

THE RIGHT TO KNOW

**Human rights and access to
reproductive health information**

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by Sandra Coliver

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ity and life expectancy between rich and poor have remained constant. The 45 per cent of Brazil's population that is black suffers higher malnutrition and mortality, and earns significantly less, than the percentage that is white. Gaps in earnings between equally qualified men and women at all income levels are greater than anywhere in the Americas: in 1985 the average male income was at least double the average female income at the same level of education.

2 FAMILY PLANNING PROGRAMMES

2.1 Government Policy

Brazil's military regime, which took power in 1961, adopted a pro-natalist position, encouraging population growth in order to settle Brazil's frontier regions. At the 1974 World Population Conference in Bucharest, the government declared itself firmly against any type of family planning.⁶ However, the government finally recognized the need for family planning in 1977, and, in 1978, President Geisel approved a family planning policy in order to "improve the quality of life". The International Planned Parenthood Federation (IPPF) and its Brazilian affiliate, Sociedade Civil Bem-Estar Familiar No Brasil (the Society for Civil and Family Well-being in Brazil or BEMFAM), had begun to operate several years earlier, with unofficial government approval and relying primarily on international funding. The government devoted scant attention or resources to family planning, however, until the debt crisis of 1982-83 forced it to enter into serious negotiations with the International Monetary Fund (IMF) and other international lenders. As a result, in March 1983, the government declared family planning to be one of its policy priorities.⁷

In 1984, the Ministry of Health established the Programa de Assistência Integral de Saude da Mulher (the Integrated Women's Health Programme or PAISM), a set of policy guidelines recommending a progressive, integrated programme that would provide comprehensive and preventive reproductive health care. Although PAISM has not been successfully implemented in most parts of the country, it is fair to say that there is now broad official consensus, even among conservatives, about the right of women to have access to family planning services and information. PAISM is funded primarily by the federal government, the United Nations Population Fund (UNFPA) and the Pan American Health Organization,⁸ and is carried out by the federal, state and municipal governments.

PAISM has been implemented unevenly throughout the country. According to a World Bank study, the states of São Paulo, Paraná, Minas Gerais and Rio de Janeiro have gone furthest in implementing the programme. Unfortunately, health information systems are not

sufficiently developed to allow researchers to analyze direct data on public sector investments or services in reproductive health. This inadequacy of monitoring data—for single, government agencies as well as for the system as a whole—makes quantitative assessment of services extremely difficult, if not impossible.⁹

A study completed in 1994 found that the public sector is responsible for 28.3 per cent of funding for family planning; NGOs (primarily BEMFAM) manage 3.4 per cent of services; and the private sector provides 68.3 per cent.¹⁰ Although private funding accounts for more than two-thirds of the money spent on family planning, only a small percentage of women obtain family planning services from private providers.

According to one international research NGO, the government of Brazil spent US\$9.35 million on family planning services in 1989.¹¹ There were 2,627 public health facilities in 1989 providing family planning services, of which 2,507 were community posts.¹² However, these facilities were not accessible to a great portion, and perhaps even a majority, of the population. A 1991 study of a sample of state and municipal health departments disclosed that the family planning services of 25 per cent of municipal departments surveyed reached only 10 per cent of the target population; 50 per cent reached between 10 and 40 per cent; and only 25 per cent reached 40 per cent or more of their populations.¹³ State health departments offered even less adequate family planning services: 50 per cent reported reaching less than 10 per cent of the target population, and none reached more than 40 per cent. Clearly, funding for women's reproductive health is inadequate. Women's health services are most accessible in the states of São Paulo and Rio. In Rio (with an estimated population of 13 million), 56 of 72 (78 per cent of) health posts offer family planning services.

2.2 NGOs and International Donors

Two broad categories of NGOs are involved in providing family planning services and information in Brazil. As in the rest of the so-called developing world, there has been a proliferation of internationally funded NGOs that in the past provided direct contraceptive services. In recent years, many of these groups have worked with the public sector to train service providers and develop education programmes; and some continue to provide contraceptive services as well.

Many of these NGOs draw upon both external donors and contracts with the public sector for financial support. They may charge sliding-scale fees for services, but almost all of their activities are at least partially subsidized. The largest of these NGOs is BEMFAM (whose budget was approximately US\$3.5 million in 1986), which works under contracts both with the private sector and state and local

supplies from pharmacies.¹⁹ Clearly, unless pharmacists provide adequate information, women who obtain pills from them are much more likely to use pills that are not well suited to them, to experience negative side-effects, and to be unaware of what to do in case of contraceptive failure or side-effects.

3.2 Availability and Accessibility of Information about Contraceptives

There are no legal prohibitions on the communication of information about contraception. Women of all ages may be given information; consent from parents, husband or others is not required; and men as well as women have access to information.

Most women who obtain information about contraceptives do so from public institutions (hospitals and health clinics) and pharmacies. Some get information from private doctors and clinics and a few rely on friends or relatives. A study conducted in Brazil's mostly rural northeast region found that more than 80 per cent of women obtained information from public institutions (57.8 per cent) or pharmacies (23.7 per cent); 15.7 per cent from private clinics or doctors; 0.8 per cent from friends or relatives; 0.1 per cent from the Church; and 1.9 per cent from other sources.²⁰

The media, both print and electronic, regularly provide information about the pill, condoms and sterilization, and such information also is available through informal networks. However, the information is inadequate to protect health. The great majority of Brazilian women have used the pill at some time in their lives, but often incorrectly and rarely with medical supervision. Studies show that many women who use the pill have contraindications and/or have experienced collateral side-effects.²¹ There is very little information available, and in most places none at all, about the IUD and diaphragm.

The chief barriers to the communication of effective information include inadequate funding and inefficiency of the public health system; the isolation of rural women; and, in some cases, women's illiteracy or low literacy.²²

The sources of information about contraception are schools (some of which are government-funded and some, private); government service providers (which receive government and international funding); private service providers (which receive private and international funding); and the media (some of which receive private funding). Although PAISM was initiated in 1984, it has not been implemented in such a way as to provide most women with the health information they need.

3.3 Misinformation about Sterilization

A major reproductive health controversy in Brazil concerns the large number of women who undergo tubal ligation under some form of misunderstanding or pressure. There is a great deal of mistrust of the sources of threats or other pressures experienced by poor women to be sterilized. Many poor and working class women report that they believe that they must be sterile in order to get or keep a job and thus seek out doctors willing to perform tubal ligation, which is often costly. Women have been subjected to unnecessary Caesarian sections performed as a cover for tubal ligation. Some people contend that the private sector—sometimes with the tacit support of local government—is the source of pressure. Employers have been known to conduct covert pregnancy tests during "routine" health check-ups or to demand proof of sterilization in order to try to circumvent their obligation under the employment law to provide paid maternity leave. Some observers point to what they see as complicity on the part of international funders and family planning organizations, whom they accuse of withholding information about alternative forms of contraception; others place the blame on greedy doctors and politicians who exchange free sterilizations for votes, a practice particularly noted in the northeast of Brazil. While there is no evidence to confirm that the federal government has used undue means to promote sterilization, it did not take any concrete measures to curb the abuse until April 1995.

A Parliamentary Investigation Commission, headed by Senator Benedita da Silva, investigated sterilization practices and reported in 1991. The Commission strongly condemned employment practices that required proof of sterilization or pregnancy testing of prospective and serving employees and concluded that sterilization had been manipulated by political interests and the international "population control" community. It identified the main problem as women's lack of access to the full spectrum of contraceptive alternatives and information through the public health system. The Commission urged the government to implement PAISM and recommended that male and female sterilizations should be regulated by law and should be performed by informed consent. In April 1995, a new law was introduced prohibiting any type of proof of pregnancy or sterilization or other discriminatory acts for the purpose of obtaining or keeping employment.

have an abortion. The researcher notes that these figures seem to be consistent with the way in which abortion is viewed throughout the country, and laments the tragedy that so many women should have to die from unsafe abortions when it seems that most people call for punishment only when an abortion causes the woman's death.

4.4 Access to Information about Abortion

There is no prohibition in Brazil against talking or writing about abortion. Information regarding the circumstances in which abortion is legal may be freely imparted. Scientific information about abortion is freely circulated, and newspapers regularly report abortion statistics and publish opinion pieces that debate the pros and cons of liberalizing the abortion law.

The government, however, has done nothing to publicize the availability of legal abortions and few women who qualify are aware that they are eligible for a legal abortion. The one exception is the Jabaquara Hospital in São Paulo, which has been publicizing information about its services since 1991.

It is understood that the prohibition of incitement to commit a crime bans advertisements about abortion services (except those that state clearly that the services are available only in cases of rape or danger to the woman's life). In addition, Law No. 3,688 of 3 October 1941 prohibits, on pain of a fine, the commercial announcement of mechanisms, substances or objects intended to provoke abortions. Although research did not uncover any prosecutions for having supplied information about abortion, the existence of the law clearly serves as a constraint on the flow of balanced and accurate information. Doctors and other hospital staff may provide limited information about availability of services for legal abortions and the possible negative consequences of abortion, but they may not, and generally do not, provide information that might encourage abortion. Clearly, counseling from medical professionals—including information about the side-effects of abortion and reiteration of its illegality—discourages many women from seeking abortions.

Women with money are easily able to obtain clandestine, safe abortions in Brazil, and a surprisingly high percentage of medical professionals have either had abortions themselves or consented to their partners having abortions.³²

5 IMPACT ON HEALTH OF INADEQUATE INFORMATION

5.1 Impact of Inadequate Information about Abortion and the Abortifacient Cytotec

Abortion ranks fourth among major causes of maternal mortality in Brazil.³³ Nationwide, the number of maternal deaths in 1988 was estimated to range from 140³⁴ to 230³⁵ per 100,000 live births (or about 6,500 to 9,300 deaths). In 1990, the maternal mortality rate was estimated to be 200 per 100,000 live births.³⁶ In São Paulo, the richest state in the country, maternal mortality in 1992 was estimated at 100 deaths per 100,000 live births.³⁷ One study reported 400,000 hospitalizations for abortion annually, out of an estimated total of 1.4 million abortions.³⁸ The percentage of maternal deaths in São Paulo due to abortion complications reportedly decreased from 19.5 per cent of all maternal deaths in 1962-63, to 25.0 per cent in 1974-75, to 10.7 per cent in 1986; the improvement has been attributed to changes in medical practice as well as to the increased use of contraceptives.³⁹

Since 1986, one of the primary means for inducing abortion has been the drug Cytotec, the commercial name for a medication used to treat ulcers.⁴⁰ Although the drug has been approved for treatment in 72 countries, only in Brazil does it seem to have gained notoriety as an abortifacient. In 1988, the drug began to be marketed by a Brazilian laboratory. In 1991, more than 570,000 units were sold (which, if used as an abortifacient, were each likely to have been used for one or two abortions, although each was capable of inducing up to seven). A study conducted at the National School of Public Health in Rio de Janeiro found that 57 per cent of the women admitted to seven public health hospitals for abortion-related complications in 1991 had used Cytotec as an abortifacient.

In July 1991, the Ministry of Health amended the relevant regulations to limit the sale of Cytotec to authorized drug stores, to require that they retain a copy of the doctor's prescription, and to limit Cytotec's use for gynaecological purposes to hospitals, with approval by the Health Ministry. In 1992, sales dropped to 150,000 units.⁴¹

Gynaecologists in the São Paulo area, surveyed in 1992, agreed that the availability of Cytotec has made abortion safer for women because it permits doctors to complete abortions without violating the law, and because uterine bleeding (the major complication arising from its use) is less serious and easier to deal with than uterine perforation and pelvic infection, complications associated with abortions induced by other means.⁴²

A 1992 survey of women who had used Cytotec showed that they had chosen it because it is inexpensive, relatively easy to obtain and administer, and safer than available alternatives.⁴³ On the other hand, most of the women interviewed stated that using Cytotec had

some educational programmes are broadcast on radio to rural areas. However, the government has not devoted much funding to HIV/AIDS education, and most programmes primarily reach literate, urban adults. Few government strategies target women.

Most state and local school systems do not offer HIV/AIDS education, although pilot projects for primary and secondary school students have been introduced in a few major urban centres, particularly by progressive party leadership such as in São Paulo under the Labour Party government of Luisa Erundina and in Belo Horizonte.

NGOs have produced some broadcasts that have aired on radio and TV. For instance, in early 1994, one NGO got movie stars to do public service announcements on radio, but these were confined to Rio.

Although public awareness has grown in large part due to media attention and the educational programmes of NGOs, behaviour has changed little, and the rate of HIV transmission has not been reduced. Social and behavioural research studies show relatively high levels of awareness matched with low levels of preventive behavioural change across class, race and gender lines. The smallest change in behaviour has occurred among poor people, who lack access to condoms as well as to virtually all health information and care.

7 ROLE OF RELIGION

Although 75 per cent of Brazilians are Roman Catholic, and Catholicism is Brazil's official religion, the Church has not had a significant impact on the decision of women to use family planning methods.⁴⁹ Many Brazilians practice a syncretic adaptation of African-Brazilian religion and Catholicism, a mixture in which official Church doctrine often is diluted.

In a survey of 2,076 Brazilian adults conducted in June 1994, 88 per cent of those questioned said they "do not follow" Church teachings on birth control and abortion; among women aged 25 to 44, the "do not follow" group accounted for 90 per cent of respondents.⁵⁰

Although the influence of the Church on daily life is limited, it continues to exert a strong influence on government and major media. The Church is the main reason that abortion and sterilization continue to be illegal in most circumstances (although widely available), and that contraceptives are not provided free through the national health service. In contrast, the Church has not taken a strong stand against the use of, or information about, various modern methods of contraception. While the Church's official position is to condone only "natural" methods of family planning, it does not vociferously insist on this position. Many priests "look the other way" when they know that parishioners use birth control, and some priests and nuns have even urged the Church to reform its official position.

8 MASS MEDIA CAMPAIGNS

There are three major national television networks, all of them privately owned. Each occasionally airs public service announcements on AIDS, cholera and other epidemics. Although there is no concerted federal government media campaign to disseminate family planning information, a few NGOs have taken some initiative. For instance, in 1993 Citizenship Studies, Information and Action (CEPIA), in Rio, produced and aired on national television three public service broadcasts dealing with condom use in relation to adolescents, abortion, and women's contraceptive freedom. These were considered quite effective.

Six magazines produced by women's NGOs have national circulations and address a range of women's issues, including reproductive health matters. A number of women's organizations produce radio programmes and some produce educational videos, but these are primarily intended to reach women's groups rather than the public at large. Few NGOs that work on family planning issues have a communications strategy designed to penetrate the mass media.

9 CONCLUSIONS AND RECOMMENDATIONS

Family Planning Information

The illegal abortion rate in Brazil is very high (estimated to be between one and two abortions for every four live births); tubal ligation, including under duress or misinformation, is high; and women needlessly suffer a high rate of negative side-effects from pills (the second most common form of contraception after tubal ligation). Inadequate information about safe, effective and reversible forms of contraception is a significant cause of these harmful conditions. Religious, social and cultural traditions do not present major impediments to the use of modern contraceptives for most of the population, with the result that Brazilian women are in a stronger position than women in many other countries to act upon information they receive. For example, one programme in Rio de Janeiro showed greatly increased use of condoms by partners of women who attended a municipal family planning programme. Although such programmes can have substantial impact, they currently reach a tiny percentage of their target audiences and are woefully underfunded.

- Federal, state and municipal governments all need to devote more of their resources to comprehensive women's reproductive health services and information. Facilities that offer family planning services need to be more accessible, and providers need to offer more

improve the amount and quality of discussion programmes and public service announcements on radio and television.

Data Collection

Government health information systems are not sufficiently developed to allow researchers to analyze direct data on public sector investments or services in reproductive health. This inadequacy of data makes accurate assessment of services difficult, if not impossible.

- Accordingly, the Ministry of Health and responsible state agencies should make a concerted effort to collect data on the delivery of reproductive health care as an important step in improving services and information.

The Role of International Funders

Many Brazilians have become distrustful of international funders and the programmes they support because, at least initially, many of them were primarily interested in reducing population growth rather than improving health. The funders' focus on demographic targets, often conditioning aid on the achievement of demographic goals, has exacerbated this mistrust. Anti-family-planning campaigners, exploiting this mistrust, have been able to generate opposition to family planning by characterizing it as a scheme of the industrialized world to reduce Brazil's population.

- International donors should focus on improving women's overall health, rather than (as some do) on demographic goals and such aims as increasing the number of contraceptive "acceptors". Donors should support programmes that improve the quality of care and increase women's economic and educational options.
- International donors should work more closely with women's organizations and female health professionals, especially in developing plans for ways in which funders could more effectively assist in strengthening the public sector (for example, through technical training or management assistance). They should support indigenous NGOs, particularly women's organizations, that contribute to the democratization process at the community level as well as address women's very practical reproductive health and rights concerns.
- The international community should primarily be concerned with strengthening the capacities of civil society to participate in the elaboration of health policy and to hold government accountable for

providing safe, effective and non-coercive services. This includes support for research, training, networking, public education and policy discussion concerning reproductive health issues.

Networking among regional and international NGOs is important to the exchange of information about the strategies and programmes that have been most and least effective in promoting women's reproductive rights.⁵¹

- Donors can play an important role by supporting exchange of information and networking among women's NGOs regionally and internationally.

Notes

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- ² *World Development Report 1993—Investing in Health: World Development Indicators* (Washington, DC: World Bank, 1993; hereinafter "World Bank Report"), 200, 299.
- ³ *Ibid.*, at 200.
- ⁴ *Ibid.*, at 200, 291.
- ⁵ Government of Brazil, Institute of Geography and Statistics, *National Census* (Aug. 1994), summarized in *The New York Times*, 2 Sept. 1994, A1.
- ⁶ See S Alvarez, *Engendering Democracy: Women's Movements in Transition Politics* (Princeton, New Jersey: Princeton University Press, 1990), 184.
- ⁷ *Ibid.*, at 185.
- ⁸ For instance, UNFPA contributed US\$15 million to PAISM over five years, beginning in 1984, and the World Bank, through its Northeast Basic Health Projects, has provided funds to PAISM for programmes in the northeast. H Sactenian, *Brazil Women's Reproductive Health* (Washington, DC: World Bank, Aug. 1991), 44.
- ⁹ *World Bank Report*, note 2 above, at 45-46.
- ¹⁰ S Corrêa, Coordinator of Research at the Brazilian Institute for Social and Economic Analysis (IBASE), unpublished manuscript (Barbados: DAWN, 1994).
- ¹¹ Ross, Mauldin, Green and Cooke, *Family Planning and Child Survival Programs as Assessed in 1997* (New York: The Population Council, 1992; hereinafter "Population Council"), 125. Of this US\$9.35 million, 35 per cent went to contraceptive services, 15 per cent to information and education, 6 per cent to research and evaluation, 1 per cent to personnel training, 30 per cent to administration, and 13 per cent to "other" expenses.
- ¹² *Ibid.*, at 164. Statistics for family planning services are merged with maternal/child health services.