Women's Health Care in Brazil

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In 1982, the ministry of health in Brazil decided to present a comprehensive programme of women's health. The programme was drafted by four doctors, two of whom were feminists and clearly reflected the politics and the philosophy of the women's movement as it had been evolving in the previous decade. The author who was closely associated with early efforts in this direction writes about the problems encountered in evolving the plan and in implementing it.

BACK in 1982, I was helping the electoral campaign of a candidate for governor in the state of Sao Paulo, and together with a handful of other volunteers, I was in charge of drafting the items on women's health to be included in his campaign agenda. It was not easy, I can tell you!

To begin with, the very legitimacy of having a special programme for women was questioned. Again and again we had to argue that yes, all human beings are entitled to good health care, but women do have special health needs, both because of their biological reproductive functions and because of the sexual division of labour prevalent in our society. Other arguments had to do with priorities and there we were repeating that: Yes, we knew that infant mortality rates were unaceptably high, *but* did they know what maternal mortality rates were? Or: yes, we agreed that work-related accidents and illnesses that reached both men and women should be greatly diminished, but wouldn't they also agree that women did have a right not to have to resort to clandestine abortion?

When feminism, after decades of demobilisation, reemerged in the Brazilian political scene in the mid-seventies, the overall national priority was the struggle for democracy and the prevailing idea was that a focus on women's specific issues was divisive and self-defeating. Even where women's subordination was acknowledged, it was dismissed as an unimportant political question, a mere byproduct of class exploitation or a cultural tradition that would naturally disappear as a consequence of the development process. Forgive me the oversimplification but, as I said, I am referring to the prevailing ideas, those that set the climate where a project can grow or fade away. And feminism managed to flourish quite well thanks to a strategy of downplaying women's specific issues and to restricting them to those in the sphere of production. It thus managed not to alienate important partners in the struggle for democracy: the left and the catholic church.

But, by the end of the seventies, it was not possible to continue ignoring women's daily struggle to control their reproduction. The fertility rate was going down quite rapidly. And that in all regions of the country, in all social classes, and even in the rural areas. The demographic figures only became available several years later, but whoever had any contact with the poor soon became aware that pills, tubal ligation and clandestine abortion—no matter their high costs—were more and more widespread. And what was more surprising was that Mothers Clubs and other grassroots organisations—most of which had been created in the sixties under the umbrella of the catholic church—having evolved from their traditional handicrafts and religious activities to the active mobilisation to press local governments for urban services, were now presenting a new demand. Can you guess what? Sex education! The rationale presented was that they needed information in order to guide their children. But as soon as the question period was open after a given lecture, the issues that used to come up were those of frigidity and power relations between the couple.

Why did these problems begin to emerge in public? Intensive migration and the growth of megalopolis had resulted in the severing of traditional family ties and neighbourhood groups. That, together with increasing work alienation, had helped to raise the expectation towards couple relationships as a major channel of personal fulfilment. Besides, women's access to the mass media—especially to TV romantic *novels*, which were reaching 75 per cent of urban homes in 1980—all acted together to question the use made by many men of women's bodies. The word *use* does not reflect my intention to shock you: it is the common euphemism used by rural women to mean sexual relationship (and that certainly tells us something about the quality of this relationship!). To cut a long story short: the fact was that tensions were mounting in the bedroom, and these were showing up in group discussions whenever poor women had an opportunity to speak.

The year 1982, as you know, was when the debt crisis came to the forefront and the country had to resort to the IMF structural adjustment policies. As always happens in crisis situations, the old neo-malthusian ideology came out of the closet again as an apparently easy solution to the difficult economic problems. In 1983, sectors of the military, together with private family planning organisations drafted a plan to curb population growth. This raised the same fears prompted by similar attempts made in the sixties and seventies. The major fears were: diversion of government efforts from the root causes of poverty, foreign intervention on national priorities and open doors for coercion of poor people to have fewer children.

But at that point those arguments were no longer strong enough to resist the creation of government programmes. On the one hand, the advantages of fast population growth, an argument which was popular in the sixties, had long been discredited. On the other hand, contraceptives were widely available to those who could buy them, and it was difficult to deny that, in the absence of government support, poor women were going through tremenduous sacrifices in order to regulate their fertility.

What happened then was that, instead of just opposing the population control plan, the ministry of health decided to present an alternative: a comprehensive programme of women's health. Drafted by a committee of four doctors, two of them feminists, the programme embodied a set of principles the women's movement had been formulating through

its practice in the previous years.

It started with a thorough diagnostic of the causes of mortality and morbidity among women over 10 years of age, which numbered around 45 million in 1980. Free health services provided through the public system or through the social security system had been mostly limited to pre-natal and natal care, and grossly inadequate both in terms of coverage and quality. The new programme was based on the idea of comphrehensiveness. Services should not be restricted to reproductive functions, they should include cancer prevention and the control of sexually transmitted diseases, and be integrated with general clinical care. Married women of fertile age were not to be the sole clients. Older women and adolescents were also to receive adequate care. And public services should include both the provision of information and all means of contraception and infertility treatment.

An important element of the preventive aspect was the educational component. In order to enable women to take control of their own health, they should have access to needed information. But much more than that, they should have the opportunity to develop the attitudes conducive to the effective use of this information. That is, instead of the prevailing authoritarian doctor-client relationships, health services should contribute to the enhancement of self-esteem and self-respect, so that women could have pleasure in taking care of their own bodies.

All this was very beautiful and very nice on paper. But a small and inexperienced staff at the ministry of health had to spend an enormous amount of time in political negotiations to make the programme viable. Opposition came from two main sources: at first, from the democratic sectors who did not trust the military government and suspected the programme to be just another disguised population control initiative. This mistrust vanished gradually with increased transparency of the decision-making processes and the election of Tancredo Neves in 1985.

The other sector was the catholic church, whose teachings have little impact upon the practices of the members of its congregations, but whose hierarchy is very vocal. The ministry diligently courted the church and apparently managed for a while to get its agreement to look the other way But the church became very active again last year, when the social security system jointed the programme. The church efforts are now aimed at restricting the availability of what they consider unethical methods of contraception, that is, barriers, pills, IUDs and all others not based on periodic abstinence.

But, in spite of this resistance, some important achievements have occurred. What has been most remarkable has been the adoption by the health system of educational practices developed by the women's movement. It is now quite well-established that doctors, nurses and semi-literate health assistants, all need refresher training, and many in-service programmes throughout the country have aimed both at technical updating and at clarification of attitudes and values.

Educational materials originally developed for consciousness-raising groups have been widely used in small-group discussions where health workers of all ranks have, for the first time, a chance to analyse critically their practices and assumptions about women as clients. The techniques used put an emphasis on respect for differences of opinion among group members, and are quite revolutionary in the sense that they cut across hierarchies in the workplace.

Another important innovation is that sex education is now a key element of the training programmes. Reproductive health issues cannot be separated from sexuality. Just to give an obvious example: if a woman cannot use a diaphragm because she cannot bring herself to put a finger inside her vagina, nothing will be accomplished by technical instruction. So sex education starts by re-examining the educational practices of our society that taught us to have shame and fear of our own bodies. And this, of course, is related to women's role in society. Therefore, a little history of Brazilian women is introduced in some of these training programmes.

As most health workers are themselves women, their evaluations of the educational programmes often point to self-awareness as an important by-product. But the ultimate aims of those programmes are two-fold: first, to influence the overall attitude of the worker towards the clients, who should be respected as autonomous human beings in charge of their own health and reproductive decisions; and second, to prepare the workers to conduct similar training sessions with the clients. This has begun to happen in many units, but it still depends largely on the initiative of interested workers.

An evaluation carried out in late 1986 pointed out as the major achievements of the programme, the development and printing of educational materials and norms of clinical procedures. These norms refer to sexually transmitted diseases, pre-natal care, breast and cervical cancer prevention. Family-planning norms have been developed put are not printed yet. Norms for childbirth are still in the drafting. The programme has also supported the development of national technology in the areas of spermicides and diaphrams. However, the units where the programme has been effectively implemented still are not more than a hundred, distributed among a few states.

What lies ahead for the future? I think it will depend on three widely different factors. First, the success of the programme requires an administrative reform to give it efficiency it now lacks. As it stands now, the decision-making is highly centralised and the decision-process quite bureaucratised. And this, of course, has greatly delayed its launching at the local level.

Secondly, the future of the programme is tied to the future of the women's movement in at least two ways. Women will have to remain active as a pressure group at the central levels of government so that the the church hierarchy does not succeed in curtailing the scope of the programme. On the other

hand, at the local level, clients increasingly aware of their rights will have to keep a constant eye on the quality of the services to avoid abuses and a tragic gap between intent and consequences.

Thirdly, resources for the programme depend on the solution to the debt crises. At the moment the programme is mostly supported by a five-year grant from UNFPA. But even so, the programme relies basically on the smooth running of the public health services. And, as you probably know, Brazil has been exporting capital to the industrialised countries in the last few years. A large proportion of the GNP is going to service the debt, the balance of payments is going down due to increasingly unfavourable terms of exchange, government revenues are being sharply cut. In this scenario, institutional stability is threatened. At the level of the health services, a most likely outcome is a sharp drop in the already low salaries of health workers. They become demoralised and spend a large proportion of their time fighting against salary cuts.

If common sense prevails, and new economic agreements allow the economies of the third world to resume growth, the Brazilian health programme will be strengthened, its difficulties corrected. Since it corresponds to such great needs, and it has been drafted with such audacity and care, it deserves this chance.

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