REPRODUCTIVE HEALTH matters

FEATURE

Equity and women's health services for contraception, abortion and childbirth in Brazil

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Abstract: *This paper addresses equity in health and health care in Brazil, examining unjust disparities between women and men, and between women from different social strata, with a focus on services for contraception, abortion and pregnancy. In 2010 women's life expectancy was 77.6 years, men's was 69.7 years. Women are two-thirds of public hospital services users and assess their health status less positively than men. The total fertility rate was 1.8 in 2011, and contraceptive prevalence has been high among women at all income levels. The proportion of sterilizations has decreased; lower-income women are more frequently sterilized. Abortions are mostly illegal; women with more money have better access to safe abortions in private clinics. Poorer women generally self-induce abortion with misoprostol, seeking treatment of complications from public clinics. Institutional violence on the part of health professionals is reported by half of women receiving abortion care and a quarter of women during childbirth. Maternity care is virtually universal. The public sector has fewer caesarean sections, fewer low birthweight babies, and more rooming-in, but excessive episiotomies and inductions. Privacy, continuity of care and companionship during birth are more common in the private sector. To achieve equity, the health system must go beyond universal, unregulated access to technology, and move towards safe, effective and transparent care.* © 2012 Reproductive Health Matters

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Equity is one of the principles of Brazil's Unified Health System (SUS), as defined by the 1988 Constitution, together with the principles of universality (health is everyone's right and a State duty), *integralidade* (comprehensiveness, health care includes prevention, treatment and rehabilitation, and their bio-psycho-social dimensions), and control by society.[1] The concept of health equity is based on the ethical notion of distributive justice, reflecting core human rights principles.[2] To promote health equity in a population, people with different needs should be treated differently, with more investments for those who need more, in prevention, treatment or rehabilitation.

Some authors also use the concept of *health disparities*, which is different from inequity. Inequity is the result of *unjust disparities*. Some health disparities are considered inevitable – for example, people over 65 tend to have more chronic diseases than younger adults.[2] Equity in health implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential, if this disadvantage can be avoided. However, "health potential" or "health needs" vary from person to person, region to region, and time to time. The focus of a policy of equity in health is not to eliminate all health differences so that everyone has the same level and quality of health, but to reduce or eliminate the disparities arising from factors considered both preventable and unjust.[3]

According to the Pan American Health Organization, gender equity in health includes the elimination of unnecessary, unjust and avoidable differences in health status and survival; fair distribution of and access to resources (technological/

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financial/ human) according to distinct needs; that women and men contribute to health financing according to their economic capacity, not their need for services; and a just social distribution of responsibilities, power and rewards for women's and men's contribution to health production (including placing value on non-remunerated health work).[4]

Two of the most important factors considered preventable and unjust are disparities in the impact of the social determinants of health (external factors that make someone sick or healthy), and disparities in access to health services (the ability to get appropriate care when needed). The aim of this paper is to address gender equity in relation to health, considering unjust disparities between women and men, and between women from different social strata, with a focus on health care for contraception, abortion and maternity care. Data from the most recent Demographic & Health Survey (PNDS 2006),[5] the National Public Health Information System (DATASUS) and epidemiological and demographic research are analysed.

Health data are more often available from the public health sector in Brazil, for both population-based and service-based research. The lack of information from the private sector makes comparability between different social strata more difficult. Beyond vital statistics (births and deaths) and diseases with mandatory notification, information about morbidity and hospitalization in the private sector is not publicly available on a regular basis, and usually only from population-based household surveys, such as Demographic & Health Surveys.[5] In many countries, in fact, the quality and availability of information comparing public and private sector outcomes tends to be poor, scarce and biased. A recent international meta-analysis of 21 such studies concluded that, "regardless of outcomes, the quality of evidence is rated… as either low or very low".[6]

Gender, women's health and health indicators

In the last two decades since the foundation of SUS, Brazil has seen a great expansion in health services, and although huge challenges persist, economic growth and public policies for social inclusion have resulted in a decrease in poverty, income concentration and regional disparities.[1]

The Brazilian health system consists of a complex network of public and private services and providers. The public sector provides care for 75% of the population, while the private sector (for-profit and not-for-profit) is financed with private and public funds, and private health insurance. The use of private vs. public sector is strongly associated with income and educational level. While in theory, people can use the services of all sectors, in practice this depends mainly on ability to pay.[1]

In 1983, a woman-centered Comprehensive Women's Health Programme (PAISM) was created, introducing contraception and other reproductive health care into the public health services. Increased education has been closely associated with improvements in health for women themselves and their families. In Brazil, as in most countries, there has been huge social progress made by women in recent decades, with a high participation in education and the workforce. Brazilian women are currently the majority of students in all age groups and educational levels, although this does not translate into better or even equal pay in the job market.[7]

Women are also the vast majority of the health workforce: 71% at university level and 85% of technicians, but men are concentrated in the upper levels of the hierarchy.[8] Informal, unpaid care at home for people who are sick or disabled is disproportionally carried out by women.[9] This is typical for most countries: according to a damning report on gender inequity in health, health systems tend to rely on a foundation of informal health workers who are poorly paid or not paid at all, and disproportionately female.[10]

In SUS, women account for about two-thirds of outpatient consultations, including for contraception, antenatal, delivery and post-partum care, attention to symptoms of menopause, ageing, and screening and treatment for cancers such as cervical and breast cancer. This disproportion is similar in the private sector as well, and *increases* after reproductive age.[11]

Nevertheless, women have traditionally evaluated their health less positively than men of the same age. These differences between men and women present a challenge to public health, and the question of why women use services more, implying they experience more health problems than men despite living longer, has been discussed extensively.[12] Male mortality tends to be higher in all age groups. There is some evidence of female biological advantage in longevity, and women tend to be more attentive to symptoms, resulting in different health-seeking behaviour. In 2010 in Brazil, women's life expectancy was 77.6 years; men's was 69.7. More men died from all violent causes

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