

## SEXUAL AND REPRODUCTIVE HEALTH

In spite of advances made in the years after the International Conference on Population and Development in Cairo in 1994 (304) and the Fourth World Conference on Women in Beijing in 1995 (305), the impact of actions to improve sexual and reproductive health (SRH) has been very weak, inasmuch as it has not yet been determined how to narrow the inequity gap or provide support to countries, their leaders, and the community in correcting the disparities in access to information and services that will lead to a more equitable distribution of health-care goods. In considering sexual and reproductive health, the International Conference issued pronouncements on several key issues (304). First, everyone has the right to the enjoyment of physical, mental, and social well-being, not merely to the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and have the capability to reproduce as well as the freedom to decide if, when, and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice; the right to access appropriate health-care services that will ensure safe pregnancy and childbirth; the right to medical care for sexually transmitted infections, including HIV/ AIDS; and the prevention of cancer of the female reproductive system, menopause-related disabilities, and sexual violence.

Although advances are being made in defining policies and programs, which in turn have brought about improvements in aspects of sexual and reproductive health in the Region, a Regional strategy has yet to be developed.

Action must be focused at political, social, and administrative levels, where effective strategic plans should be formulated, the capacity to define priorities in the field of sexual and reproductive health developed, legal and political constraints eliminated, political will mobilized, and the visibility of the problem and accountability of the various actors enhanced. Activities also must focus on sexual and reproductive health promotion and services, in which utilization of human resources must be improved; the adoption of good practices at the national and regional levels must be fostered; and the barriers preventing or limiting the use of services by individuals, families, and the community must be eliminated.

## Status of Sexual and Reproductive Health in the Region's Countries

The total estimated population of the Region in 2005 was 892 million, with 561 million (63%) living in Latin America and the Caribbean. Each year, slightly more than 16.2 million children are born in the Region, 11.7 million of them in Latin America. Although the population continues to increase (306), birth and fertility rates are clearly declining, which in conjunction with falling mortality rates has meant that 10 countries in the Region have completed or have nearly completed their demographic transition. For example, the overall estimated fertility rate in Cuba is 1.6 children per woman. At the other extreme is Guatemala, however, with a fertility rate of 4.3 children per woman.

This decline in the birth rate, along with changes in mortality, translates into a slowing of the natural growth rate of the Region, but also into major growth of the population of adolescents and young people owing to demographic inertia, as well as to a clear trend towards the aging of the population in most countries. This situation, combined with the increase in the absolute number of poor people in Latin America and the Caribbean (currently estimated at more than 150 million persons), the feminization of poverty, and a sharp increase in unemployment in most countries, translates into a widening of inequity gaps for large population groups, an increase in poverty transmitted from generation to generation, and an ever-increasing shift of major population groups to urban peripheries and to nearby or distant countries. The conditions described impose additional burdens on health-care systems in general and adversely affect sexual and reproductive health in particular.

Sexual and reproductive health accounts for approximately 20% of the total illness burden among women and 14% among men, revealing a clear-cut gender gap. Individual countries and the Region as a whole have advanced in some aspects of sexual and reproductive health, but there is a very marked contrast between the health indicators of the Region's most developed countries (Canada and United States) and those of Latin American and Caribbean countries. This disparity can be partly explained by the sharp economic adjustment these countries have undergone, which has widened existing inequity gaps between countries and within countries.

Contraceptive use in the Region exceeds 60%, although Bolivia, the Dominican Republic, Guatemala, Haiti, Honduras, Mexico, Paraguay, and Venezuela still see limited progress (306). Emergency contraception and condom use for preventing sexually transmitted infections and unwanted pregnancies are barely practiced by users or in the health care services in the Region.

## Women's Health and Maternal Health

Maternal health can be regarded as a summary gauge of reproductive health and can be used as an indicator, for lack of a more accurate one, of the status of maternal health. Estimates published in the annual yearbook of health statistics (307) show 22,680 maternal deaths (circa 2003) and 16.2 million births (same year) in the Region; accordingly, the maternal mortality rate is around 140 per 100,000 live births. Yet PAHO basic indicators informed by reports from the countries' ministries of health for the same year show a maternal mortality rate of 71.9 per 100,000 live births (11,652 deaths due to maternity-related causes).

If the risk of maternal death in Latin America and the Caribbean is compared with the risk in Canada, the average in the former is 21 times greater than that in the latter. Moreover, when national averages of maternal death rates are examined, a broad range is seen, ranging from 523 per 100,000 live births in Haiti to 13.4 in Chile (306). Another way to analyze these differences is by the time lag of the indicator, which can be measured by comparing the current rate in one country with a time series in another. For example, if the current rate of maternal mortality in Haiti is compared with a time series of the same rate in the United States, the former corresponds to the 1930 rate in the United States; in other words, a lag of more than 75 years. If the current rate in Haiti is compared with the time series for Chile, the former corresponds to the 1980 rate in the latter, or a lag time of more than 25 years.

**TABLE 24. Leading causes of maternal mortality, by mortality rate and availability of reproductive services, groups of countries, Region of the Americas, 2004.**

Service coverage	Maternal mortality rate per 100,000 live births			
	< 20	20–49	50–100	>100
Contraception, 70%–75% Prenatal care, 100% Delivery, 100%	<b>Group A countries</b> 1. Indirect 2. Preeclampsia 3. Infections			
Contraception, 45%–69% Prenatal care, 90%–100% Delivery 90%–100%	<b>Group B countries</b> 1. Abortion 2. Preeclampsia 3. Hemorrhage			
Contraception, 45%–66% Prenatal care, 45%–96% Delivery 83%–97%	<b>Group C countries</b> 1. Preeclampsia-eclampsia 2. Hemorrhage 3. Abortion			
Contraception 28%–58% Prenatal 53%–86% Delivery 24%–86%	<b>Group D countries</b> 1. Hemorrhage 2. Preeclampsia-eclampsia 3. Obstructed delivery			

*Note:* Group A countries: Canada, United States, Puerto Rico; Group B countries: Argentina, Brazil, Chile, Costa Rica, Cuba, Mexico, and Uruguay; Group C countries: Colombia, Ecuador, Panama, Nicaragua, and Venezuela; Group D countries: Bolivia, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Paraguay, and Peru.

*Source:* Based on Schwarcz R, Fescina R. Maternal Mortality in Latin America and the Caribbean. *Lancet* 2000; 356 (suppl.) S11:3245–87. (Figures updated to 2004).

An analysis of the indicators in several countries of the Americas (accounting for approximately 98% of the total population), in terms of their maternal mortality rates (less than 20, 20–49, 50–100, and over 100 per 100,000 live births), their prenatal and delivery care coverages, and the prevalence of contraception use (Table 24), shows that the basic causes of death are almost the same in the four groups, although their rank order differs (308).

This type of analysis enables more specific interventions to be proposed. For example, a recommendation for group A would be to strengthen care in pre-pregnancy for the most vulnerable populations; for group B, the recommendation would be to intensify sex education and family planning programs, including emergency contraception; for group C, prenatal monitoring coverage should be broadened; and for group D, access to care should be guaranteed through the elimination of economic and cultural barriers, the establishment of birthing homes near health-care services, and improvements to services.

Prenatal care coverage of at least one office visit averaged higher than 85%. However, an analysis by income quintile shows that in Bolivia, Brazil, Colombia, Guatemala, Haiti, Nicaragua, Paraguay, and Peru, 90% or more of pregnant women in the highest-income quintile had prenatal check-ups, compared to just 35%–68% in the lowest-income quintile (309). It bears noting that this level of coverage is not a measure of the real prenatal care situation. Prenatal care should consist of at least four or five duly scheduled office visits, with early enrollment and a well-defined procedure. If these standards were applied, actual coverage figures would be much lower.

In terms of delivery care by trained personnel, an increase of 11% between 1999 and 2002 was observed; as a result this indicator averages above 88% in Latin America (309). Nonetheless, there are still nine countries with below-average figures, with coverage ranging from 24% (Haiti) to 84% (Guatemala). An analysis of qualified delivery care by income quintiles shows that it exceeds 90% among the wealthiest in countries such as Brazil, Bolivia, Colombia, Guatemala, Haiti, Nicaragua, Paraguay, Peru, and the Dominican Republic. Yet among lower-income quintiles it stands at just 20% in Bolivia, Guatemala, Haiti, and Peru; between 30% and 40% in Nicaragua and Paraguay; and between 60% and 85% in Brazil, Colombia, and the Dominican Republic (309).

The incidence of cesarean section is an indicator of the quality of perinatal care. A WHO recent study in different regions found an overall cesarean section rate of 35% in Latin America. Data from the 2006 World Yearbook of Health Statistics (307) show wide variations between countries, from 2% in Haiti and 8% in Belize, to 36% in Brazil and 37% in Chile. WHO has indicated that the optimal rate of cesarean section is between 15% and 20%.

The prevalence of modern contraceptive use in Latin America and the Caribbean averaged 65%, with a range from 28% in Haiti to 84% in Uruguay.

A serious public health problem is unsafe abortion, one of the three leading causes of maternal deaths in all countries (except Canada and the United States). Estimates are that more than four million abortions are performed every year in Latin America, 2.2 million of them in three countries (Brazil, 1.2 million; Argentina, 500,000; and Mexico, 500,000) (310). In addition, one-quarter of



maternal deaths in Chile were the result of an abortion, and in Argentina, Jamaica, and Trinidad and Tobago the proportion exceeds 30%.

The rate of HIV infection among pregnant women and newborns has increased in recent years. The rate of HIV seroprevalence among pregnant women, which is an approximate measure of the extent of infection among the population at large, is as high as 13% in Haiti as a whole, 10% among urban adults, and 4% in rural areas (311). In several regions of the Dominican Republic, 1 of every 12 women receiving prenatal care was infected, with rates of 7.1% in Guyana, 3.6% in the Bahamas, 2.5% in Belize, 1.5% in Jamaica, and 1.4% in Honduras (311).

## Perinatal Health

Several indicators provide a comprehensive assessment of perinatal health, including fetal, neonatal, and perinatal mortality rates. However, due in part to significant underreporting and because countries continue to use different cutoff points for these indicators, the magnitude of fetal and perinatal mortality is not well known Regionwide. Despite reporting-related difficulties, in 2006 WHO estimated a total of 280,000 perinatal deaths (a rate of 17.3 per 1,000) in the Americas, around 45% of which were late stillbirths and 55% (152,000) early neonatal deaths (312). The risk of perinatal death in Latin America and the Caribbean is, on average, three times higher than that in Canada and the United States (312).

Moreover, 85% of all neonatal deaths are associated with low birthweight (<2500 g); the most common causes are preterm births and fetal growth retardation. In the Region, the proportion of low-birthweight children ranges from 5.7% in Canada to 12% in Guatemala. The neonatal component accounts for the highest proportion of infant mortality (61%) in Latin America and the Caribbean. The infant mortality rate in Latin America and the Caribbean circa 2003 averaged 24.8 per 1,000 live births, or an approximate 290,000 infant deaths, 177,000 of them associated with the perinatal period (306).

## Sexual and Reproductive Health of Adolescents

Every year there are some 54,000 births to mothers under age 15 and two million to mothers between 15–19 years old. The specific birthrate among mothers 15–19 years old ranges from 23.4 per 1,000 live births in Chile to 136 per 1,000 in Honduras. Among 10–14-year-olds, the rate ranges from approximately 1% in Uruguay and Cuba to 4% in Brazil and Haiti (302, 313). In the latter age group the rate of maternal mortality doubles that of the 15–19-year-olds (Table 25).

Adolescents tend to be sexually active at early ages in the Region, where the average age at which both sexes start having sexual relations is 16; the lower end is 14 in the Caribbean and the higher end, 17 in Paraguay. In the United States, 77% of adolescent girls have had their first sexual relationship, but only 17%

**TABLE 25. Maternal mortality rate (per 100,000 live births) by age of adolescents, selected countries, Region of the Americas, circa 2003.**

Country	10–14 years old	15–19 years old
Mexico	131	37
Argentina	190	23
Chile	42	20
Brazil	65	38

*Source:* Statistics from the countries:

Mexico: Secretaría de Salud. <http://www.salud.gob.mx/>.

Argentina: Instituto Nacional de Estadísticas y Censos <http://www.indec.mecon.gov.ar/>.

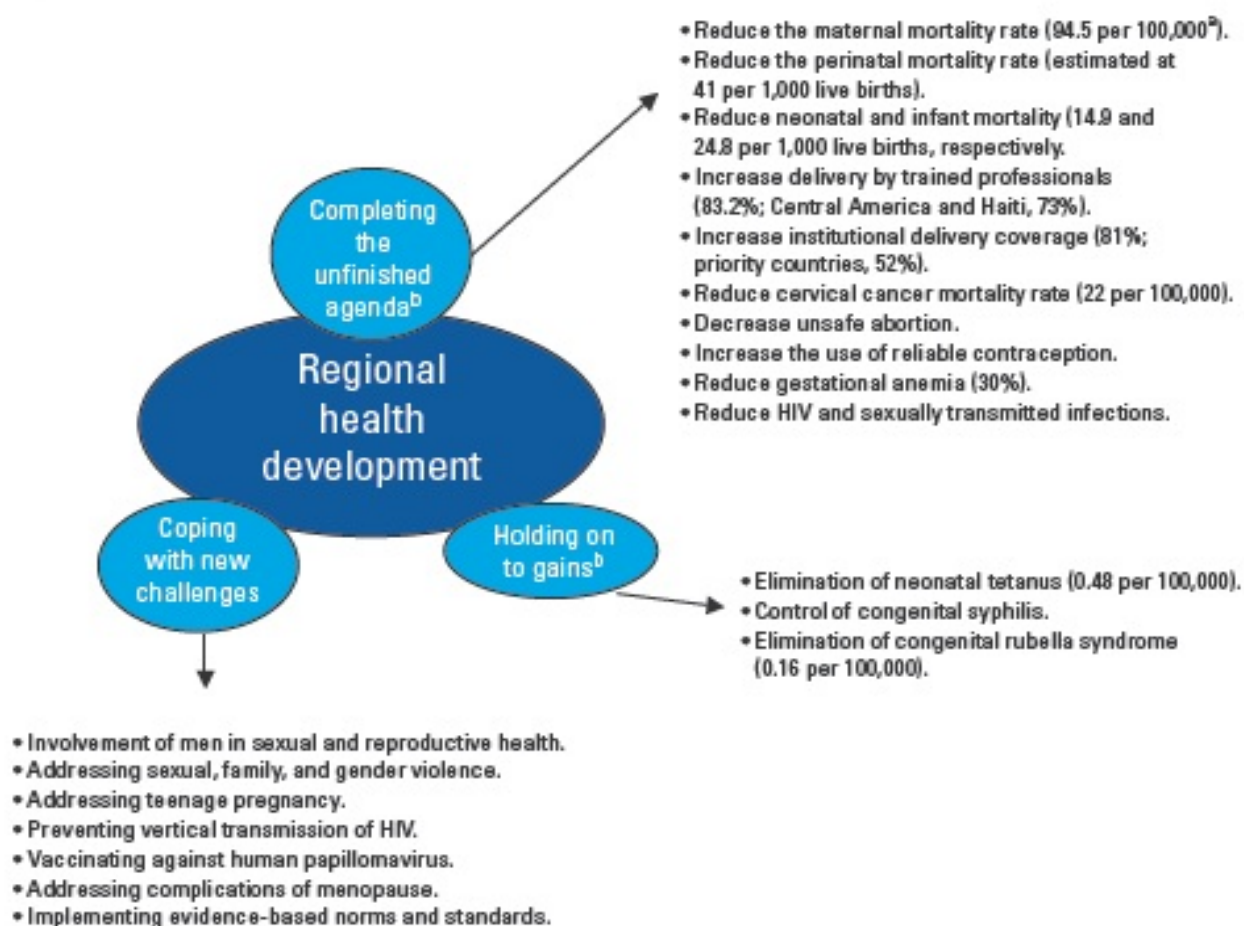
Chile: Instituto Nacional de Estadística [http://www.inec.cl/inec/canales/chile\\_estadistico/home.php](http://www.inec.cl/inec/canales/chile_estadistico/home.php).

Brazil: Ministério da Saúde. Datasus <http://w3.datasus.gov.br/datasus/datasus.php>. (Accessed 6 November 2006).

become pregnant; in contrast, in Latin America and the Caribbean, only 56% have started having sex, but 34% have had a child before age 19. This situation could be explained by the difference in education, especially with regard to sexual and reproductive health, and differences in access to contraception between the two subregions (304). Besides the repercussions of pregnancy for adolescent mothers themselves, neonatal and infant mortality is twice as high among mothers in that age group than among 20–24-year-olds. Fetal mortality is not substantially different.

Sexual and reproductive health in the Region requires safeguarding advances already made and addressing unresolved issues (unfinished business) and any new challenges. The framework for technical cooperation to cope with the future is presented in Figure 29.

**FIGURE 29. Conceptual framework for technical cooperation in sexual and reproductive health.**



<sup>a</sup>Estimated rate: 190 per 100,000 (UNICEF/UNFPA/WHO, 2002) and 140 per 100,000 (World Health Statistics, 2006).

<sup>b</sup>The latest available figures are given in parentheses.