WOMEN'S RIGHT TO HEALTH IN THE ANGLO-CARIBBEAN: INTIMATE PARTNER VIOLENCE, ABORTION AND THE STATE

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Abstract

Women's sexual and reproductive health is a public health concern globally, yet in the Caribbean region academic publications exploring this topic from a rights approach are uncommon. A document review was conducted based on the application of the Health Rights of Women Assessment Instrument to the strategic health plans of three Anglo-Caribbean countries. Gender was the underlying theme used to conduct a comparative analysis focusing on intimate partner violence, access to legal abortion and government commitment. The results reveal that important steps have been taken by all countries to address intimate partner violence and abortion, yet effective implementation is threatened by ambiguity in the states' approach to those issues as well as financial, social and infrastructural challenges. Accountability mechanisms are either lacking or underutilized and much remains to be done to effectively demonstrate governments' commitment to women's sexual and reproductive health and rights.

Keywords: Gender, Anglo-Caribbean, Abortion, Intimate partner violence, Sexual and reproductive rights, HeRWAI.

Resumen

La salud sexual y reproductiva de las mujeres es un tema clave de salud pública, sin embargo en la región del Caribe son escasas las publicaciones que exploran este tema desde un enfoque de derechos. En este artículo utilizamos el Instrumento de Health

Rights of Women Assessment Instrument [Evaluación de Derecho a la Salud de las Mujeres] para analizar los planes estratégicos de salud de tres países del Caribe anglófono. Utilizando el género como eje transversal, realizamos un análisis comparativo de estos planes, poniendo énfasis en tres aspectos: la violencia de compañero íntimo, el aborto seguro y los compromisos estatales. Los resultados revelan que los tres países han tomado medidas importantes contra la violencia de compañero íntimo y para mejorar el acceso a aborto seguro; sin embargo la implementación efectiva de estas medidas queda amenazada por el enfoque ambiguo que los estados adoptan en estos temas, por factores socio-culturales, así como por limitaciones presupuestarias y de infraestructura. Los mecanismos de veeduría son escasos e infrautilizados, y queda mucho por hacer para que los gobiernos de estos tres países demuestren un compromiso real con los derechos sexuales y reproductivos de las mujeres

Palabras clave: Género, Caribe anglófono, aborto, violencia de compañero íntimo, derechos sexuales y reproductivos, HeRWAI.

1. Background

The World Health Organization considers women's health to be an issue in need of special consideration, because *«in many societies they are disadvantaged by discrimination rooted in socio-cultural factors* [...] *potential of or actual experience of physical, sexual and emotional violence (and) unequal power relationships between men and women»*[1]. Globally as well as in the Latin American and Caribbean region, the main causes of death among women aged 20-59 are maternal conditions, ischemic heart disease, stroke, tuberculosis and cancer[2].

Nonetheless, from a public health perspective, women's sexual and reproductive health remains an area of significant concern as existing data demonstrates that the leading causes of ill health and death for women of reproductive age are related to their sexual and reproductive health[3]. One thousand women die every day as a result of complications related to pregnancy and child birth[4]. Unintended pregnancies are estimated to be in the tens of millions each year, with many women resorting to unsafe abortions because legal restrictions deny them the option of a safe procedure[5, 6]. Intimate partner violence (IPV[7]), the

1. <http://www.who.int/topics/womens_health/en/>, consulted on 28-02-2011.
2. <http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf>, consulted on 02-03-2011.
3. <http://www.who.int/mediacentre/factsheets/fs334/en/>, consulted on 02-03-2011.
4. <http://www.who.int/mediacentre/factsheets/fs348/en/>, consulted on 02-03-2011.
5. SINGH, S., WULF, D., HUSSAIN, R., BANKOLE, A. and SEDGH, G. *Abortion worldwide a decade of uneven progress*. New York, Guttmacher Institute, 2009.
6. KLIMA, C.S., «Unintended pregnancy. Consequences and solutions for a worldwide problem». *Journal of Nurse-Midwifery*, 43 (1998), pp. 483-491.
7. This study focuses on violence perpetrated against women by current or former partners. Therefore the term IPV is used instead of domestic violence, which could refer to any type of violence within the family. However, the legal documents from the three countries favour the term domestic violence so when describing those documents that term will be used.

most common form of violence against women[8, 9], is another public health and human rights violation facing women on a global scale[9], irrespective of their socio-economic, religious or cultural backgrounds[10]. It is considered to be an important risk factor for women's health[11] and is experienced by 15% to 71% of women during their lifetime[9].

A discussion of women's sexual and reproductive health would be incomplete without acknowledging that gender inequality is of foremost importance. Whatever, we understand gender to be, it incorporates the affirmation that one group of human beings is privileged over another based on the creation of a social construction derived from alleged biological differences. This multi-dimensional and dynamic construction[12] which is learned and consequently lived[13] varies across cultures and times[12]. Gender relations, are concerned with the relationships that people, groups and institutions construct, and take place at individual, institutional and societal levels. While gender regimes and the gender order exert much influence on the individual practice of gender, the possibility also exists for groups and individuals to influence gender regimes and the gender order. This process is by no means instantaneous but requires time to develop[12]. The connections between the societal gender order, institutional gender regimes and gender relations at the individual level becomes especially relevant when exploring women's sexual and reproductive health and rights issues. In the case of IPV sexist gender orders get translated into legal systems that criminalize safe abortion and/or health systems that disregard issues of IPV.

Many of the issues that remain controversial and sensitive in public health research show deep connections with gender relations and disproportionately affect women, i.e. intimate partner violence (IPV) and the criminalization of abortion. Intimate partner violence and criminalization of abortion could

8. Garcia-Moreno, C., Jansen, H.A.F.M., Ellsberg, M., Heise, L. and Watts, CH. «Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence». *Lancet* 368 (2006), pp. 1260-69.
9. Saltzman, L.E., Fanslow, J.L., Mcmahon, P.M. And Shelley, G.A. *Intimate partner violence surveillance: uniform definitions and recommended data elements version 1.0*. Center for Disease Control, 1999
10. Jewkes, R. «Intimate partner violence: causes and prevention». *Lancet* 359 (2002), pp. 1423-9.
11. Campbell, J.C. «Health consequences of intimate partner violence». *Lancet* 359 (2002), 1331-6.
12. Connell, R.W. *Gender*. Cambridge, Polity Press, 2002.
13. Fenstermaker. S., West, C. *Doing gender, doing difference: Inequality power and institutional change*. New York, Routledge, 2002.

both be understood as consequences of unequal gender orders that place women (and women's problems) in subordinated positions.

1.1 Women's right to health: what it is and how to assess it

Women's right to health conveys the message that all women irrespective of their ethnic background, socio-economic status, being an urban or rural dweller are entitled to an effective health system which responds to their needs[14, 15]. In that respect, individual women have a role to play as right holders while governments assume the role of duty bearers in relation to the right to health. As duty bearer, the government is responsible for and has a legal obligation to make available a health system which is accessible, acceptable and of good quality[16]. Moreover, states are also responsible for reducing inequalities that negatively affect the health of certain populations– the social determinants of health. Gender, together with social status, education or environmental factors, plays a key role in ensuring equal access to the right to health. It is therefore imperative that in their capacity as right holders, individuals –women– actively participate in matters related to their health system. As stated in the Declaration of Alma-Ata: *«The people have the right and duty to participate individually and collectively in the planning and implementation of their health care»*[17].

Women's right to health was explicitly incorporated into international human rights documents with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979[18]. The explicit distinction with regard to women's right to health was made due in large part to the barriers and multiple forms of discrimination which affect women's ability to exercise their right to enjoy the highest attainable standard of health[19]. CEDAW draws focus to issues of women's sexual and reproductive health, legally binding governments to address obstacles such as gender discrimination, gender based violence and restrictive laws, in order to ensure the provision

14. LEARY, V.A. «The right to health in international human rights law». *Health and Human Rights* 1 (1994), pp. 24-56.
15. HUNT, P., BACKMAN, G. «Health systems and the right to the highest attainable standard of health». *Health and Human Rights* 10 (2008), 81-92.
16. BRAVEMAN, P., GRUSKIN, S. «Poverty, equity, human rights and health». *Bulletin of the World Health Organization* 81 (2003), pp. 539-545.
17. <www.who.int/hpr/NPH/docs/declaration_almaata.pdf/>, consulted on 30-03-2011.
18. UN. Convention on the elimination of all forms of discrimination against women. New York, United Nations, 1979.
19. <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf/> consulted on 19-02-2011.

of essential services including, but not limited, to family planning, the promotion of healthy sexuality and access to safe abortion[20].The United Nations International Conference on Population held in Cairo in 1994, officially recognized reproductive rights as human rights[21], which are inalienable, emphasize equality and non discrimination as well as implying both entitlement and responsibility[14, 22, 23].

In spite of the international recognition of the relevance of women's sexual and reproductive rights, research using a rights approach to investigate important aspects affecting women's health is limited globally and even more so in the Anglo-Caribbean context. Research and advocacy on women's sexual and reproductive rights has focused on legal frameworks and court litigation. Despite the achievements of these approaches, there is increasing recognition of the need to further develop mechanisms to monitor progressive realization and hold governments accountable. In order to fulfil this goal, human rights impact assessment instruments have been developed, aimed at bridging the gap between the right to health in theory (commitments made by states) and in practice (the ability of individuals and groups to realize those rights). Among these human rights impact assessment instruments, the Health and Rights of Women Assessment Instrument (HeRWAI) focuses exclusively on women's right to health and is based primarily on the contents of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW). HeRWAI facilitates the realization of a systematic revision of policies in order to identify the gaps between the current situation regarding women's health and how the situation should be, based on the government's obligations to honour the human rights commitments it has made. Despite its usefulness it has rarely been used within academia, –for some exceptions Zaid[24]

20. Glasier. A., Gülmezoglu, A.M., Schmid, G.P., Garcia Moreno, C. and Van Look, P.F.A. «Sexual and reproductive health: a matter of life and death». *Lancet* 368 (2006), pp. 1595-1607.
21. UN. International Conference on population and development. Cairo, United Nations, 1994.
22. Otto, D. «Linking health and human rights: A critical legal perspective». *Health and Human Rights* 1 (1995), pp. 272-281.
23. Braveman, P. «Social conditions, health equity, and human rights». *Health and Human Rights* 12 (2010), pp. 31-48.
24. Zaid, R. *Gender reform action plan: A breakthrough for Pakistani women? A policy research using Health Rights of Women Assessment Instrument (HeRWAI)* [dissertation]. Washington, University of Washington, 2007.

and Goicolea[25]–, and, to the extent of our knowledge, it has never been applied to the Caribbean context.

The purpose of this study is to explore the incorporation of women's right to health into the main health policy documents of St. Lucia, St. Vincent and the Grenadines and Guyana. The HeRWAI was used to make a comparative assessment of government commitment, focusing on two controversial women's health issues: intimate partner violence and access to legal abortion.

2. Methods

2.1 Study Setting

St. Lucia, St. Vincent and the Grenadines and Guyana are all middle income countries in the Anglo-Caribbean. The first two are island nations, while Guyana is the only Anglophone country in South America.

In the Anglo-Caribbean, the leading causes of death among women are quite similar to the global trend: non-communicable diseases such as cancers, cerebro-vascular disease, and heart disease. With regard to sexual and reproductive health, HIV and AIDS are of grave public health concern[26]: 53% of people living with HIV in the Caribbean are women. The rate of unsafe abortion in the Caribbean is estimated at 16 per 1 000 among women aged 15-44[5]. Official attempts by states to measure IPV are very recent[27] and there are serious challenges to obtaining accurate estimates of this problem in the Caribbean[28]. However, the few available studies indicate that IPV is a serious concern in this setting[29, 30].

25. GOICOLEA, I. *Adolescent pregnancies in the Amazon Basin of Ecuador: a rights and gender approach to girls' sexual and reproductive health* [dissertation]. Umeå, Umeå University, 2009.
26. Leading causes of death and mortality rates (counts and rates) in Caribbean Epidemiology Centre Member Countries (CMCs):1985 1990 1995 2000 2009
27. ALMÉRAS, D., BRAVO, R., MILOSAVLJEVIC, V., MONTAÑO, S. and NIEVES, R. M. «Violence against women in couples: Latin America and the Caribbean. A proposal for measuring its incidence and trends». *Mujer y desarrollo,* (2004).
28. ECLAC. An evaluative study of the implementation of domestic violence legislation: Antigua and Barbuda, St Kitts/Nevis, Saint Lucia and Saint Vincent and the Grenadines (2001)
29. ARSCOTT-MILLS S. «Intimate partner violence in Jamaica: A descriptive study of women who access the services of the Women's Crisis Centre in Kingston». *Violence against Women* 7 (2001), pp. 1284-1302.
30. QUAMINA-AIYEJINA, L., BRATHWAITE, J.A. *Gender-based violence in the Commonwealth Caribbean: An annotated bibliography*. Centre for Gender and Development Studies, UWI, Mona & UNIFEM Caribbean Office 2005.

2.2 Data Collection

Central to data collection was the aforementioned HeRWAI. This tool was developed by Aim for Human Rights, and has previously been used for advocacy purposes in several countries. Its design permits the identification of gaps between 1) government commitments at the level of policies, and as stated in CEDAW, and 2) current fulfilment of women's right to health.

The instrument comprises six steps, which allow the researcher to explore several areas, linking government responsibility and women's right to health. Step one identifies and describes the policy, while step two explores the government commitment, and step three looks at the government's capacity to implement the policy. Step four concentrates on the impact of the policy on women's right to health, and step five explores state's obligations in relation to the policy. Finally, step six sums up with recommendations for informing key stakeholders and suggesting changes to the policy which could result in a better impact on women's health rights. Each step consists of a series of questions accompanied by explanatory notes to guide the researcher in obtaining the necessary information[31].

In this study HeRWAI was applied to the five year strategic health plans of St. Lucia, St. Vincent and Guyana, which serve as the guiding documents for health related matters, since none of the studied countries had a national health policy. Data was collected primarily through an extensive online review of documents including the strategic health plans, budget addresses, the Constitutions of the respective countries, and reports from other relevant authorities, such as the WHO and CEDAW. Pertinent information was extracted and compiled in table format. This allowed the researchers to see the information for the individual countries alongside each other, and get an overall view of the similarities, differences as well as identifying gaps in the data.

Focus was placed on the areas of IPV, access to legal abortion and government commitment, as a way of broadening the debate on two – IPV and legal abortion– very controversial and sensitive topics by tackling them from a slightly less conventional perspective.

3. Results

A summary of the findings for each of the countries, St. Lucia, St. Vincent and the Grenadines and Guyana are presented according to the first three steps

31. BAKKER. S., PLAGMAN, H. *Health rights of women assessment instrument*. Utrecht, Aim for Human Rights, 2006.

of the HeRWAI, namely policy description –focusing on the Health Strategic plans–, capacity to implement and government commitment –exploring international and national signed compromises, and focusing on abortion and IPV–, and capacity to implement.

3.1 St. Lucia

The aim of the Strategic Health Plan 2006-2011 is to «*increase equity in health care delivery, effectiveness and efficiency in health care provision and ultimately increase health outcomes for the entire population.*» It was developed on the basis of discussion in the 1990's surrounding the issue of health sector reform and the eventual Health Sector Reform Proposals in the year 2000. Among the programmes prioritized in the Plan were: Sexual and reproductive health, Child and adolescent health, and Violence and injuries including gender based violence.

Responsibility for the implementation of the Strategic Health Plan lies mainly with the Ministry of Health. However, it is ultimately distributed among several entities. Financing for the public health sector comes from government allocations, out of pocket expenditure and donors. There is not a sustainable plan in place for funding the health sector and for many years St. Lucia has experienced a chronic problem of acquiring and retaining adequate levels of health workers, particularly nurses. The budget allocation for health between 2006 and 2010 revealed that the majority of the funds were directed towards infrastructural improvements.

Regarding government's commitment to women's right to health, at the international level St Lucia ratified the CEDAW in 1990, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women «Convention of Belem do Para» in 1995. Of six reports that should have been submitted to CEDAW between 1983 and 2003, only one combined report was submitted in 2005 and was followed in 2006 by the submission of a shadow report[32]. At the national level St. Lucia's Constitution does not make specific reference to the right to health, but the Strategic Health Plan explicitly recognizes the access to health services as a human right.

32. Shadow reports are created by NGOs and they supplement the information provided by official government reports to human rights committees. They may include issues that have been omitted or point out areas where the government may have misled the committee. As a result the committee is able to get overall view of the real situation. (http://www1.umn.edu/humanrts/iwraw/reports.html)

Abortion is legal under limited circumstances – rape, incest, deformed foetus and to protect the life of the mother–, under any other circumstances it remains a criminal offence punishable by imprisonment. The amendments to this section of legislation to approve limited access to abortion were highly controversial and vehemently opposed. The use of contraceptive methods are supported and encouraged. However, the 2006 CEDAW shadow report indicated that tubal ligation requires the consent of the woman's spouse.

IPV is included in the portfolio of the Ministry of Gender Relations. Existing legislation addresses some aspects of this issue and reference is made to it within the Strategic Health Plan. The Domestic Violence Act of 1995 makes it possible for survivors of domestic violence to seek protections orders, which are granted by the Family Court. Additionally, the concept of marital rape is included as a sexual offence in the Criminal Code. There have been a number of actions aimed at sensitizing different sectors on the issue of domestic violence: community, police, members of the judiciary, and the education system. In addition, there is one Women's Support Centre fully funded and managed by the government, which offers shelter and support services to sufferers of domestic violence.

Some reports express concern about the implementation of the Domestic Violence Act due, in part, to delays in providing protection orders, understaffing of the police service, and a pervading societal attitude that domestic violence is, for the most part, a private matter.

3.2 St. Vincent and the Grenadines

The aim of the Strategic Health Plan 2007-2012 is *«to improve the health status of the people of St. Vincent and the Grenadines.»* It forms part of the wider vision of the health sector *«to have a healthy population living in environmentally sound communities empowered with a holistic knowledge of health, developmental and environmental issues.»* The strategic health plan makes specific reference to women's health and gender inequality affecting women's health by stating: *«notwithstanding the strides made in empowering females to take control of their health, there continues to be inequities and dysfunctional gender relations denying females the right to control and make choices which can affect their sexual and reproductive health...among STIs, female infection rates double that of males»*. The strategic plan includes two programmes directly related to women's health: – reproductive health and women's health.

Health care is financed by the government through budgetary allocations, out of pocket expenditure and contributions from other entities both local and international. Between 2008 and 2010 there was an increase in the

government's budget allocation for health. External funding is an important supplement to the national health budget and international agencies and governments played a key role in the development of the Strategic Health Plan, together with national governmental and non-governmental entities. There are difficulties within the health sector in maintaining an adequate number of skilled medical personnel, particularly emergency medical technicians and nurses.

St. Vincent and the Grenadines' international human rights commitments were established by its accession of the CEDAW in June 1981, and the International Covenant on Economic, Social and Cultural Rights in November of that same year. It also signed the Protocol to Prevent, Suppress and Punish Trafficking in persons, especially women and children in November 2002. On the regional level, it ratified the Inter-American «Convention of Belem do Para (1994)» in May 1996. Since it acceded to CEDAW in 1981, one government report has been submitted to the committee in 1991, and was resubmitted in 1994 with some additional information. No evidence of submission of shadow reports was found. At the national level, the Constitution does not contain any specific reference to the right to health, even if some sections may be relevant to the issue of women's right to health – the right to protection from inhumane treatment in section 5, the right to protection from discrimination on the grounds of sex in section 13.

Abortion legislation permits the procedure in cases of rape or incest, to preserve the mental and physical health of the mother, to save the life of the mother, in cases of foetal impairment and for economic and social reasons. Another reproductive health procedure which requires approval by someone other than the woman herself is that of tubal ligation, for which a woman needs to first obtain spousal consent.

The Domestic Violence Act was passed in 1995 and makes provision for the protection of the victim. According to the St. Vincent and the Grenadines Human Rights Association, domestic violence cases are normally charged under assault, battery, or other similar laws. In addition, very often, domestic violence goes unpunished because of the choices that the women make. Police are often reluctant to respond and follow up on domestic violence cases which fall under the jurisdiction of the Family Court. Shelter support services are limited and provided by an NGO.

3.3 Guyana

The National Health Sector Strategy 2008-2012 aims *«To provide equitable access to high quality and 'consumer-friendly' health services.»* Among the priority

health areas are: family health (formerly maternal and child health), HIV (together with tuberculosis and malaria), mental health, and health promotion and risk reduction. Several international actors play an important role in providing funding to the health system.

The country's health services are highly decentralized. Guyana's allocations to health have increased steadily from the beginning of the period (2008). The 2010 budget was the largest to date, however the majority was allocated to infrastructure and improving human resources. The government relies on external funding to help finance the health sector and, as such, donor agencies play an important role in the government's capacity for implementation. Much of the assistance has been directed towards HIV, in spite of the fact that there are other priority areas that the government would like to address.

Guyana ratified the International Convention on Economic, Social and Cultural Rights in February 1977, and the CEDAW in July 1980. On the regional level it ratified the Inter-American «Convention of Belem do Para 1994» in February 1996. It then acceded to the Protocol to Prevent, Suppress and Punish Trafficking in persons, especially women and children in September 2004. The government submitted three combined reports to CEDAW between the date of ratification and June 2003, all after the due dates.

Guyana's Constitution contains specific references to the right to health. One article addresses the right of every citizen to receive free medical attention, and in another it acknowledges that everybody is duty bound to participate in protecting the nation's health. On the right to non-discrimination, the Constitution is explicit with regard to women's right to be treated equally to men in all spheres of life in society, and goes further to state the illegality of discrimination against women on the basis of gender.

Regarding access to safe abortion, the Medical Termination of Pregnancy Act allows a woman to decide on having an abortion as long as she is psychologically fit to do so.

Domestic violence is not addressed in the strategic health plan; however, there is a National Policy on Domestic Violence (2008). This policy notes that women are the most commonly and seriously affected by domestic violence and recognizes gender stereotyping and discrimination as the root of this problem. Its main objective is to guide interventions and programmes geared towards preventing domestic violence and providing services to victims. The policy acknowledges that the terms domestic violence, family violence and intimate partner violence are used interchangeably. Some of the key areas the policy aims to address are monitoring and enforcing legal sanctions,

providing services for survivors, involving the health sector, and educating the public on domestic violence. There is only one organization providing shelter to women suffering from domestic abuse, and between the years 2000-2006 it was forced to cease operation several times due to lack of funding and low occupancy.

4. Discussion

4.1 Sexual and reproductive health and rights

4.1.1. Intimate Partner Violence

The results reveal that all States under consideration have ratified CEDAW as well as the Inter-American «Convention of Belem do Para 1994». This provides the legal framework which requires States to implement laws, policies, programmes and services to address the issues of violence against women and, in the case of this study, IPV. However, IPV is hardly limited to the legal arena: enforced legal systems might contribute to reducing cases of IPV, but eradicating IPV needs to be based on challenging gender unequal relations.

Domestic Violence legislation has been in existence in all three States since the mid 1990s. Guyana is the only country which has, in addition to the Domestic Violence Act, a National Policy on Domestic Violence. NGO's continue to play an important role in the provision of support services to women suffering from IPV, especially in Guyana and St. Vincent and the Grenadines which, unlike St. Lucia do not have Support Centres which are fully funded and managed by the government. In spite of the current efforts, the instability of funding poses a threat to the availability and accessibility of services for women suffering from IPV.

The availability of shelter services in particular are limited and concentrated in or near the capital cities or urban areas. Although no practical investigation was conducted to confirm the effect of that situation on the accessibility of services, it is quite possible that this situation puts women who live in rural areas at an even greater disadvantage than their urban counterparts. Accessibility is a problem in all three countries; however, the geographical dynamics of St. Vincent and the Grenadines – a multi-island country– and Guyana – due to its size and the large proportion of rural dwellers – may further exacerbate the situation.

In spite of the steps taken in St. Lucia which, arguably, has the most comprehensive approach to IPV –police training, state run shelter, sensitization exercises, court based batterer intervention programme– the mechanisms of the justice system such as delays in providing protection orders and

understaffing of the police service, are a cause for concern. According to Fenrich and Contesse[33], such issues with the justice system are liable to have a negative impact on the public's view of domestic violence if they perceive from these actions that the government's representatives do not take the issue seriously. The findings also show that women hesitate to report IPV and that is likely an indication that the efforts of the State thus far have not met the expectations of those who need them most.

Based on the information gathered, the judicial system appears to play a central role with regard to IPV, as opposed to other sectors. This is an indication that the efforts to combat intimate partner violence are more reactionary than preventative. All three governments have at some point engaged in various sensitization campaigns and other related activities, however, the current situation is testimony to the need for a more sustained effort on a wider scale.

4.1.2 Abortion

Termination of a pregnancy is a controversial issue and religious factors play an important role in that debate in the Anglo-Caribbean[34]. Guyana has the most liberal legislation of the three countries and was only the second Anglo-Caribbean country, after Barbados, to enact the Medical Termination of Pregnancy Act in its current form in spite of strong opposition based on religious ideology[35]. Legislation in St. Lucia and St. Vincent and the Grenadines, in spite of being more restrictive than Guyana's, is among the most liberal in Latin America and the Caribbean[36]. Whereas the full effects of the change in abortion legislation are not clear, it is widely acknowledged that restrictive legislation on abortion is a major determinant of unsafe abortion[37]. Although all countries have exercised a certain degree of political will in addressing this issue, the legislation continues to be discriminatory in St. Lucia and St. Vincent and the Grenadines, and as such, a barrier to the women's right to health.

33. FENRICH, J., CONTESSE, J. *«It's not OK»: New Zealand's efforts to eliminate violence against women*. New York City, Fordham Law School, 2009.
34. PHETERSON, G., AZIZE, Y. «Abortion practice in the northeast Caribbean: 'Just write down stomach pain».' *Reproductive Health Matters* 13 (2005), pp. 44-53.
35. NUNES, F, E., DELPH, Y.M. «Making Abortion Law Reform Happen in Guyana: A Success Story». *Reproductive Health Matters* 3 (1995), pp. 12-23.
36. <http://www.guttmacher.org/pubs/IB_AWW-Latin-America.pdf/>, consulted on 12-03-2011.
37. MUNDIGO, A.I. «Determinants of unsafe induced abortion in developing countries», in I.K WARRINER and I.H.SHAH (Ed): *Preventing unsafe abortion and its consequences: Priorities for research and action*. New York, Guttmacher Institute, 2006, pp. 52-54.

4.1.3 Gender Structures

Gender is an important part of the discussion on the rights approach to sexual and reproductive health. The discourse in the previous sections makes it evident that women are not provided with the array of services that would permit them to exercise their right to health. This study illustrates the individual, institutional and societal levels of gender relations as posited by Connell[12]. With regard to IPV, women are subordinated to the men who exercise power and control over them through violence. Those relations form part of the gender order of society and their emotional dimension is reflected in the very concept of IPV. The legislation on abortion and family planning –tubal ligation– in St. Lucia and St. Vincent and the Grenadines demonstrates the lack of decision making power that women have over their sexual and reproductive health. In both cases, permission has to be granted by another individual, most often a man. This state of affairs also demonstrates that at an institutional level, the gender imbalance of power is at best overlooked and at worst, condoned.

Characterizing the State as an institution opens the way for discussions of IPV from the perspective of a gender regime. The approach to IPV in all three countries is based on the Domestic Violence Act, except that Guyana is more advanced in also having a National Policy on Domestic Violence. The consistent use of the term domestic violence when referring to IPV gives the impression that this problem is conceived as a private one to be dealt with by the parties involved. Therefore the position of the State on the issue remains ambiguous, and IPV rooted in gender inequality continues to be overlooked. Guyana's National Policy which includes references to IPV is quite advanced in comparison to St. Lucia and St. Vincent and the Grenadines. Nonetheless, some of the practical problems highlighted, such as the reluctance of police officers to intervene as well as the reluctance of women to report reflect that societal norms have not been sufficiently impacted by the sensitization programmes, and other measures that have been taken by all three governments to address this problem.

4.1.4 State commitment and accountability

As previously mentioned, States Parties to CEDAW have an obligation to submit a report at four year intervals. This is a mechanism to establish accountability as well as being one of the factors which gives an indication of State commitment. Reporting in all countries has been inconsistent. However, St. Vincent and the Grenadines had the worst reporting status, not having submitted a report in over fifteen years, and only one since ratification, nearly

thirty years ago. In terms of reporting it is evident that there has been a decided lack of accountability on the part of all three States. Mechanisms also exist to promote the active participation of civil society in the form of submission of shadow reports. However, such reports from the three countries have been virtually non-existent. London[38] advocates very strongly that in order for paper commitments to treaties to be of any real value it is necessary to have an active civil society.

Another important aspect of being State Party to international human rights treaties is the creation of policies and programmes, as well as the addition of legal provisions, to promote the rights under consideration. To that end, Guyana's amendment to the Constitution which eliminates the need for separate legislation by automatically incorporating all human rights contained in the treaties that it signs, makes it the most progressive of the States in that regard. While this action is commendable, the actual relevance could only be determined by its incorporation into future policies and programmes and its practical impact on the lives and well being of the people whose right to health is not fully realized. The lack of specific reference to the right to health in the Constitutions of the other two States is a further indication of a certain level of ambiguity as it pertains to the right to health. Their Strategic Health Plans, on the other hand, reflect an intention to address several issues related to women's health, and in some cases, recognizing existing gender inequalities.

The principle of progressive realization, which requires governments to do everything possible to realize the right to health, is an important measure of state commitment. All three countries experience low resources and a lack of sustainable funding for the health sector and, consequently, programmes directed towards women's health. Financial and technical assistance has been sought from external actors in all cases, with particular attention being paid to physical infrastructure. However, one area of considerable concern for which evidence of progress is lacking is the retention of trained medical personnel to stem the problem of brain drain which plagues the Anglo-Caribbean.

4.2 Methodological considerations

While the authors are aware that governments are not the only actors in the realization of women's right to health, the discussion will focus mainly on the

38. LONDON, L. «What is a human rights approach to health and does it matter?» *Health and Human Rights* 10 (2008), pp. 65-80.

role of governments, since the data was collected almost entirely from official documents representing government's perspective.

The heavy reliance on the review of documents available on the internet is a limitation of this study, although the use of this method also highlighted the difficulties in accessing as well as the unavailability of information that should be public. Further study on this issue could be enriched by interviews and on site review of documents not available online.

The social determinants of health are an important aspect of the right to health but in this study most of the focus was placed on gender while other determinants such as education level and income and ethnicity (in the case of Guyana) were not explored.

Chapman[39] and Farmer[40] make a valid argument that quite often in low income countries, external actors have more influence on a country's health budget than its own government. Although none of the countries in this study are low income, they could possibly be considered low resource and as such, a more in depth exploration of the relations with major external actors like the World Bank could have been beneficial to the study.

It is important in research for the findings to reflect what the study aimed to measure as well as being presented in such a way that a reader in another context can judge the transferability of those findings to his/her own context. The ability to adapt to what emerges from the data while leaving a clear decision trail that can be followed by another researcher is also important. The neutrality of the data is the final measure of trustworthiness and it implies that the conclusions should be obvious from the data[41]. An attempt was made to clearly state the sources used to acquire the data and how the findings would be distributed and addressed, in order to aid the reader in better understanding the author's research process and allowing the reader to come to their own conclusions.

5. Conclusions

The results indicate that, at the very least, there is a consciousness on the part of all three Anglo-Caribbean States included in the study, that women's health issues require special attention. This was evident in the inclusion of programmes specially targeting women's health not only from a sexual and

39. Chapman, A.R. «Globalization, human rights, and the social determinants of health». *Bioethics* 23 (2009), pp. 97-111.
40. Farmer, P. «Challenging orthodoxies: The road ahead for health and human rights». *Health and Human Rights* 10 (2008), pp. 5-19.
41. Lincoln, Y., Guba, E. *Naturalistic inquiry.* New York, Sage, 1985

reproductive health standpoint but also, as in the case of St. Vincent and the Grenadines, by focusing on other areas. Several important steps have been taken to address two controversial problems impacting women's health; intimate partner violence and abortion. Nonetheless, there appears to be a certain level of ambiguity on the part of governments as well as financial, social and infrastructural challenges which pose a threat to the advancement of realizing women's right to health. In spite of the progressiveness exhibited thus far, it is imperative that states further consolidate their efforts and demonstrate consistent political will in order to avoid accusations of tokenism. In that regard, Human Rights Impact Assessment instruments such as the HeRWAI could be used by governments and civil society in a collaborative manner for the improvement of women's right to health.

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