vast majority of cases of forced sex and sexual abuse the aggressors are known to the victims, including fathers and stepfathers. Births among 10- to 14-year-old girls have increased notably as a result of sexual violence, although the aggressors frequently go unpunished. The rape of women who are no longer virgins is rarely reported and often not even recognised as such, particularly when the aggressor is known and much less when he is the husband or ex-husband.

All of the countries have laws against human trafficking with the purpose of eliminating in the countries of origin, transit and destination this practice aimed at sexual exploitation and forced labour. In Mexico the magnitude of trafficking has turned it into the second most profitable illicit business for organized crime, ranking it above arms trafficking and only below drug trafficking.

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CHAPTER 5

women in all their diversity

CHAPTER V. WOMEN IN ALL THEIR DIVERSITY

Lesbians in Latin America

Discrimination based on sexual orientation is rooted in the erroneous idea that only one kind of sexual-emotional expression—i.e. the heterosexual one—is possible, and that all other expressions are the result of illness or sin. That belief impoverishes the complex phenomenon of human sexuality, defining the status of human emotional bonds based on an element as superficial as the gender of the people involved without paying any attention to the quality of those bonds. That conception is installed in the very foundations of the legal order and social practices that govern us, and it is one of the main sources of all of the injustices suffered by people who express their sexuality and affection in ways that differ from the heterosexual model.[447]

In the patriarchal society, being lesbian means not being a mother. For centuries, lesbians have been perceived as sterile women incapable of maternity. The heterosexual and lesbophobic discourse links female sexuality to reproductive obligatoriness and denies that capacity to women who do not comply with the heterosexual regulations. Being a "lesbian mother" is therefore seen as a contradiction in terms: "as women, lesbian women should have children; and as lesbians they should renounce them."[448]

As perceived by the patriarchy, the family is an essential place for the reproduction of the forms and ideologies in which males impose themselves over females and the females over the smallest ones. And we are all made to believe that imposition is the only possible form of organization, both privately and collectively.

In the words of the Autonomous Feminist Lesbians of Argentina: "While civil rights will facilitate certain things, the important thing is cultural and social change..."

In the labour sphere, lesbian women face discrimination that translates into dismissals, marginalization, pressure to resign, invasion of one's private life, and sexual harassment. The economic consequences of non-recognition of the rights of lesbian couples are related to the right to social security, medical care and family benefits. When lesbians—and bisexual, gay, transgender and intersex people—claim their right to social security, they know that the Latin American and Caribbean States do not guarantee that right to any kind of family, no matter how traditional it is. Women receive wages that are lower than their male counterparts, and as a result, "because they are formed by women, lesbian families are more exposed to poverty than families in which there are men (both heterosexual and formed by gay men)."

With respect to political participation, according to the report by the International Gay and Lesbian Human Rights Commission in 2003, there were LGTBI candidacies in the elections in Brasil, Mexico and Colombia and none of them were elected.[449]

There is domestic violence among lesbian couples, and the difficulties in denouncing it and being able to escape it are aggravated by the lack of training among the personnel of the institutions that work on the issue, as well as social pressure due to discrimination. There are initiatives such as the "*Desalambrando*" (removing the wires) project[450] in Argentina that is exclusively dedicated to the issue of domestic violence among lesbians. But this is an issue that is still not very well known and rarely addressed by the lesbian movement.

Relations with the gay movement have been and continue to be conflictive. In various Latin American and Caribbean countries there have been experiences of mixed organizations that have gone through processes of organizational breaking up and splintering. The fight for lesbian visibility starts with the demand to be named, the need to become "subjects" with their own identity compared to the male sphere, which is used as the generic identity. The integration of lesbians into homosexual collectives therefore implies an internal struggle for visibility.[451]

Alejandra Sarda[452] has stated that "...the struggle for the rights of lesbians in Latin America and the Caribbean is a matter that is little known and silenced, but that does not mean it is not without its infinite small achievements, thousands of work hours, countless paths to travel down. Each country has its own routes and it is always very difficult to try to cover something as extensive as the struggle for the recognition of rights in a context as diverse as it is in this region. We know we have elements in common both with other struggles and with other continents."

Health and violence among lesbians

According to the conclusions of a research study on the main obstacles to lesbians in Latin American fully enjoying their right to health,[453] "the obstacles experienced by lesbians in Latin America are related to the very serious economic situation the region is going through and that affects the whole of the population. One serious problem is the prejudices of medical professionals, particularly distinguished figures in gynaecology and mental health. Other prejudices are linked to the legal system

and professionals that work on domestic and sexual violence. The prejudices and disinformation of the lesbian community itself represent another serious problem, given that many lesbians share the professionals' prejudices, believing that they are immune to sexually transmitted infections or less requiring of gynaecological care due to their sexual practices.

"On the issue of domestic violence, it is notable that many lesbians assume that women are not violent or that they must preserve the good image of the lesbian community and deny situations of violence that occur in their environment. In this context, the lesbian organizations, which are few in Latin America, develop with limited financial support and facing many prejudices, with multiple activities based on voluntary work. The main task is providing support to women finding it difficult to assume their lesbianism.

"The feminist groups, which should be allies in the struggles of lesbian women, do not incorporate lesbian women's health issues and are afraid of being identified with these groups; they show resistance and an incapacity to incorporate the issue of lesbianism into the commitment to fight for the right of all women to freely exercise their sexuality."

The rights of indigenous women

Gender roles and the relationships between indigenous women and men, their communities and society in general determine their capacity to achieve good health and quality of life. In the Latin American region, indigenous women are at a triple disadvantage due to belonging to an ethnic group, their sex and their predominantly rural location.

There are approximately 42 million indigenous people from 400 different ethnic groups[454] living in the Americas, accounting for 6% of the total population and almost 10% of the population of Latin America and the Caribbean. Eighty-percent of them live in Central America and the central Andes, the majority in Mexico, Guatemala, Peru, Bolivia and Ecuador. The high concentration of indigenous people in many of these countries indicates that their health concerns should be a national priority. However, they have very high morbidity and mortality rates and the most limited access to health services of their national populations.

In the last 20 years, the struggle and participation of indigenous women have focused on the defence of life, which has involved learning about and using instruments and mechanisms to respond to the worsening of poverty in the countryside, where indigenous families are the most affected. Organized participation at the local, national and regional levels has allowed progress in terms of trusting in their own capacities and political management to achieve support programmes for extreme poverty and even participation with their own voice in multi-sectoral commissions and local governments.

Like the population in general, indigenous communities define cultural roles and specific standards for men and women, some of which precede the colonization, while others have been incorporated as a result of it. The social position of indigenous women is characterized by their subordination to the men and their triple productive, reproductive and community burden.

The conception that indigenous women have about their role in family and community life and in society has enabled them to develop their creativity, ingenuity and wisdom, as well as develop their capacities to respond to the challenges involved in their triple function, in which the magnitude of their contributions are not fairly recognised or made visible. The impoverishment of the family economy, the poverty in the countryside and the deterioration of indigenous society due to internal and external factors means that they have been obliged to take on responsibilities that are currently overburdening them with tasks.

In situations of conflict when there are no men at home, they have created organizations of different natures to help them survive and defend their lives both inside and outside of the community. They make contributions as the repositories of knowledge on medicine, biodiversity for health and food; as well as the conservation of their environment, language and culture, which provides them with recognition in their community.

In countries that have had dictatorships and/or internal armed conflicts, such as Guatemala, Nicaragua, Peru and Colombia, it has been the women who have responded to the violation of their human rights by organizing to denounce to the world the abuses and the disappearance of family members, and to defend the rights and particularly the autonomy of indigenous peoples, assuming the full responsibility for their families in the absence of their husbands and other relatives.[455]

Seventy percent of Quechua women spend as much time as the men marketing their agricultural products. In Ecuador, 53% of indigenous women are illiterate, compared to 35% of men.[456] In Nicaragua, 32% of rural women say that it is acceptable for their husband to hit them if he so much as suspects that they have been unfaithful, while 75% of married Nicaraguan women have been hit, forced to have sexual relations, or maltreated in some way.[457] In Guatemala, health services cover 54.4% of the overall population, but only 25% of rural people.

In relation to the health situation of indigenous women, PAHO has highlighted high fertility rates and close birth spacing as a result of marriage at an early age, resulting in an average of 6.8 children. There is limited use of contraceptive methods: 41.3% of Shipibo women in Peru do not use any kind of contraception, while the majority of the men do not use condoms.[458] High maternal mortality rates are reported, for example in Peru which

has 489 deaths x 100,000 live births, due to the lack of care during childbirth and to consequences such as anaemia, urinary incontinence, uterine prolapse, genital infections and vaginal fissures, which generally speaking do not receive any attention.

Good quality public health care services are still a long way off for indigenous women, who prefer to turn to traditional medicine because they do not have the resources to buy medicines or out of cultural prejudices, but mainly due to the humiliating treatment they suffer at the health posts. Indigenous women's right to health includes their physical, spiritual and emotional health. Their low self-esteem is the result of the different forms of aggression to which they are subjected, so attention needs to be paid to the most appropriate ways of recovering their self-esteem, self-worth and self-respect.

With regard to sexual health and reproductive health, there is a need to recognise and incorporate positive indigenous medical practices and to recognise the contribution of traditional doctors, who should be incorporated into the health system.

This panorama requires feminists across the continent to support the women of the original peoples of Latin America and the Caribbean, demanding their rights in accordance with ILO Convention 169, the United Nations Declaration on the Rights of Indigenous Peoples, the Durban Declaration and Programme of Action, the CEDAW commitments, the Beijing Platform for Action and the Cairo Programme of Action, which have been ratified by the majority of States in the region as a way of overcoming the barriers of inequality and social exclusion.

Afro-descendant women facing up to discrimination and inequality

In the Cairo Conference, the connections between culture and health were highlighted and it was declared that the sociocultural circumstances in which women live influence their morbidity and mortality.

The pluri-national States of Bolivia, Brazil, Colombia, Ecuador, Guatemala, Mexico, Nicaragua, Paraguay and Peru have incorporated ethnic identification into at least one survey. But although all of them identified their indigenous groups, their Afro-descendant groups were only included by Brazil and Nicaragua.[459]

There are at least 150 million Afro-descendant people in the region; the equivalent of 30% of the population. Almost half of them are women. Together with the indigenous peoples, the around 75 million Afro-descendant women are the poorest in the continent. According to the censuses for the first decade of this century, people with African ancestry account for significant percentages of the population of countries such as Brazil (45%) and Colombia (10.6%), while in others, like Nicaragua, they account for 0.5%.

Like the indigenous groups, the Afro-descendants have important gaps in many human capital indicators. Specifically, educational parity is far from being a reality for Afro-descendant girls and women at higher education levels, although the same cannot be said for the prevalence of HIV/AIDS and other sexually transmitted diseases.[460]

In the Beijing+10 process, Afro-descendant women demanded visibility, participation and equity in the workplace, highlighting culture as one of the areas of exclusion, given that there is a strong link between race and equal development in society. The Declaration of Managua in 2006[461] recognised new forms of racial discrimination and warned of new conservative and nationalist tendencies. It took up the task of fighting against sexism, racism, racial discrimination, xenophobia and all kinds of discrimination, targeting the analysis of the inter-sectionality of gender, ethnic group and race.

At the same time it proposed the need to develop actions that update the national assessments with a gender-, ethnic- and race-based focus; improve health conditions, with an emphasis on sexual and reproductive rights and HIV/AIDS; and improve formal and non-formal education, economic and cultural development, communication and the use of new technologies, leadership capacity, political advocacy, and participation, democracy and human rights. It argued for an emphasis on regional linkages to exploit resources, and thematic coordination, reaffirming their identity, spirituality and cultural values.

Closing the inequity gaps implies recognising that it is impossible to advance with the definition of inclusive public policies if there is no clear and systematic disaggregated information on their living conditions and how they relate or compare to those of the rest of society.

The systematic invisibility of Afro-descendant women in Latin America and the Caribbean has hindered the building of consensus to define and formulate appropriate indicators to generate information that reveals their condition, or for the development of alternative ways for the community to participate as an active subject in the gathering of official information on its own living conditions.

It is recognised as a clear pattern in Colombia and Argentina that the Afro-descendant population lives in conditions of generalized poverty, with low health, nutrition, education and income indicators.[462] Afro-descendant women leave school early and only a reduced percentage reach intermediary education, with an even more reduced group getting to university. They enter the labour market early, generally in informal work with low wages and limited benefits. When they gain access to

the labour market, they generally receive a lower salary and obtain lower-ranking posts, even when they have the same educational conditions.

Almost without exception, indigenous and Afro-descendant girls have a higher percentage of adolescent pregnancy than the rest of the population. There is an increasing number of unwanted pregnancies, generating abortions in unsafe conditions, in many cases leading to death. Maternal death is a serious problem that needs to be tackled. In Nicaragua it is reported that 8.9% of adolescent Afro-descendant girls are already mothers, with the figure 9.7% in Brazil; and in Nicaragua 30.9% of Afro-descendant women between 18 and 19 are mothers, while in Brazil the figure is 28.2%.[463]

Violence is manifested in all forms of racial discrimination, forced displacement, human trafficking, and limited access to employment, health services and education. The persistence of unequal relationships between peoples, languages and cultures blocks ethnic communities from making full use of their rights. The communities are not always informed about the national and regional policies and they rarely manage to influence them.

The Afro-descendant women in the Latin American and Caribbean region are demanding the building and strengthening of States that are secular, democratic, pluri-national, anti-racist and inclusive, whose development model is not based exclusively on the production and accumulation of wealth, but also on the idea of generating a kind of development centred on human beings, promoting the exercising of citizenship.

They are also demanding the following for Afro-descendant women: universal access to comprehensive and intercultural health services in all stages of the life cycle, incorporating and valuing the knowledge and practices of ancestral medicine; guaranteed access to contraceptive methods with free, prior and informed consent; and the implementation of effective policies for the prevention, diagnosis and treatment of HIV/AIDS.

The situation of women with disabilities

At least half of the people with disabilities in the world are women and the situation of both sexes reveals a marked disadvantage.[464] While there are no reliable statistics, based on WHO figures we can say that over 300 million of the world's women and girls have some kind of disability.[465] Due to their gender and their disability, they suffer a triple discrimination as they are also the poorest of the poor.[466]

They experience discriminatory treatment in multiple areas of their life, from access to education and health to participation in politics and work. The stereotypes surrounding women with disabilities, which are profoundly rooted in society, mean they are considered to be dependent and incapable of taking their own decisions. Their carers and/or relatives act in their name without consulting them.

In less developed countries where the traditional role of women as mothers and wives prevails, the popular belief is that women in this condition are not apt to fulfil these roles and their social value is therefore null. They face generalized prejudices as they are considered to lack the ability to participate in public life and be economically productive. The stigma that women with disabilities suffer generates a lack of self-esteem, which helps perpetuate their social exclusion.[467]

Women with physical and sensory disabilities have great difficulties accessing services under equal conditions and those with psycho-social disabilities are particularly discriminated against.[468] There is synergy between disability and aging according to gender, as the advance of age increases the possibility of experiencing health problems that increase their functional limitations and interaction with society.

According to population censuses, the prevalence of disability among women between 2000 and 2004 was 7.3 in Argentina, 15.3 in Brazil, 10.4 in Mexico and 11.3 in Nicaragua. And in all of the countries the highest prevalence rate corresponded to women.

The panorama of access to health care for people with disabilities is not very different:[469]

The international Convention on the Rights of Persons with Disabilities was approved on December 13, 2006, as the result of a long process in which organizations of people with disabilities and their families played a prominent role.[470]

This new instrument implies important consequences for people with disabilities, stressing their "visibility" within the United Nations' human rights protection system and the irreversible acceptance of disability as a human rights issue, as well as providing a binding legal tool with which to assert their rights.

Most of the projects aimed at the social inclusion of women with disabilities are limited to academic and labour aspects. The work focuses on getting them to read, write and receive training in order to have the possibility of integrating themselves into productive life, which is undoubtedly very important. But there are a limited number of studies or programmes for their comprehensive development, including their sexual and emotional practices.[471] This is due to the belief that people with disabilities are not sexually active and do not need to control their fertility. This situation, added to the stereotypes that mark them as "asexual," often mean that women with disabilities have to confront many deficiencies in the quality of attention and the coverage of the services, which is a clear violation of their sexual and reproductive rights.

On November 25, 2011, the International Disability Alliance[472] called for urgent and concerted measures to eradicate violence against women and girls with disabilities worldwide and to address the causes and effects of violence for their full and equal participation in all aspects of society. The European Disability Forum, meanwhile, has referred to the existence of data from many countries that demonstrate that forced sterilization continues to be practised in the case of many people with disabilities. It is particularly suffered by girls and women with intellectual and psycho-social disabilities and those with great support needs, without them giving their consent or understanding the specific purpose of an intervention done under the pretext of being for their own well-being.

The commitment of Latin American feminists is required to demonstrate the need to review the programmes and strategies and to demand of the States specific measures to guarantee that women and girls with disabilities can access justice and exercise their rights in equal conditions. Disaggregated statistics are also needed that provide a precise picture of the situation of violence against women and girls with disabilities in order to prevent and eliminate it.

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CHAPTER 6

emblematic cases

CHAPTER VI.
EMBLEMATIC CASES

Argentina: The re-victimization of a raped girl who became pregnant

In August 2011, in the city of Posadas, the capital of the Argentinean province of Misiones, a 14-year-old girl became pregnant after being raped by an uncle. The case was discovered when a teacher asked her pupils write an essay on "the saddest day." The girl described how she and her 10-year-old sister were sexually abused by her father's brother. The school informed the girl's mother, who pressed charges. The lack of action from the State bodies allowed the uncle to take revenge on the girl by waiting for her at the school gates and raping her again.[473]

The girl's mother took her to the City Hospital where it was confirmed that she was pregnant. With the girl's agreement, the mother requested an abortion but the doctors sent her to the courts to request authorization. Although the judge said that the abortion could be performed in the hospital, they refused to perform it but kept the girl hospitalized. After the media got to know about the case, the girl and her family were re-victimized and pursued by people who supposedly want to help them.

The hospital director and other professionals exaggerated the risks of interrupting the pregnancy to the mother, while multiple governmental and private religious organizations simultaneously addressed the family, offering support if they went ahead with the pregnancy. The mother, scared by her husband who viewed this as an opportunity to receive support to lift them out of poverty, acceded and withdrew the request to interrupt the pregnancy.

In January 2012 the girl gave birth to an underweight daughter by caesarean section. The case did not continue in the justice system as the request was withdrawn, but it mobilized the Supreme Court of Justice into taking a decision. In 2012, the Supreme Court ruled on a similar case in the province of Chubut, in which it pointed out the reiterated cases in which the health system had unnecessarily requested authorization for abortion as a result of rape, given that it has been permitted in article 86, paragraph 2 of the Penal Code since 1921.

The Under-Secretary for Community Health at the Ministry of Health recognised in 2011 that the girl's pregnancy should have been interrupted, even though the Health Ministry had not approved by resolution the healthcare protocol for non-punishable abortion produced in 2010. That protocol is in line with the Penal Code and the Supreme Court judgement, but is not adequately applied.

Brazil: Pain converted into strength for all women

In 1983 bio-pharmacist María da Penha was the victim of a double homicide attempt in her house in Fortaleza, Ceará. The aggressor, economist and university lecturer Marco Antonio Heredia Viveiros, was her husband at the time and the father of her three daughters. He shot her in the back while she was asleep, causing irreversible paraplegia, among other serious damage to her health. On a later occasion he tried to electrocute her in the bath. In 1998, over 15 years after the crime, there was still no definitive decision in the case, despite two sentences by the Ceará Court of Juries, and the aggressor was still at large. In response, Maria da Penha, CEJIL and CLADEM presented the case to the Organization of American States' Inter-American Commission on Human Rights (IACHR). The Brazilian State did not respond to the petition at any time during the procedure.

In 2001 the IACHR found the State of Brazil responsible for omission, negligence and tolerance in relation to domestic violence against Brazilian women. It considered that this case displayed the conditions of domestic violence and State tolerance defined in the Belém do Pará Convention and that the State bore responsibility for the lack of compliance with the rights guaranteeing a life free of violence; respect for life; respect for physical, moral and psychic integrity and personal safety; personal dignity and equal protection before the law and from the law; and simple and speedy recourse to the corresponding courts.

The IACHR considered that the obligation to respect and guarantee the rights to judicial guarantees and judicial protection established in the American Convention on Human Rights had been violated as there had been unjustified delays and negligent handling of the case.

This was the first case in which the Belém do Pará Convention was applied in the Inter-American system and in which a country was held responsible with respect to domestic violence against women. The penal process ended in March 2002 and the aggressor was arrested in October of the same year. In 2003 the case was also reported to the CEDAW committee, which recommended that the State adopt "without delay legislation on domestic violence." On August 7, 2006, Law 11,340 was approved. Known as the María da Penha Law, this act creates mechanisms to stop domestic and family violence against women.

Brazil -Inter-American Court of Human Rights - Violence against women[474]
María da Penha Maia Fernández - Report No. 54/01 Case 12,051

Colombia: High impact litigation to liberalize abortion laws

In April 2005, Women's Link Worldwide launched a bold and innovative challenge to the Colombian Constitutional Court, asking the judges to liberalize the country's abortion law, which outlawed the procedure under all circumstances.[475]

On May 10, 2006, the Constitutional Court took a historical decision, with a majority vote establishing that abortion could not be considered a crime in three specific circumstances:

- When a woman's life or physical or mental health is in danger.
- When the pregnancy is the result of rape or incest.
- When serious foetal malformations are diagnosed that make life outside the uterus unviable.

The Women's Link's case was the first to challenge Colombia's abortion laws on the grounds of unconstitutionality using arguments from international human rights law. The Colombian Constitution explicitly states that international human rights treaties ratified by Congress take precedence over national laws and serve as a guide in interpreting the rights established in the Constitution. Now that a woman's right to access safe and legal abortion has been legally acknowledged, Women's Link is working to:

- ensure the proper implementation of the new legal framework
- protect and strengthen the judicial decision that brought about this change

Colombia –Constitutional Court-Right to abortion in determined circumstances

Martha Solay Case-

Mexico: Violence and discrimination

In September2001, after finishing her shift as a waitress, 17-year-old Laura Berenice Ramos Monárrez failed to return home.[476] On October 10 of the same year, 20-year-old Claudia Ivette González was last seen leaving the LEAR 173 *maquiladora* (assembly plant, often of garments, for re-export), where she was not allowed in because she showed up for work two minutes late. On October 29, 15-year-old Esmeralda Herrera Monreal disappeared on her way home after working as a maid in a family home in Ciudad Juárez. When their relatives reported their disappearance, the local authorities failed to conduct any searches, assuming that the women were with their boyfriends.

In November 2001, eight bodies were found with signs of extreme sexual violence in a cotton field of the area and the "Cotton Field" case began to take shape.

In November 2007, the Inter-American Commission on Human Rights filed an application to the Inter-American Court of Human Rights against Mexico, in relation to the Cotton Field cases, in which it stated that the Mexican State was internationally responsible for the lack of protective measures for the victims, two of them minors; for the lack of preventive measures taken against these types of crimes despite being fully aware of the existence of a pattern of gender violence that resulted in the murders of hundreds of women and girls; for the lack of any response by the authorities when the disappearances were reported; for the lack of due diligence in the investigation of the murders; and for the denial of justice and reparation to the families.

After eight years, the Inter-American Court ruled that the young women González, Ramos and Herrera were victims of violence against women in accordance with the American Convention and the Convention of Belem do Para. For the same reasons, the Court found that the homicides were committed for gender reasons and within a recognised context of violence against women in Ciudad Juárez. The ruling also sanctioned Mexico for not offering the proper guarantees of protection for the three victims' lives and integrity.

The Court concluded that the State did not act promptly during the hours and days after the disappearances were reported, wasting valuable time. In the period between the reports and the discovery of the victims' bodies, the State limited itself to formalities and taking testimonies that, while important, lost their value when no specific search actions resulted. Additionally, the attitudes and declarations of public officials towards the relatives, indicating that the disappearance reports did not warrant urgent and immediate response, led the Court to conclude that there were unjustified delays. The Court considered that the State violated the rights to access justice and to legal protection enshrined in the American Convention on Human Rights.

In November 2009, the Inter-American Court of Human Rights found the Mexican State guilty of violating the human rights of Esmeralda Herrera Monreal, Laura Berenice Ramos Monárrez and Claudia Ivette González in the cases of feminicide in Ciudad Juárez.

Mexico –Inter-American Court of Human Rights

Violence against women - Feminicides

Cotton Field feminicides, Ciudad Juárez

Nicaragua: Illegal abortion = state violence

In 2010, the Nicaraguan Human Rights Centre (CENIDH) took up the case of "Amalia," a 27-year-old pregnant woman who was denied treatment for advanced cancer by the Nicaraguan State and was forced to continue her pregnancy.

In February 2010, CENIDH, the Strategic Group for the Decriminalization of Therapeutic Abortion and other organizations asked the IACHR for the adoption of precautionary measures to protect Amalia's life and physical and psychological integrity in view of the Nicaraguan State's refusal to provide her the medical treatment required, based on the absolute criminalization of abortion.

On February 26 of the same year, the precautionary measures were granted and the IACHR ordered the Nicaraguan State to take the necessary measures to ensure that Amalia had access to the medical treatment she needed for her illness.

Following the IACHR's request, the Nicaraguan State provided chemotherapy treatment. In its report to the IACHR in March 2011, the State informed that the treatment would be applied with interrupting the pregnancy. It should be pointed out that the request for precautionary measures came in a context of absolute prohibition of abortion in Nicaragua, an issue that has been pending resolution in the country's Supreme Court of Justice since 2006. Following the complete criminalization of abortion, on two occasions various individuals and CENIDH have appealed to the Supreme Court to rule on the unconstitutionality of articles 144, 148 and 149 of the Penal Code, which refer to the total prohibition of abortion, based on the current Constitution and the international human rights treaties ratified by the Nicaraguan State. As of October 2012, the Supreme Court has yet to pronounce on the alleged unconstitutionality, violating national standards on reasonable time periods established in the constitutional procedure and the international obligations derived from the American Convention on Human Rights.

The total prohibition of abortion in Nicaragua is a clear example of discriminatory implications for the female population and produces adverse effects on women's lives and health. In August 2010, the IACHR was informed about Amalia's childbirth and how the foetus was stillborn on July 23 due to malformations incompatible with life. The IACHR was later informed that Amalia died on December 18, 2011, from cancer with advanced metastasis. The LACWHN National Liaison denounced the expressions of State violence to which Amalia had been a victim when the treatment was not immediately applied, putting her life at risk, and when the risks involved in her pregnancy were not explained to her, subjecting her to almost nine months of psychological torture due to the State's political manoeuvres.

Ref.: MC-43-10 [477]
"Amalia" – Nicaragua

Dominican Republic: Life and health between terrestrial and celestial rights

Sixteen-year-old Rosaura Arisleyda Almonte Hernández from the Dominican Republic, known as "Esperancita," was hospitalized on July 2, 2012, in the SEMMA Hospital for Teachers, where acute lymphoblastic leukaemia was diagnosed along with a seven-week pregnancy. She had been referred by the Extreme Morbidity Committee with a recommendation for therapeutic abortion, but the medical team refused this as it is prohibited under article 37 of the country's Constitution, which states that life is inviolable from conception to death. They recommended waiting to see the natural outcome of the pregnancy.

In addition to not performing the therapeutic abortion, they also did not apply chemotherapy until 12 weeks into the pregnancy in order to avoid damaging the foetus. The mother demanded an abortion and the application of chemotherapy. During her stay in hospital she was seen by a psychologist to get her to accept the pregnancy, her access to the press was limited and she was denied admission to another hospital that offered better conditions for her state of health. Her demand was supported by a broad sector of society and the great pressure exerted led to the decision to belatedly apply chemotherapy, but not the abortion. "Esperancita" died on August 17, 2012.

Dominican Republic - Violation of Women's Human Rights
Rosaura Arisleyda Almonte Hernández [478]

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CHAPTER 7

recommendations

CHAPTER VII. Recommendations for the commitments of the ICPD Programme of Action

The participants from each country addressed four main aspects and recommended urgent change as a priority for continuing to develop the process of applying the Programme of Action after Cairo+20. They also recommended commitments from the governments with respect to sexual rights, reproductive rights, access to quality sexual health and reproductive health services, investments in health by the institutions, and the participation of international cooperation agencies providing financial resources transparently and in line with the principles of autonomy, equality and equity, promoting women's citizens' participation.

Policy changes supported by the ICPD Programme of Action in relation to health, sexual rights and reproductive rights

Abortion

- Legalize abortion so that it can be safe and free of risk in the framework of respect for human rights, recognizing the sexual rights and reproductive rights of women, adolescents and youth in all of the region's countries. Guarantee humanized abortion care through appropriate legislation, implementing standards and/or protocols, providing good quality care at all levels, and guaranteeing care to women through free services, psychological support and post-abortion advice, including safe contraceptive methods, respecting a woman's right to make a free and informed decision.
- Provide training to health, education, police and judicial personnel so that they know about the legislation and attention standards and protocols, guaranteeing good quality attention and avoiding the inequities and injustices to which women are subjected when they go to health, police and judicial facilities due to abortion under any circumstances.

Maternal mortality

- Guarantee the reduction of maternal mortality in the region through specific programmes aimed at: prevention and care for women during all of the stages of their reproductive life; ensuring access to pre-natal care in the most isolated communities; extending the provision of safe contraceptive methods, including emergency contraception, at the different healthcare levels in both the public and private sectors; ensuring the compliance with standards defining the appropriate use of all contraceptives according to the characteristics of the users, both female and male, providing timely and accurate information.
- Implement mass dissemination campaigns on different maternal mortality reduction strategies in the region. Register the causes of maternal mortality applying the international classification, particularly avoiding masking maternal deaths due to abortion.

Genital and breast cancer

- Promote at the public and private levels total coverage of periodical preventative examinations to detect genital and breast cancer for all women of fertile and post-menopausal age. Provide comprehensive accompaniment for women throughout the treatment process, creating inter-sectoral support networks that strengthen community work in such a way as to strengthen the care and the response to their needs.
- Guarantee the availability of medicines and treatments for all kinds of cancer and offer users acceptable natural alternatives. Implement national registration systems on genital and breast cancer, also disaggregated by gender variables. Develop mass cancer self-care and prevention campaigns.

HIV/AIDS

- Comply with the legislation on STIs, HIV and AIDs, developing comprehensive prevention and care strategies, guaranteeing compliance with them without violating the human rights of the people affected, promoting broad participation from women's organizations.
- Guarantee appropriate comprehensive care services for women from childhood, complying with standards and protocols that guarantee humanized health care. Ensure the availability of medicines and treatments, as well as support for affected families.

Violence

- Have a non-discriminatory legal framework that facilitates unrestricted respect for the exercising of human rights, access to justice and compensation for victims and their families, thus stopping the re-victimization of women, adolescent and child victims of violence.
- Ensure compliance with the legislation and adopt measures to prevent actions or behaviours based on gender discrim-

ination that cause death, damage or physical, sexual or psychological suffering to women, both in the public and private spheres, in accordance with what is established in the Belem do Pará Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women.

- Guarantee national records that allow comparisons to be made among the region's countries, fostering exchanges of experiences with those where the issue of violence has been better developed. Establish national and regional alliances with the aim of sharing legal arguments that facilitate the eradication of violence.

Adolescents – girls

- Guarantee public- and private-level comprehensive sex education from childhood, based on human rights and gender equity and that is culturally and generationally relevant, through appropriate methodologies. Provide adolescents with access to safe, age-appropriate contraceptive methods.
- Recognise adolescents in their diversity as rights holders and establish mechanisms for their participation in the design and implementation of public policies. Access must be ensured to education and health services in the areas of sexuality, reproduction and non-violence.

Guarantee that government and donor investments in women's sexual and reproductive health and rights reflect their commitment and are on-going and sustained

- Continue demanding that international cooperation invest in projects and programmes aimed at women in the countries. Conduct research to demonstrate the need to maintain the commitment of international aid to the health of the region's women, which is increasingly deteriorating as the result of neoliberal globalization and gender inequities in all development spheres.
- Demand that the governments allocate disaggregated budget items for specific priorities and programmes aimed at women's comprehensive health; and items to achieve linkage among the State, women's organizations and civil society organizations.
- Guarantee that all women have social security that allows them to achieve a dignified standard of living with access to comprehensive health services, including diagnostic means and treatment, as well as the right to pensions in the adult stage of their lives.
- The UNFPA and other UN agencies must review their limited commitment to Chapter XV of the Programme of Action in relation to facilitating dialogue with and promoting the participation of organized women, assigning funds for the definition, execution and monitoring of the national public policies recommended by the ICPD.

Establish rights to sexual and reproductive health and sexual and reproductive rights, particularly for women and people of different sexual orientation and gender identity

- The States must guarantee, promote and protect all of the citizens' rights of women, taking into account their particular health needs based on their diversity and living conditions. They must eliminate the legal, economic, political, religious and cultural barriers to sexual and reproductive health care.
- Promote in society in general and among decision makers in particular respect for women's sexual rights and reproductive rights as human and citizens' rights.
- Implement education and sensitization processes specifically with the gay, lesbian, bisexual, transvestite, transgender, transsexual and intersex community, with the aim of achieving their empowerment through legal and political tools that allow them to actively participate in the defence of their rights in the different arenas where there is discrimination, violence, hatred, rejection and repudiation.

Recommendations with respect to the priorities of the Latin American region's women's movement

The countries' constitutional, legal and public policy priorities. What legislation should be immediately approved or repealed?

Call for and demand: the re-establishment of the rule of law as a priority in order to guarantee the rights of citizenship and participatory democracy in all spheres of economic, political, social and cultural development; and the ratification of the CEDAW Optional Protocol, allowing access to justice and to protection when women's rights are violated, assuming the recommendations and complying with the human rights-related obligations and commitments. Demand the promotion and recognition of the international framework with regard to gender in public laws and policies that positively influence the life and health of women, and recognise them as citizens with full rights and access to goods and services.

Repeal the laws criminalizing the right to interrupt one's pregnancy, establishing the Day of the Unborn Child and those legal instruments that violate the rights of women, female adolescents and youth and girls.

Possible linkage with other social sectors

Strengthen the linkage with national, regional and international human rights organizations and with academia, especially in the areas of medicine, law and psychology, addressing and/or strengthening the discourse in relation to abortion. Link with unions, political parties, civil organizations, and social movements that are either emerging or "of the moment" in the interest of defending human and citizens' rights. Involve the mass and alternative media as generators of opinion. Build a strategy linked with women's organizations, feminist organizations and social movements in defence of a secular State. Strengthen international feminist linkage through the recognition of alliances and supporting their struggles and demands through solidarity.

Are the organizations of the women's movement carrying out activities in coalitions or alliances?

Continue working with women and based on women in coalitions and alliances, strengthening the discourse and action based on a feminist focus and human and generational rights. Strengthen the national, regional and international alliances and coordination in defence of women's life and health.

There are campaigns promoted by the women's movements on key dates. They are relevant

Continue developing campaigns for sensitization and the dissemination of information in the local and regional contexts, particularly on the situation of the rights of women and female adolescents and youth. Include the campaigns as an integral part of the national, regional and international agendas and action strategies of feminist and women's organizations. Promote campaigns and public debate on the right to abortion, as well as the consequences of unsafe abortion on women's health and lives.

How to strengthen the movement

The main challenge with the 21st century well underway is real linkage on the issue of health and sexual and reproductive rights, with a clear local, national, regional and international action strategy.

Build less competitive, joint solidarity-based agendas, with fewer disputes over who takes the lead, promoting collective strategies through alliances, pacts and common agendas.

Strengthen the feminist and women's movement by sharing information, disseminating successful actions, and systematically analysing contexts and moments. Promote individual and collective leaderships that enable advocacy and active participation, fully exploiting the new information and communication technologies.

What are the relevant issues that require urgent promotion?

Promote access to non-punishable abortion and comprehensive sex education, as well as the right of women to health, a life free of violence, and to exercise their sexuality with freedom and autonomy. Demand, promote and strengthen respect for and the validity of the secular state in the fight against religious fundamentalisms that dominate, control and subject women's bodies and sexualities.

Proposal for following up on Cairo after 2014 from the women's movement

Design strategies that guarantee that the evaluation of Cairo beyond 2014 is a joint process among governments, women's organizations and civil society organizations, stressing collective arenas in their cultural, ethnic, social, youth and feminist diversity. Recover the strategy of feminist advocacy; expand organization and lobbying abilities; and reactivate the national and sub-regional dialogue mechanisms with a new focus, in accordance with the international, regional, national and local contexts. Advance with the review of compliance with the Cairo Programme of Action, demanding the participation of youth and women's organizations in consultation meetings and in national work groups. Strengthen the national and regional monitoring and follow up mechanisms that enable the measurement of compliance with the agreements of the Cairo Programme of Action; and promote the establishment of agreements, through the implementation of clear participation mechanism, with rules for the evaluation of the strategies.

North-South linkage

Establish North-South linkage mechanisms that guarantee equal conditions, demanding the mobilization of resources in a framework of respect and autonomy and fostering funding for development on gender equality and the rights of women beyond gender mainstreaming. Review and contextualize the North-South cooperation standards to enable their actions to respond to the regional reality.

How the women's movement is strengthening itself and how we can have a strong position again. Who we need to make agreements with

Strengthen relations with the media and men and women of the press to mobilize the discourse on the human rights of women and female adolescents and youth. Strengthen the national networks and arenas of the feminist and women's movement, establishing horizontal relations through the exercising of democratic practices and design overall strategies that integrate the particular needs of the diversity of women in the region.

Analyse advances and reversals and define how agreements are reached, what is agreed and how they are progressing. Strengthen the citizens' rights of young people to guarantee the continuity and strengthening of the monitoring and follow up processes.

Role of the NGOs and national/regional/international participation

Promote the women's rights agenda in the context of UN and ECLAC conferences, conventions and commissions. Demand coordinated participation as part of the official delegations, as well as linkage with global and regional networks. Build alliances to share experiences and knowledge and to generate new strategies that allow advances in the recognition of women's rights; and continue developing mobilization strategies at the national level through press releases, bulletins, calls to action and political positioning and pronouncements that place the defence of women's rights in the national, regional and international spheres.

How we advanced following Cairo. At least 75% of our demands have been met

Guarantee that the evaluation of the Cairo Programme of Action beyond 2014 is a process between governments and civil society organizations, stressing the collective arenas of women and feminists, which includes their cultural, sexual, physical, ethno-racial, social and generational diversities. Conduct efforts to guarantee women's reproductive autonomy, including sex education, access to modern contraceptive methods and assisted reproduction techniques, and access to legal and safe abortion.

Demand the review of legislations that criminalize the voluntary interruption of pregnancy. Promote the development of and access to advances in knowledge and scientific research in sexual and reproductive matters. Eradicate avoidable maternal deaths and reduce extreme maternal morbidity. Recognize female and male youths in their diversity as rights holders and establish mechanisms for their participation in the design and implementation of public policies. Recognise the human and citizens' rights of older women who perform sex work.

Maintain the autonomy of the women's organizations and their leaders against the pressure exerted by cooperation agencies that impose their own agendas and priorities on issues related to sexual health and reproductive health in the region.

APPENDIX OF TABLES

Table I

Status of Major International Human Rights Instruments

Country	International Covenant on Civil and Political Rights (1966)	International Covenant on Economic , Social and Cultural Rights (1966)	Convention on the Elimination of All Forms of Discrimination Against Women (1979)	Convention on the Rights of the Child(1989)
Argentina	1986	1986	1985	1990
Brazil	1992	1992	1984	1990
Colombia	1969	1969	1982	1991
Mexico	1981	1981	1981	1990
Nicaragua	1980	1980	1981	1990
Dominican Republic	1978	1978	1982	1991

Source: Human Development Report 2007/2008

http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf

Table Ia

Reservations of CEDAW

Country	Articles for which declarations or reservations have been made
Argentina	Article 29, para. 1
Brazil	Article 29, para. 1
Colombia	
Mexico	
Nicaragua	
Dominican Republic	

Source: UN Meeting of States Parties to the Convention on the Elimination of All Forms of Discrimination against Women. Fourteenth meeting New York, 23 June 2006. CEDAW /SP/2006/2

http://www.un.org/womenwatch/daw/cedaw/Article 29:

1 Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree on the organization of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.

Table II

Governments who participated in and endorsed International Conferences & Reservations on the ICPD Programme of Action

Country	International Conference on Population and Development (ICPD 1994)*	Beijing Platform for Action (1995)**	Millennium Development Goals (2000)***
Argentina	1994	1995	2000
Brazil	1994	1995	2000
Colombia	1994	1995	2000
Mexico	1994	1995	2000
Nicaragua	1994	1995	2000
Dominican Republic	1994	1995	2000

Source: From ICPD Programme of Action (PoA)*; Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995**; MDG Monitor: Tracking the Millennium Development Goals. Available online at: http://www.mdgmonitor.org ***

With regards to the ICPD PoA, the following countries made comments or expressed reservations:

On the Chapter II, Argentina

On the Chapter V, Nicaragua, Dominican Republic

On the Chapter VII, Argentina, Nicaragua

On the Chapter X, Dominican Republic

Table III

Life Expectancy at Birth

Country	2001		2005	
	Female	Male	Female	Male
Argentina	77.4	70.3	78.6	71.1
Brazil	72.3	63.7	75.5	68.1
Colombia	75.0	68.6	76.0	68.7
Mexico	76.1	70.1	78.0	73.1
Nicaragua	71.5	66.8	75.0	69.0
Dominican Republic	69.3	64.4	74.8	68.6

Source: Human Development Reports 2001 and 2005. Available online at: http://hdr.undp.org/en/media/hdr03_sp_complete2.pdf

Table IV

Infant & Under-5 Mortality Rates

Country	Infant Mortality Rate (per 1,000 live births)			Under-5 Mortality Rates (per 1,000 live births)		
	1990	2001	2005	1990	2001	2005
Argentina	25	13	15	28	16	18
Brazil	50	31	31	60	36	33
Colombia	29	19	17	36	23	21
Mexico	37	24	22	46	29	27
Nicaragua	52	36	30	66	43	37
Dominican Republic	53	41	26	65	47	31

Source: Human Development Reports 1995, 2003, and 2005. Available online at:
http://hdr.undp.org/en/media/hdr03_sp_complete2.pdf
http://hdr.undp.org/en/media/HDI_2008_EN_Tables.pdf

Table V

Human Development Index

Country	Population	1995	2005	2011
Argentina	VALUE	0.882	0.869	0.797
	RANK	30	38	45
Brazil	VALUE	0.804	0.800	0.718
	RANK	63	70	84
Colombia	VALUE	0.836	0.791	0.710
	RANK	57	75	87
Mexico	VALUE	0.842	0.694	0.770
	RANK	53	52	57
Nicaragua	VALUE	0.611	0.583	0.589
	RANK	109	110	129
Dominican Republic	VALUE	0.705	0.628	0.689
	RANK	96	79	98

Source: Human Development Reports 1995, 2005, and 2011. Available online at:
http://hdr.undp.org/en/media/hdr_1995_es_indicadores1.pdf
http://hdr.undp.org/en/media/hdr03_sp_complete2.pdf
http://hdr.undp.org/en/media/HDR_2011_ES_Complete.pdf

Table VI

Gender-Related Development Index (GDI)

Country	Population	2005	2011
Argentina	VALUE	0.865	0.372
	RANK	36	67
Brazil	VALUE	0.798	0.449
	RANK	60	80
Colombia	VALUE	0.789	0.482
	RANK	66	91
Mexico	VALUE	0.820	0.448
	RANK	51	79
Nicaragua	VALUE	0.696	0.506
	RANK	99	101
Dominican Republic	VALUE	0.773	0.480
	RANK	74	90

Source: Human Development Reports 1995, 2005, and 2011. Available online at:
http://hdr.undp.org/en/media/hdr_1995_es_indicadores1.pdf
http://hdr.undp.org/en/media/hdr03_sp_complete2.pdf
http://hdr.undp.org/en/media/HDR_2011_ES_Complete.pdf

Table VII

Combined gross enrolment ratio for primary, secondary and tertiary education (%)

Country	Combined gross enrolment ratio for primary, secondary and tertiary education (%)			
	2000		2005	
	Female	Male	Female	Male
Argentina	94	85	94	86
Brazil	97	93	89	86
Colombia	72	69	77	74
México	74	74	76	75
Nicaragua	66	63	72	70
Dominican Republic	77	71	78	70

Source: Human Development Reports 1995, 2000, 2007/8. Available online at: http://hdr.undp.org/en/reports/global/hdr2007-2008/

Table VIII

Net enrolment ratio in primary education

Country	Net enrolment ratio in primary education	Girls' share of primary enrolment*	
		Year	%
Argentina	99 (2004)	2007	0.99
Brazil	95 (2004)	2008	0.93
Colombia	87 (2005)	2007	1.0
Mexico	98 (2005)	2008	0.98
Nicaragua	87 (2005)	2008	0.98
Dominican Republic	88 (2005)	2009	0.86

Source: Human Development Reports 2007/8.
Available online at: http://hdr.undp.org/en/reports/global/hdr2007-2008/
http://www.cepal.org*

Table IX

Net enrolment ratio in secondary education

Country	Net enrolment ratio in secondary education	Girls' share of secondary enrolment*	
		Year	%
Argentina	79 (2004)	2007	1.1
Brazil	78 (2004)	2008	1.1
Colombia	55 (2005)	2007	1.11
Mexico	65 (2005)	2008	1.1
Nicaragua	43 (2005)	2008	1.1
Dominican Republic	53 (2005)	2009	1.1

Source: Human Development Reports 2007/8.
Available online at: http://hdr.undp.org/en/reports/global/hdr2007-2008/
http://www.cepal.org*

Table X

Tertiary gross enrolment ratio

Country	Tertiary gross enrolment ratio		Women's share of tertiary enrolment	
	Women	Men	Year	%
Argentina	83.2	54.6	2008	68.7
Brazil	29.0	22.4	2005	25.6
Colombia	40.9	37.4	2010	39.1
Mexico	27.6	28.4	2010	28.0
Nicaragua	18.7	17.2	2003	18.0
Dominican Republic	41.4	26.1	2003	33.7

Source: http://websie.eclac.cl/sisgen/ConsultaIntegrada.asp?idAplicacion=11&idTema=193&idIndicador=99

Table XI

Consolidated National Health Accounts

Country		2003	2008	2010
	Argentina			
	Total expenditure on health as percentage of GDP (THE)	8.3	8.4	8.1
	General government expenditure on health as percentage of total government expenditure	52.3	62.6	54.6
	Per capita total expenditure on health (in PPP $)	283$	698$	742$
	General Government expenditure on health as percentage of total health expenditure (GHE)	8.3	8.4	8.1
	Private expenditure on health as percentage of total health expenditure (PHE)	64.4	59.2	65.8
		2003	**2008**	**2010**
	Brazil			
	Total expenditure on health as percentage of GDP (THE)	7.0	8.3	9.0
	General government expenditure on health as percentage of total government expenditure	44.4	42.8	47.0
	Per capita total expenditure on health (in PPP $)	214$	715$	990$
	General Government expenditure on health as percentage of total health expenditure (GHE)	7.0	8.3	9.0
	Private expenditure on health as percentage of total health expenditure (PHE)	62.6	56.0	57.8

continues

		2003	2008	2010
Colombia				
	Total expenditure on health as percentage of GDP (THE)	6.3	6.9	7.6
	General government expenditure on health as percentage of total government expenditure	84.1	70.6	72.7
	Per capita total expenditure on health (in PPP $)	146$	377$	472$
	General Government expenditure on health as percentage of total health expenditure (GHE)	6.6	6.9	7.6
	Private expenditure on health as percentage of total health expenditure (PHE)	47.2	76.3	71.5
		2003	**2008**	**2010**
Mexico				
	Total expenditure on health as percentage of GDP (THE)	5.8	5.9	6.3
	General government expenditure on health as percentage of total government expenditure	44.2	46.9	48.9
	Per capita total expenditure on health (in PPP $)	392$	598$	604$
	General Government expenditure on health as percentage of total health expenditure (GHE)	5.8	5.9	6.3
	Private expenditure on health as percentage of total health expenditure (PHE)	94.7	92.9	92.2
		2003	**2008**	**2010**
Nicaragua				
	Total expenditure on health as percentage of GDP (THE)	7.9	9.3	9.1
	General government expenditure on health as percentage of total government expenditure	56.6	54.8	53.3
	Per capita total expenditure on health (in PPP $)	61$	105$	103$
	General Government expenditure on health as percentage of total health expenditure (GHE)	7.9	9.3	9.1
	Private expenditure on health as percentage of total health expenditure (PHE)	88.7	93.0	92.6
		2003	**2008**	**2010**
Dominican Republic				
	Total expenditure on health as percentage of GDP (THE)	6.0	5.7	6.2
	General government expenditure on health as percentage of total government expenditure	33.1	37.1	43.4
	Per capita total expenditure on health (in PPP $)	129$	269$	323$
	General Government expenditure on health as percentage of total health expenditure (GHE)	6.0	5.7	6.2
	Private expenditure on health as percentage of total health expenditure (PHE)	70.2	66.3	65.7

Source: Global Health Expenditure Database http://apps.who.int/nha/atabase/StandardReportList.aspx

Table XII

The original six emergency obstetric care indicators, with modifications

Indicator	Acceptable level
1. Availability of emergency obstetric care: basic and comprehensive care facilities	There are at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500 000 population
2. Geographical distribution of emergency obstetric care facilities	All sub-national areas have at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500 000 population
3. Proportion of all births in emergency obstetric care facilities[a]	(Minimum acceptable level be set locally)
4. Met need for emergency obstetric care: proportion of women with major direct obstetric complications who are treated in such facilities[a]	100% of women estimated to have major direct obstetric complications[b] are treated in emergency obstetric care facilities
5. Caesarean sections as a proportion of all births[a]	The estimated proportion of births by caesarean section in the population is not less than 5% or more than 15%
6. Direct obstetric case fatality rate[a]	The case fatality rate among women with direct obstetric complications in emergency obstetric care facilities is les than 1%

Adapted from reference (1).

[a] While these indicators focus on services provided in facilities that meet certain conditions (and therefore quality as emergency obstetric care facilities), we strongly recommend that these indicators be calculated again with data from all maternity facilities in the area even if they do not quality as emergency obstetric care facilities.

[b] The proportion of major direct obstetric complications throughout pregnancy, delivery and immediately postpartum is estimated to be 15% of expected births.

http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf

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