ELSEVIER
www.rhm-elsevier.com

Reproductive Health Matters 2005;13(25):72–80
0968-8080/05 $ – see front matter
PII: S0968-8080(05)25165-0

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

The Population and Reproductive Health Programme in Brazil 1990-2002: Lessons Learned

A Report to the John D and Catherine T MacArthur Foundation

Sonia Corrêa, Peter McIntyre, Carla Rodrigues, Anabela Paiva, Cecilia Marks

Abstract: *The story of Brazil's evolution in sexual and reproductive health and rights during the 1990s documents not only a decade of change in the population field, but the powerful role of social movements in a democracy. Between October and December 2002, 23 people were interviewed about where they believe progress has been made in Brazil and where there are still needs in relation to population trends, sexual and reproductive rights, and health policies. This paper contains excerpts from the full report and covers the economic and political background of Brazil; the role of non-governmental and women's organisations in influencing the national agenda; the intersection of national and international agendas on population and development, HIV/AIDS, human rights, racism and other issues; changes in sexual and reproductive health policies; HIV/AIDS policy progress, perhaps most importantly mandatory free treatment for people with HIV/AIDS; recent progress in women's health, especially in relation to antenatal and obstetric services, and services addressing violence against women. Finally it describes the role of policy accountability mechanisms that aim to ensure that the many excellent policies that have been passed since 1990 are implemented in a decentralised health system of national, state and local management and services.* © 2004 John D and Catherine T MacArthur Foundation. All rights reserved.

Keywords: advocacy and political process, non-governmental organisations, sexual and reproductive health and rights, reproductive health services, HIV/AIDS, law and policy, Brazil

BRAZIL is a land of contradictions. While it is one of the world's top ten economies, it rates only an average score on the human development index. Though it is an influential giant in its region, Brazil's maternal mortality ratios are worse than those of some of its poorer neighbours. Inequality is at the heart of this contradiction. While the average income in Brazil in 1999 was US$3,000 a month, 40% of the population were living on a tiny fraction of that – just US$65 a month.

These inequalities express themselves in sexual and reproductive health as in many other aspects of life. The country's fertility rate has fallen sharply since 1970, from 5.8 births per woman to 2.34. Although rates are still high in the North (3.2) and in the Northeast (2.7), historical analysis indicates a clear convergence of fertility patterns across regions and social groups. This means that Brazil cannot be portrayed as a country experiencing a ''population growth problem''. Rather, one of its major policy problems is that many people, especially women, cannot yet fully exercise their sexual and reproductive rights. The pace, features, and implications of Brazilian demographic changes achieved broad public visibility in the 1990s. The decline in fertility was first identified in the 1970s, and by the mid-1980s its core characteristics were already clear. The immediate causes were the increased use of contraception by women, especially the pill and the ''preference'' for female sterilisation – often associated with unnecessary caesarean sections – along with recourse to (illegal) abortion. Despite this general decline in fertility, reproductive health indicators such as

maternal mortality and cervical cancer rates remained unacceptably high.

Thanks to advocacy work by non-governmental organisations (NGOs) since the late 1980s, maternal mortality became a priority policy issue in the 1990s. In Brazil, despite the fact that about 95% of deliveries take place in hospitals, maternal mortality ratios are still high. Recent research sponsored by the Minister of Health concluded that the maternal mortality ratio was 84 deaths to 100,000 live births in 2001. These deaths resulted from lack of antenatal care, poor assistance at delivery and unsafe abortions. About 90% of them would be preventable with timely, good quality care. Nationally, abortion is the fourth most common cause of maternal mortality. In a country where abortions are only legal after rape or to save the life of the mother, and where even legal abortions are hard to obtain, there are many unwanted pregnancies, leading to somewhere between 700,000 and one million unsafe and illegal abortions annually, according to the public health system database. Some poor women go to unskilled abortionists, putting themselves at high risk of haemorrhage and infection; others use the prostaglandin drug misoprostol (Cytotec). Most of them go to a public hospital looking for help after a clandestine procedure.

Political and economic background

In 1990, Brazil was experiencing political troubles that would lead, two years later, to the impeachment of President Fernando Collor. The political institutional crisis of the late 1980s and early 1990s negatively affected the relationship between civil society and the state, especially in the area of sexual and reproductive health. One example was the downgrading of the status of the government's National Council on Women's Rights in 1989. In addition, the implementation of the 1988 Constitution's sections on the public health system were delayed.

After that crisis, civil society regained its strength and re-directed its energies towards reproductive health issues: instead of pressuring the executive, women's health and rights organisations began educating policymakers in the parliament. They also worked through the courts to overcome discrimination and to gain access to treatment. Many institutions were established in this period, including Casa de Cultura da Mulher Negra; Católicas pelo Direito de Decidir Brasil; Cidadania, Estudo, Pesquisa, Informação e Ação (CEPIA); Centro Feminista de Estudos e Assessoria (CFEMEA); the Commission on Citizenship and Reproduction; Cunhã Coletivo Feminista; ECOS Comunicação em Sexualidade; and Rede Nacional Feminista de Saúde e Direitos Reprodutivos (RedeSaude). Some strategies proposed by these and other NGOs would later be incorporated into law and policy. For example, their evidence to the Federal Parliamentary Commission on Sterilisation helped in the formulation and approval of Law 9263 (1996) regulating the Constitutional Provision of Family Planning. And a series of lawsuits paved the policy ground for the 1996 legislation ensuring free and universal treatment for people living with HIV/AIDS.

From 1989, the Brazilian AIDS movement opted for a judicial strategy because we did not have the time to wait for specific legislation to be approved. As we kept winning different lawsuits the Executive and Parliament were under pressure and this resulted in the National AIDS policy and later on (1996) in free access to treatment. (Miriam Ventura, Advocaci)

In 1994, a new Economic Stabilisation Plan (Plano Real) was adopted and Fernando Henrique Cardoso was elected President; he would be re-elected in 1998. Cardoso's long administration completely changed the Brazilian policy environment, creating paradoxical patterns in Brazilian policy. On one hand, the country experienced unusual economic, political, and institutional stability, which favoured the establishment of a wide range of mechanisms for social accountability and the legitimisation of a national policy agenda on human rights.

On the other hand, these were also years of erratic economic growth, with bouts of financial instability and fiscal stringency. There were major negative trends, including high levels of unemployment, stagnation of income and an increase in everyday violence. Fiscal stringency put the brakes on public investment in many strategic areas, particularly in social policy. However, these constraints were not as detrimental to health policy as they were in other areas, for two reasons. First, the 1988 constitutional changes provided a safeguard to the public health system. Second, beginning in 1993, the Integrated Health System (SUS) was decentralised and its