REPRODUCTIVE HEALTH IN POLICY & PRACTICE

BRAZIL

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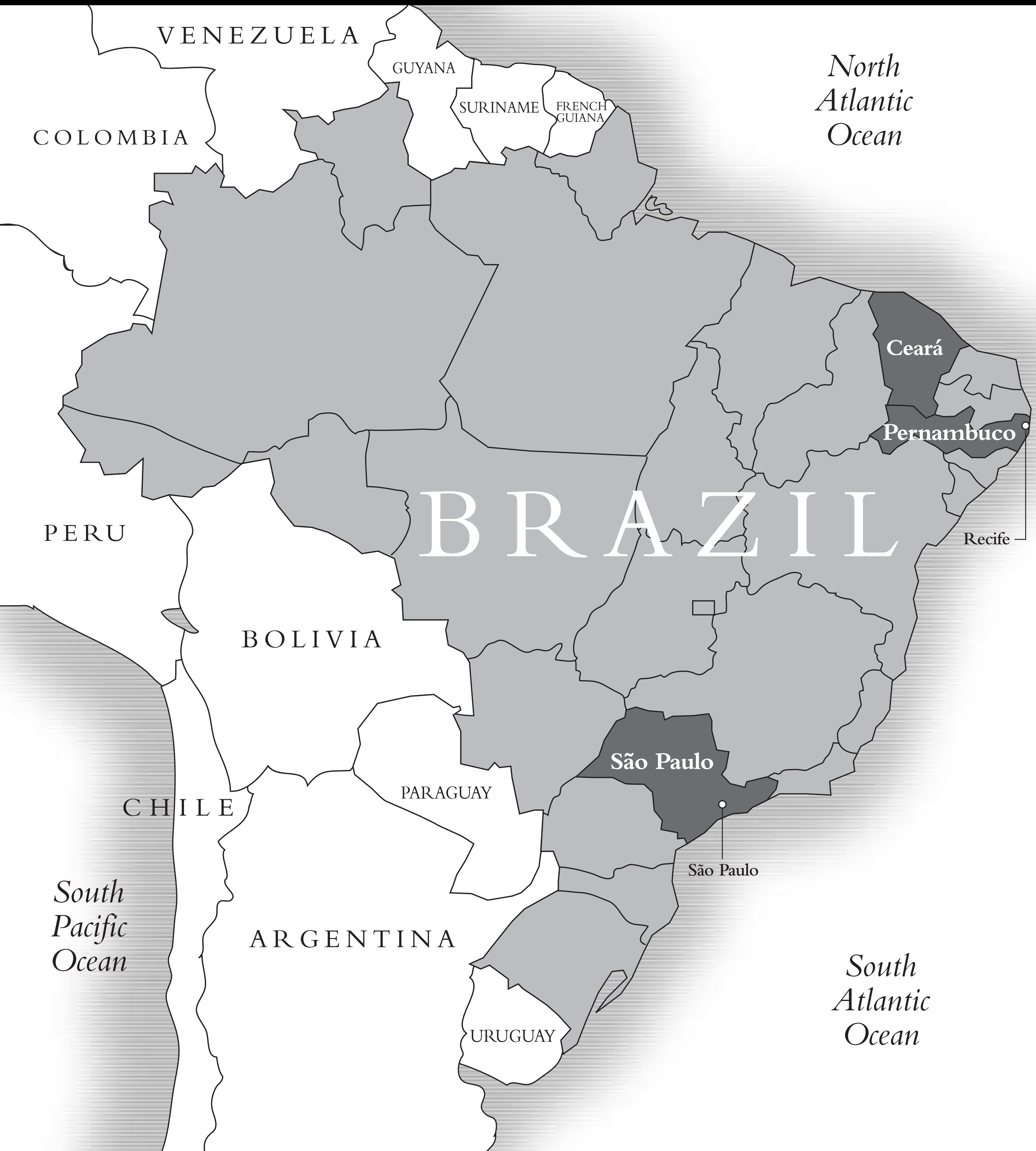
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Summary

In Brazil, a comprehensive approach to reproductive health (or PAISM, *Programa Assistencia Integral a Saúde da Mulher*) was defined in 1984. It included nearly all of the reproductive health care elements called for 10 years later in the Programme of Action of the 1994 International Conference on Population and Development (ICPD), held in Cairo. In addition, Brazil's 1988 Constitution recognized reproductive self-determination as a right and defined the state's responsibilities in providing a full range of reproductive health services, including family planning. In that sense, the adoption of the Cairo agenda did not imply a major policy shift, as it did in many other countries. Brazil's earlier experience with implementing a reproductive health approach strongly influenced developments in the post-Cairo period.

In the late 1980s, political turmoil and economic crisis in Brazil hampered health reform, reproductive health policy initiatives, and the implementation of constitutional rights. As late as 1995, public health services still lacked basic interventions such as prenatal and maternity care, and cervical and breast cancer screening and treatment. The PAISM comprehensive agenda remained a stand-alone program, never funded or implemented as part of the country's universal health system. And it lacked important linkages that would have made it more effective, such as with the Adolescent Health Program, the National HIV/AIDS Prevention Program, or the Family Health Program.

More positive developments occurred after 1994. Brazil has experienced reasonable institutional stability and a political climate favorable to the ICPD agenda, and reproductive health and rights issues gained greater visibility as a result of the 1995 Fourth World Conference on Women. In the last five years, the management structures of the universal health system have undergone reforms. In spite of a climate of economic austerity, the government has approved additional health financing, advanced basic health approaches through a combination of family health and community-based strategies, and accelerated the decentralization of health services. In this environment, a large number of service improvements have taken place. Reproductive health care is increasingly integrated with municipal-level primary health services. Basic interventions such as prenatal and maternity care have improved: Between 1995 and 1997, prenatal consultations increased by 51 percent nationally. Legal abortion services are now available in 12 sites, and the quality of postabortion care is improving. Adolescent services and prevention and treatment of sexually transmitted diseases (STDs) and HIV are better integrated with family planning and reproductive health services. Access to reversible contraceptive methods is expanding in primary health programs in many settings. Finally, national cancer-screening programs have been launched, and cervical and breast cancer screening increased 14 percent and 44 percent, respectively, between 1995 and 1997.

In spite of a climate of economic austerity, the government has approved additional health financing, advanced basic health approaches through a combination of family health and community-based strategies, and accelerated the decentralization of health services.

Lessons learned

Several factors can be credited with facilitating the process of change. First, since the 1980s, Brazil's political system has allowed for the greater participation of its people. More democracy has lengthened the policy decisionmaking process, but it has also given

voice to the advocacy community and allowed for debates about the reproductive health and rights agenda. More recently, open political debate persuaded other actors to adopt this agenda.

Second, reforms in the health sector have paved the way for the integration of reproductive health services in the universal health system. The major principles underlying health reform—universal access, comprehensive care, equity, decentralization, and social accountability—have proved to be a prerequisite for effective implementation of a comprehensive reproductive health approach.

Third, a committed and expanding reproductive health and rights advocacy community has influenced national policies, from the establishment of PAISM in 1984 to the present day. The ability of the advocacy community to interact with the Ministry of Health and Congress, as well as to move into policy-related positions—as health managers and providers—has worked in favor of reproductive health goals.

One the other hand, progress in Brazil has been uneven because of a combination of issues. At the national policy level, economic stabilization programs have lowered the priority placed on social services, and opposition from conservatives has stalled efforts to make legal abortion services more widely available. At the operational level, inefficiencies in the public health bureaucracy and the relative importance of private providers in providing contraceptives and other services have prevented the development of a unified, comprehensive strategy.

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The influence of financial resources

Total health spending in Brazil is estimated at US$50 billion, or about US$320 per capita—a high amount for a developing country. The public sector accounts for 43 percent of spending and the private sector accounts for 57 percent. The federal government spends a small proportion of its total budget on reproductive health: US$1 billion in 1997, including the cost of childbirth procedures (US$500 million) and HIV/AIDS treatment costs. Between 1995 and 1997, federal government spending on reproductive health services grew by 34 percent. This increment is almost entirely a result of the increase in funds for supplying STD and AIDS medications.

In this context, local-level managers say that limited funding is not the major obstacle to improving reproductive health services. In their view, the commitment of managers, the training and attitude of health professionals, and the bias of the system toward curative care are more relevant at this stage. At the same time, their own policy experiences—after decentralization of the health system—show that the impact of additional resources can be tremendous.

International donor funds are minimal in relation to total national expenditures. In 1996, donor funding for reproductive health was about US$28 million. However, international resources have been critical in the national HIV/AIDS program, as well as in providing technical support to the women's health program in Ceará. Moreover, donor funds remain critical for policy research initiatives, data collection, and the sustainability of the efforts of nongovernmental organizations (NGOs).

Introduction

This case study focuses on the implementation in Brazil of the ICPD recommendations on reproductive health and rights. The study was coordinated by the Population Reference Bureau under the Cairo in Action Project. It includes an assessment of the demographic and political trends that preceded the Cairo conference, which are essential to understanding the challenges of ICPD implementation. In Brazil, reproductive health policies predated Cairo by 10 years, and the country had a strategic role in the negotiations on the ICPD Programme of Action approved in 1994.

To assess the impact of ICPD in Brazil, we consulted policymakers, health professionals, health and reproductive rights advocates, and journalists. We analyzed progress in policies and service implementation in the Ministry of Health and in three states—Pernambuco, Ceará, and São Paulo (see map on p. 2). The following criteria were used to select the states: a positive history of previous reproductive health initiatives, the status and implementation of health reform, and the presence and role of the reproductive health and rights advocacy community.

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The study covers various actions included in the reproductive health agenda: prenatal care, obstetrical assistance, gynecological cancer; prevention of STDs and HIV/AIDS; incomplete abortion care and access to abortion services, as permitted by law; and contraception assistance. The study emphasizes abortion-related issues and contraception assistance—the former because of the increased national debate on abortion since the late 1970s, the latter because this area of reproductive health policy has been characterized by obstacles.

In the case of Pernambuco and São Paulo, we analyzed municipal policies in Recife, Cabo de Santo Agostinho, and the city of São Paulo. In Ceará, we focused on coordination among international agencies that support the state's reproductive health program and coordination between these agencies and the state health department. The team visited services in all states and, in Pernambuco, focused attention on primary care programs. In both Pernambuco and São Paulo, we evaluated services that offer abortion procedures in the two cases permitted by law—rape and life-threatening circumstances to the mother—and services that introduced innovative approaches to incomplete abortion assistance.

The study also includes an analysis of public and international funding of reproductive health activities. We examined trends in federal spending on outpatient services between 1995 and 1997 and on hospital services between 1995 and 1996. The amount and composition of international funds invested in programs related to the ICPD agenda were analyzed exclusively for 1996.

Challenges Before Cairo

Between 1964 and 1985, Brazil was under military rule. Economic growth rates were high, but social inequality increased. From the 1960s to the 1970s, the population growth rate was 2.9 percent, and the total fertility rate was 5.8 children per woman in 1970. A population redistribution policy was initiated in the 1970s, but no contraceptive measures were established because of opposition from the Catholic Church and the military. However, the military regime did not restrict the marketing of contraceptive methods or the work of nongovernmental family planning programs, which had been operating in the country since the mid-1960s.

In the late 1970s, Brazil started a long and tumultuous democratization process, accompanied by economic crises and rampant inflation. During this time, the responsibility for public health care was fragmented, excessively centered on hospitals, focused on cure instead of prevention, and heavily dependent on contracted private service providers.

Between 1970 and 1980, the military regime implemented four strategic policies that analysts have seen as contributing to a 25 percent reduction in fertility rates for the country as a whole.[1,2] These policies included expansion of the hospital network, expansion of consumer credit, wider coverage by the National Health and Security System, and expansion of communication systems, particularly television. Along with rapid urbanization, these policies led to a preference for smaller families and increased exposure of the population to modern medical practices. Among women, the demand for contraceptives increased rapidly.

The 1980s were primarily a period of increased democratization and greater political participation by the people. This had a significant effect on health policies and national initiatives in reproductive health. A strong demand for reform of the health system, spearheaded by professional and academic circles and social reform movements, led to the passage of the 1988 constitutional provisions that established the Universal Health System (SUS). The SUS is a universal, integrated, and decentralized system that includes social accountability mechanisms in the form of health councils at all levels—national, state, and local.[3]

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Also during this time, women's rights groups demanded the distribution of contraceptives by government agencies and the legalization of abortion.[4] This discourse contributed to a wider acceptance of the principle that reproductive freedom of choice is a woman's right. However, in 1983, a petition to legalize abortion was turned down by the Committee for Constitution and Justice.

In 1984, the Ministry of Health developed the PAISM, which integrated prenatal care, birth, and postnatal assistance; cancer prevention; STD care; adolescent and menopausal care; and contraception assistance. About the same time, state councils on women's rights were created, as well as the National Council on Women's Rights (CNDM) and the Committee on Human Reproductive Rights (under the Ministry of Health), all of which supported the program.

The CNDM played a critical role in mobilizing women's organizations during the drafting of the new Constitution. The Constitution guaranteed an individual's right to reproductive freedom of choice and access to family planning, as well as the government's responsibility for offering information and services to guarantee these rights. Despite religious lobbying by both Catholics and Protestants, the 1988 Constitution did not include the principle known as "the right to life from the time of conception."

Between 1984 and 1988, PAISM introduced technical standards, distributed educational materials, provided technical training, and improved awareness among service professionals. However, subsequent

economic, institutional, and political turmoil delayed the passage of enabling legislation under the constitution, and progress on implementing a women's health program languished.

In 1993, while preparing for the ICPD in Cairo, the PAISM principles were revived through debates and dialogues involving both the government and civil society organizations (see Box 1). Three consultation seminars were carried out involving the Ministry of Foreign Relations, academic groups, and civil society—one of them covering health and reproductive rights specifically. The positions adopted by the Brazilian government in Cairo, and one year later in Beijing, were supported in the 1988 constitutional provisions.

Box 1

Strategic Mobilization Initiatives, 1989 to 1993

CIVIL SOCIETY

- **1990-1993**—Creation of the Committee on Citizenship and Reproduction to revive the vision of the Study Committee on Human Reproduction Rights
- **1991**—Formation of the National Health and Reproductive Rights Network (RedeSaúde)
- **1992**—Creation of CFÊMEA, an NGO, to monitor legislative processes

These groups worked to implement PAISM at the state and local levels, where political conditions were more favorable, and to influence the legislative arena (enabling legislation under the constitution and abortion-related proposals, among others).

LOCAL LEVEL AND CONGRESS

- **1990-1993**—Development of a model experiment in the city of São Paulo to handle abortions as permitted by law (such as in the case of rape and life-threatening circumstances to the mother)
- **1991-1993**—Establishment of Investigation Committees by the Federal Congress and the São Paulo, Goiás, and Pernambuco state legislatures, which studied the high rates of female sterilization and concluded that they could be reduced by implementing PAISM
- **1997**—Final approval by Congress of the constitutional definition of family planning

GLOBAL LEVEL

In the 1990s, the Brazilian experience in advocacy and policy formulation contributed to the paradigm change that occurred at the ICPD.

- **1992**—Hundreds of women met at the NGO Global Forum at the Earth Summit (UNCED) in Rio de Janeiro to discuss population control and reproductive health and rights policies
- **1994**—Meeting of the International Conference on Reproductive Health and Justice in Rio de Janeiro

Cairo challenges for Brazil: back to the future

"Brazil already had a history—a positive one—in reproductive health, and only minor effort was necessary to convince people and institutions of the relevance and pertinence of ICPD. On the other hand, there was no breaking point, and the danger exists that everything will stay just the same."

George Walmsley, United Nations Population Fund Representative in Brazil

During PAISM's 10-year existence, services were enhanced in some locations. The first women's health program was implemented in São Paulo, and the departments of health of both the city of Recife and state of Pernambuco invested in reproductive health. In Ceará, where initiatives in prenatal and obstetrics assistance had already been developed, PAISM training led to a more comprehensive approach to women's health. However, in the early 1990s, only 20 percent of the state services and 46 percent of the municipal services offered prenatal assistance to more than 40 percent of the population.[5] And only three municipal health departments provided contraception services to more than 40 percent of the women of reproductive age in their areas.

By 1995, the situation was not substantially different. Since 1993, the Infant Mortality Reduction Program, which included maternal death reduction strategies, was considered a priority, and the Safe Child-Bearing Initiative gained importance within the PAISM agenda. But these measures were insufficient. According to the ICPD guidelines, a reproductive health program should include, at a minimum, uterine and breast cancer prevention strategies, contraception

assistance, adequate treatment for incomplete abortions, and expansion of abortion care services where permitted by law. In Brazil, it was also necessary to integrate the reproductive health actions into those implemented by the STD-AIDS National Program (PNAIDS). Yet by 1995, no consistent coordination existed within the Ministry of Health between PAISM and PNAIDS, even for the purchase and supply of condoms for the basic distribution network. Fragmentation and overlapping of responsibilities were also observed at the state and municipal levels.

Abortion: legislative debates and services

During the 1980s, Brazilian women's rights advocates lobbied to make abortion, where permitted by law, more accessible under the public health system. The Brazilian penal code of 1940 authorizes abortions in cases of rape and life-threatening circumstances. However, until the late 1980s, women's access to abortion was allowed only in cases of life-threatening circumstances to the mother, and were virtually nonexistent for pregnancies resulting from rape.

According to legal experts consulted by women's advocacy groups in the mid-1980s, the penal code automatically permits provision of abortion services in both cases permitted by law; no complementary regulation or judicial authorization would be required. The only necessary measure would be an administrative directive issued by the Municipal Health Department. Following this guideline, the first legal abortion service began operating in Jabaquara Hospital in 1989.

In 1991, a bill was introduced in the Brazilian Congress to ensure that the services would be universal, and not subject to the will and inclinations of local administrators. By 1994, only one legal abortion service, aside from Jabaquara Hospital, had been implemented. Improved care was also needed in incomplete abortion cases. In 1996, the public health system carried out 250,000 postabortion curettages (see Table 1, Appendix 2). Subsequently, a study [6] showed that women were still being brutalized at the services, and in many cases, the technical quality of the care left much to be desired.

Contraception assistance: unrelenting obstacles

Until 1985, when the public health system began to offer contraceptives, women depended mainly on the private market and nongovernmental family planning providers to supply contraceptives, primarily the pill. The volume of contraceptive pills sold jumped from 1.7 million packets in 1960 to 61.2 million in 1980,[7] but information and screening were not adequately provided. The quality of services provided by the nongovernmental sector was also very problematic. The lack of adequate screening and information resulted in contraceptive failures, adverse side effects, and access problems, and reversible methods became increasingly discredited among women. Since abortion was illegal and risky, the demand for surgical sterilization increased.

Sterilization began to be offered widely by private hospitals, by contract service providers, and by individual physicians in public hospitals. To justify its increased frequency, doctors often performed the procedure during Caesarean sections. By the early 1980s, this trend had already become apparent, and PAISM made the goal of reducing the number of sterilizations a priority. But 10 years later, the program's impact in this area was minimal. Although contraceptive use among married women grew from 66 percent to 77 percent between 1986 and 1996, pill usage declined from 25 percent to 21 percent. Some of the decline was due to an increase in condom use (from 1 percent to 4 percent) and vasectomy among partners (from 1 percent to 3 percent), but use of sterilization increased from 27 percent to 40 percent of married women (see Tables 2 to 4, Appendix 2).

Thus, tubal ligation is the most widely used contraceptive method offered by the SUS system (see Table 5, Appendix 2). In preparation for Cairo, a prominent demographer and health expert coined the expression "the culture of sterilization" to describe the widespread use of sterilization, which in Brazil affects women of different generations and races, as well as physicians, and permeates both the private and public health systems.[8]

The Reproductive Health Agenda After Cairo

Rebuilding the agenda

"In a hospital run by the state of São Paulo, women were walking around wrapped in sheets, with no underwear. The management's explanation was that if their clothes remained at the hospital, they would be stolen, and then the women would blame the hospital for the theft... Faced with such primitive conditions, any change would be significant."

Dr. Tânia Lago, Coordinator of the Women's Health Area of the Ministry of Health

In early 1995, new federal and state administrations were inaugurated. That same year saw the beginning of administrative reform and implementation of more rigorous control of federal public expenditures, with effects on social management and investments. The National Congress declared the reform of the state a priority, and delayed the legislative debate on relevant projects recommended by the ICPD. Pending in Congress then were a proposal to prepare enabling legislation on family planning and various abortion-related proposals, including the bill requiring universal access to abortion services in the two cases permitted by law.

However, the discussions at the 1995 Fourth World Conference on Women, held in Beijing, had greater impact than the ICPD on the media, institutions, and society. The Platform of Action adopted in Beijing reaffirmed and extended Cairo definitions on reproductive health and rights, especially regarding abortion and reproductive rights. In Brazil, after 1996, the Cairo and Beijing agendas were implemented as a joint effort.[9] Although the reproductive health agenda regained visibility, difficulties delayed the consolidation of SUS, and, more specifically, its financial sustainability and decentralization until 1996.

Box 2

The Impacts of Cairo and Beijing: Testimonies

"In 1995, I heard more about the commitments undertaken by the conference. It struck me that they coincided with PAISM guidelines."
Dr. Álvaro Machado, Ministry of Health

"Today, on the government side, the emphasis is on active policies designed to fulfill positive goals. Infant mortality rates have been declining. Now our attention is drawn to more refined indicators: neonatal mortality, maternal mortality and adolescent pregnancy." **Professor Vilmar Faria, Social Policies Coordinator, President's Office**

"Cairo has confirmed our doctrine. We make constant reference to Cairo in our discussions with managers, agencies, and other professionals. For us, it has been a key political instrument." **Dr. Dirlene Mafalda, Coordinator of the "Viva Mulher" Reproductive Health Program, Ceará**

"Our priorities have been maternal mortality, legally accepted abortions, and cervical cancer. But our inspiration did not come from the international agenda; we started from socially-related issues: grass-roots causes, gender, and freedom." **Dr. Giliatti Falbo, State Secretary of Health, Pernambuco**

"In September of 1994, an abortion clinic was raided. The press reported the argument of the movement: 'While paragraph 8.25 is being discussed in Cairo, in Recife abortions are treated as criminal cases.'" **Márcia Laranjeiras, SOS Corpo, Gender, Citizenship, Pernambuco**

"We were the first state to implement a legal abortion program, and also acted in the area of infant and maternal mortality and women's health... I am sure that actions in this area depend on the political will, and the conference agenda has been an important contribution." **Dilson Peixoto, PT Camaragibe Mayor, Pernambuco**

"We did not know the Cairo language, but this is the argument we used: It is a health problem; if it is legal, then it must be safe, and treatment has to be more humane. It worked like wireless communication." **Veranice Alves, CISAM's Director, Pernambuco**

The Universal Health System, 1995–1998: recent policy definitions

Today, the SUS provides over 70 percent of outpatient and hospital care, managing a vast network of public units and accredited private services

(see Box 3). For approximately 120 million Brazilians, SUS is the sole source of medical care. In 1994, SUS national guidelines incorporated primary care strategies to correct the hospital-centered bias. In 1996, new operational guidelines for SUS were approved. This regulation, which grants local managers autonomy to define priorities and allocate resources, constitutes one of the crucial elements in the advancement of reproductive health policies, with respect to both access and quality of services.

The same year, a new source of health financing was created that temporarily solved the persistent SUS funding problems: the temporary fee on financial transactions (a 0.2 percent fee on bank transactions). Since private plan users who are covered by insurance also have access to SUS-provided services, in 1998 a new regulatory framework instituted rules for reimbursing the SUS. Box 4 and the flow chart in Appendix 3 provide a description of how funds are allocated in the Brazilian health system.

Box 3

Universal Health System: Basic Health Coverage, Services, and Strategies

COVERAGE

Universal, free, all-inclusive benefit package

RESPONSIBILITIES

- *Local government:* Provides assistance
- *Ministry of Health:* Establishes norms and regulations
- *States:* Have a planning role, but may still run many hospital units
- *Federal government:* Has its own network of hospitals (cancer hospitals and university hospitals), controls endemic diseases and basic sanitation

COMMUNITY HEALTH AGENTS PROGRAM (PACS)

Almost 64,500 health agents, mostly women, involved in follow-up and health education activities. Each agent is responsible for an average of 166 households.

FAMILY HEALTH PROGRAM (PSF)

Promotes health, basic care, and door-to-door assistance. Teams consist of a general practitioner, nurse, nurse's aide, and community agents, and are responsible for 600 to 1,000 households each. By June 1998, PSF covered 4.6 percent of the Brazilian population.

ACCOUNTABILITY MECHANISMS

At the federal and states levels and in most municipalities, there are health councils where one-half of the participants are users and the other one-half consists of government officials, service providers, and health workers. The councils are charged with monitoring the implementation of programs and expenditures of health funds.

Reproductive health and system reform

The present structure of the SUS resulted from experiments and programs that grew during the 1980s. PAISM was among these pioneer initiatives. But PAISM had been implemented as a vertical (separately-managed) program. One of the difficult tasks begun in 1995 was to reactivate the reproductive health agenda and make it compatible with the new SUS operational and financing rules and structures. With decentralization, the vertical approach became untenable; under the new conditions, reproductive health activities could only advance if local managers were convinced of their relevance.

However, the vertical approach in health programming was not limited to PAISM. In 1988, the adolescent component had already become a new "special program." The National AIDS Program had been conceived as a separate, vertical program. National policies on cervical and breast cancer were monopolized, until recently, by the National Cancer Institute, which has its own chain of hospitals and diagnostic centers. This bias is related both to the way special programs are funded and the problems faced in SUS implementation. It is easier to "walk alone" than to share decisionmaking when the overall system is not well-structured.

In particular, PAISM's vertical structure resulted in bottlenecks in distributing contraceptives. Centralized purchasing brought advantages of scale and price, but supplying the network of health care providers and facilities was beset by

logistical problems and inefficiency and corruption at the Central Medicine Unit of the Ministry of Health that closed in 1997. Even with decentralization, many managers see no reason to dedicate funds to expand the offering of contraceptive methods, because the demand can be satisfied directly by drugstores.

The Cairo agenda and the institutional framework

Between 1995 and 1998, a series of institutional initiatives influenced the development of national reproductive health policies. In 1995, a presidential decree created the National Commission on Population and Development (CNPD). The CNPD is a technical advisory body whose mandate is to monitor policies and carry out evaluations in areas relevant to population and development, in accordance with ICPD recommendations. Given the importance of reproductive health and rights in the ICPD Programme of Action and in Brazil, this was made a priority area for the CNPD.

Also in 1995, the new minister appointed a women's rights advocate to one of the positions reserved by the National Health Council for people of reputable knowledge. In 1996, the Women's Health Intersectorial Commission (CISMU) started operating as an advisory board to the National Health Council, with the participation of the CNPD, the National Council of Women's Rights, and the Reproductive Rights Network (RedeSaúde), among others.

The National Health Council and CISMU helped to reactivate and support a comprehensive approach to reproductive health (beyond maternal health issues). In July 1997, a new coordinator was appointed to PAISM, who was closely acquainted with the ICPD agenda. In April 1998, the new minister of health made reproductive health activities (here understood in their broadest sense) a priority. Even though management decisions are increasingly decentralized, the ministry continues to have a role in defining national health priorities, setting standards, and regulating providers. Box 1 in Appendix 2 describes the monitoring activities of the National Health Council, CNPD, and CISMU in more detail.

The Cairo agenda and civil society

"The impact of Cairo will be strong or not, depending on how its definitions are translated or not translated by the women's movement for the sake of the network managers and professionals, since the latter are normally so detached from the international debate. If no one exists to provide the connection, nothing happens."

Dr. Lilian Vidal, Women's Health Coordinator at the State of Pernambuco Health Department

From 1995 to 1998, there was an increase in the number of interactions between government and society in which reproductive health issues gained more visibility (for example, the formation of councils, commissions, and SUS social accountability mechanisms). The mobilization of advocacy organizations was also significant, especially the increased ability of these organizations to influence public debate.

The heated congressional debate on abortion after 1995 was a unique opportunity to attract public attention to reproductive rights issues, establish new

Box 4

Universal Health System: Funding and Resource Allocation

FEDERAL GOVERNMENT—Provides 63 percent of funding. Distributes hospital assistance and funds for outpatient assistance to the states. The Ministry of Health distributes about 50 percent of assistance funds directly to providers.

STATE—Provides 20.6 percent of funding

LOCAL—Provides 16.4 percent of funding

ALLOCATION OF RESOURCES FOR ASSISTANCE—Federal resources for hospital assistance are distributed to the states and their municipalities according to number of inhabitants and certain financial limits. The Ministry of Health still transfers about 50 percent of assistance funds directly to providers. The other half is transferred directly to states and municipalities.

OTHER RESOURCES AND SUPPLIES—The Ministry of Health gives local governments additional funds for investments, food supplements, basic medicines, sanitation inspection, incentives for the Community Agents Program, and the Family Health Program. It also distributes vaccines and special medicines (for AIDS, tuberculosis, and leprosy).

(See also Appendix 3)

alliances within Congress, and design creative mobilization techniques. In September 1995—while representatives of the Brazilian women's rights movement were in Beijing—a constitutional amendment was proposed to the National Congress to establish the right to life from the time of conception. During the next six months, the proposal was discussed by a special commission, which recommended its rejection. Advocacy groups played a major role in the debates and public education. Another positive example was the Campaign for Women´s Lives in favor of PL20/1991, a mobilization under a broad coalition that called for 20,000 signed postcards to be sent to the National Congress between September and November 1998.

Between 1995 and 1998, dozens of meetings and seminars took place involving managers, physicians, and women's rights groups. In some states and municipalities, many programs designed to more significantly involve professionals were reactivated, after having been abandoned toward the end of the 1980s. In Brazil, as well as in other countries, the background, attitude, and ideology of health professionals have always been a significant obstacle to the performance of reproductive health programs. These initiatives, while not highly visible, were as important as the expansion of the public debate.

Increased local autonomy resulting from the new decentralization rules, as well as the dialogue and negotiations undertaken by managers, can bring about a "positive contamination" chain, that is, a situation in which one good practice breeds another.

Implementation strategies: new directions

"In the state of Pernambuco today, women's health is very well accepted as a priority, and it is unlikely that this situation will regress as in the past. Not even administrative changes, such as the replacement of a health secretary, have affected the implementation of activities."
Silvia Cordeiro, Director of the Women's Center, Cabo

Until 1995, the obstacles to PAISM were seen as lack of political will, inadequate coordination, or the lack of specific women's health resources. More recent experience has shown that it is also essential to match reproductive health strategies to the new SUS policies, and especially to optimize or even redirect the millions of dollars annually spent on outpatient and hospital procedures.

Increased local autonomy resulting from the new decentralization rules, as well as the dialogue and negotiations undertaken by managers, can bring about a "positive contamination" chain, that is, a situation in which one good practice breeds another. This outcome is desirable because when the system does not operate well in one place, women will look for services elsewhere. In fact, current SUS rules make it possible to rechannel resources to those municipalities that are meeting the demand.

Seen in this light, some recent Ministry of Health policies are relevant because they directly affect the system's funding logic. An example is the range of activities covered by minimum basic assistance (see Box 5), which includes prenatal assistance, gynecological care, family planning, and educational activities. These activities have fostered the expansion of reproductive health services in basic health care programs. Similarly, in May 1998, the Ministry defined rules governing the payment of fees charged for births, and the establishment of percentage limits for Caesarean sections that are SUS-funded. These rules provide local managers with an effective service control tool, whether such services are public or accredited by SUS. Measures undertaken to reform obstetric assistance include the following:

- Increase reimbursements paid for obstetric surgery and pay for procedures related to high-risk births.
- Routinely gather information regarding infant and mother discharge from the hospital.
- Implement state hospital referral systems in high-risk birth care, and increase natural birth fees paid to hospitals accredited under this system.

- Define percentage limits for the number of surgical births that will be paid for in SUS-accredited facilities: 40 percent by the end of 1998, 35 percent by the end of 1999, and 30 percent by the year 2000.

Coordination among programs and agencies

Since 1995, there have been increasing efforts on both the national and state levels to coordinate sexual and reproductive health programs. In 1997, an agenda was created for collaboration between the Women's Health Area and the STD/AIDS National Coordination for supplying condoms and for joint activities at the state level. In 1998, the National Program to Combat Cervical Cancer was established as a partnership between the Women's Health Area organization and the National Cancer Institute. In Ceará, the highlight is the coordination between international agencies that provide support to the *Viva Mulher* program. This integrated vision is essential to guide the investments made by international agencies and to prevent each of them from focusing exclusively on their own priorities.

Maternal mortality, prenatal assistance, obstetric care, and cervical cancer prevention

The priorities of the Ministry of Health and the three states studied from 1995 to 1998 were maternal mortality reduction, expansion of prenatal assistance, improvements in obstetric care, and prevention of cervical cancer. The first three priorities are directly related to the national priority, set in 1993, of reducing infant mortality.

Both nationally and in the states, initiatives were launched to improve investigations of maternal deaths. Sixty maternities were evaluated and certified in São Paulo, and a Central Office of Maternity Vacancies was set up to serve greater São Paulo. A program was created in Pernambuco to better integrate maternal mortality reduction initiatives with the infant and neonatal program. Technical training is being provided to local health surveillance personnel and professionals responsible for childbirth. In Ceará, *Projeto Luz* was created to improve obstetric assistance in referral hospitals directly related to the *Viva Mulher* program.

But the progress seen in cancer prevention is more directly linked to the broader reproductive health agenda and to the recommendations of the Cairo and Beijing conferences. Between 1993 and 1994, women's organizations in Recife mobilized in a cervical cancer prevention campaign. It involved managers and health professionals, community groups, community leaders, communication professionals, and the female population in general. After the campaign, the number of Pap smears increased 75 percent in the Recife metropolitan

Box 5

Activities Funded Under Minimum Basic Assistance

- Basic dental care
- Basic care provided by intermediate-level and other high-ranking professionals
- Visits/outpatient and home care provided by members of the family health team
- Vaccination
- Community educational activities
- Prenatal assistance
- Family planning activities
- Minor outpatient surgical procedures
- Activities of the community health agents
- Nutritional and food guidance provided at outpatient clinics and in the community
- Assistance to home births from Family Health Program physicians
- Emergency care
- Medical appointments in basic specialties

Box 6

Prenatal Care and Cervical Cancer Prevention, 1995-1998: Indicators of Progress

- Nationally, the number of prenatal appointments increased 50 percent, from 2.8 million to 4.2 million. The number of diagnostic procedures performed also increased.
- In Ceará, coverage of prenatal assistance increased from 72 percent of pregnant women in 1991 to 87 percent in 1996. In rural areas, the increase was from 59 percent to 78 percent.
- Nationally, the number of Pap smears grew by 14 percent between 1995 and 1997, the number of mammograms and breast echographs increased by an average of 44 percent, and the number of breast prostheses jumped from 1,000 to 3,000.
- During the National Cervical Cancer Screening Program intensive phase (August 1998 through October 1998), 3.1 million Pap smears were performed; 65 percent of the women screened were in the priority age group, ages 35 to 49.

region main laboratories. Results of the Pap smears were released more quickly, and the municipal cytology lab was reactivated.

In Beijing, in 1995, breast cancer attained much visibility. In 1996, the CNDM and the Ministry of Health signed the Protocol for the Prevention and Treatment of Cervical and Breast Cancer. Later that same year, the protocol spawned the *Viva Mulher* Cervical Cancer Program, a pilot initiative implemented in five cities. Cervical cancer was emphasized because it affects mostly low-income women. In August 1998, the National Cervical Cancer Prevention Program was launched, with a goal of performing Pap smears for 4 million women ages 35 to 49.

Reproductive health and HIV/AIDS prevention

In 1997, the reproductive health initiatives started to be consolidated with the National AIDS Coordination. The state-level supervisors of the Women's Health and AIDS programs had already developed joint activities, including supplying condoms, in Ceará and in Pernambuco. In Recife, the two abortion assistance services provided by the state referred women victims of rape to the STD-HIV/AIDS diagnostic center of one of the health districts (*Casa Amarela*). A new condom distribution strategy developed in 1988 used the women's community as a starting point. In Cabo, STD-HIV/AIDS prevention is fully integrated into the Health at Home Program. In São Paulo, the Women's Health Area worked with the AIDS Referral Center to coordinate family planning services and gynecological and STD care. As a result, condom distribution doubled, as did STD treatment rates among women.

Female condom introductory trials have been conducted since 1996 in various regions. In light of the rapid spread of HIV among women, prevention and treatment of HIV among poor women has been defined as a priority for the next phase of the National HIV/AIDS program.

Abortion assistance: cases permitted by law and incomplete abortion

Among the various components of the Cairo and Beijing agendas, the recommendations on abortion are without doubt the most controversial. In August 1997, the Constitution and Justice Commission approved PL-20/1991 (abortion assistance services by SUS in the two cases permitted by law). Catholic representatives tried to delay the bill in the House. The provision was subjected to a congressional public hearing in November 1997, but its final approval is still pending.

The abortion issue is where the ICPD has had the most significant impact. In 1996, the ICPD monitoring project developed by RedeSaúde found that women suffering from the effects of incomplete abortions were not receiving adequate treatment in the public hospitals. In contrast, by 1998, over 20 hospitals linked with SUS now offer intrauterine manual aspiration procedures under humane conditions. There are now 12 services operating in the five regions of the country that provide services to women who are victims of rape or whose pregnancies represent a risk to their lives. Also, after 1994, judges were more willing to allow termination of pregnancies where the fetus suffered severe abnormalities.

After approval of PL-20 in August 1998, CISMU requested that the National Health Council present a motion to support the project, as well as a resolution requesting the ministry to prepare and approve a technical regulation governing SUS abortion assistance in the cases permitted by law. The request and technical resolution were approved, and the Ministry developed a technical protocol to guide counseling and clinical procedures of abortion and establish rules for reimbursing them. The new definitions are an important instrument to facilitate the universal implementation of services. One of its requirements is that the services provide psychological care and guidance to victims of sexual violence.

Box 7

Prevention and Treatment of STDs and HIV/AIDS: Indicators of Progress

- Significant drop in AIDS mortality rates in the two main metropolitan regions of the country
- Universal, free access to antiretroviral medication to approximately 60,000 people
- Establishment of a national laboratory support network
- Implementation of national network of Testing and Counseling Centers and of alternative assistance
- Consolidation of the National Human Rights Network within STD-AIDS
- Inter- and intra-institutional articulation within government
- Expansion and consolidation of the partnership network with international organizations, NGOs, community organizations, and the private sector
- Increase in availability and usage of condoms
- Evidence of behavior changes among male and female health workers, sex workers, young people, and men having sex with men

Source: *"AIDS no Brasil: Um Esforço Conjunto Governo-Sociedade."*

Abortion assistance services in cases permitted by law

The research team surveyed three services that assist abortions in cases permitted by law: Jabaquara Hospital in São Paulo, and the Amaury de Medeiros Integrated Center (CISAM) and the Agamenon Magalhães Hospital (HAM) in Recife, Pernambuco. The Pernambuco state health department was the first to establish a regulation for abortion assistance.

São Paulo

Between 1993 and 1996, the quality of services provided by SUS began to be publicly debated. New models of service have been proposed, and in the case of the municipality of São Paulo, a new format for the public health system, known as Health Assistance Plan (PAS), has been adopted. The implementation of PAS had an immediate negative impact in the abortion service of the Jabaquara Hospital, as part of the professional staff team refused to adopt new PAS rules and resigned. Despite the initial impact of PAS, the quality of Jabaquara Hospital's reproductive health services has not been affected. The current team consists of two social workers, two psychologists, and three gynecologists. Aside from abortion services, there is a contraception assistance program that operates in two health units of the hospital. The hospital also created a sperm bank to facilitate the identification and punishment of rapists.

In the case of abortion assistance, women victims of violence receive social and psychological support and are directed to a medical examination. In a case of rape, the woman is instructed to take the "morning-after" pill if the rape occurred within the previous 72 hours. Exams are conducted to detect STDs. Women receive psychological care before, during, and after the procedure. Users of the service after 1996 confirm that the quality of service has not been compromised (see Box 8 p. 16).

Pernambuco

CISAM combines a maternity school and an outpatient unit offering prenatal service, pediatrics, gynecology, and contraception assistance. HAM is a general regional hospital with a referral service for high-risk pregnancies and an outpatient unit for prenatal care, gynecology, and contraception assistance. The two services have assisted women victims of rape, women with life-threatening pregnancies, and women carrying fetuses with serious

abnormalities, where women can legally have an abortion. Women are referred by other services (including private services) by the Forensic Medical Institute, and by NGOs.

CISAM structured a multidisciplinary team that was well-prepared to handle gender and violence issues. A psychologist and social worker are both involved in all activities. At HAM, there was no specific awareness program. In both cases, resistance to implementation of services was considerable. However, at CISAM, institutional development and management commitment overcame the resistance.

Box 8

Users' Perceptions of the Jabaquara Hospital Service

BEFORE PAS

"The policewoman treated me very nicely before she called Jabaquara. I was a mess by the time I got there. But Tilde was waiting for me at the door: She was my guardian angel in white. I had to wait three days for the decision, and when the result came positive, I went on to talk to the social worker, the psychologist, the medical team, and did some exams. I had to tell my story over and over, and then sign some papers.

Dr. Jorge said he would do an aspiration, a much faster method, and that I wouldn't stay very long in the hospital. I said I didn't care what he did, provided he got rid of it for me.

Six days later I was bleeding. I thought it was strange, so I went back there. Once again, they treated me very nicely, they said a little something had remained, and that they had to do a curettage. I was given some medicine, and stayed four days in the hospital, just to make sure everything was all right... The people in Jabaquara really helped out, it was like I was dead and they brought me back to life..."

AFTER PAS

"All I wanted in life was to have a kid. I have a medical plan, and I was doing everything just right. Then my doctor said something was wrong, so she sent me to Campo Belo to talk to people specialized in human genetics. They told me my daughter had anencephaly, and that she would not survive. I was desperate. They referred me to Jabaquara Hospital....

I went there by myself, and talked to the social worker and the psychologist. I didn't have to wait in line, and thought the hospital was simple but clean. Dr. Cláudio came to see me, what a great guy! He told me I could terminate the pregnancy, even then, at seven months. I decided to wait the nine months, because my religion would not allow me to take out the baby.

He scheduled a few visits; I had to go there every month and be examined. After nine months, I went in and he gave me medication to induce labor. My daughter was born dead, and I buried her. Now I'm doing a treatment to get pregnant again. I really want to be a mother."

Humane treatment of incomplete abortion: CISAM's experience

In 1993, manual intrauterine aspiration (AMIU) was introduced to simplify the postabortion curettage procedures. Today, more than 20 units in Brazil have adopted this approach. The number of professionals trained in AMIU has multiplied. CISAM's team was one of the first in the country to be trained.

An estimated 42,000 women had unsafe abortions in Pernambuco in 1996.[10] The ratio of postabortion curettages to total number of births varies between 20 percent and 25 percent in the four hospital units surveyed in the state, and may reach an absolute number of 100 occurrences per month in larger units.

Since 1994, CISAM's team has made efforts to incorporate AMIU and the humane treatment of abortion routinely in the units. Local anesthesia is preferred since it reduces the duration of hospital stays and increases dialogue and interaction between doctors and patients. General anesthesia is used if necessary. Despite all efforts, AMIU is used in only 10 percent of the procedures for incomplete abortion situations, primarily because it requires time and interaction with the patient.

The study heard from 16 CISAM users who were treated for an incomplete abortion or bleeding from other causes. Their perceptions were compared with those of eight other women seen at two other public hospitals in Recife. The results show that the use of AMIU and adoption of humane care have resulted in a substantial improvement of the physical, and, especially, the emotional well-being of the patients (see Box 2, Appendix 2).

Recent initiatives to improve assistance for incomplete abortion are essential for two reasons. Where abortion continues to be

illegal, treating women according to accepted medical standards, as well as humanely and respectfully, has not only a positive health impact but also becomes an empowerment tool. It is no small accomplishment that impoverished women are increasingly being treated as "human beings" in social situations that their culture traditionally associates with crime and sin. Each year, thousands of women undergoing incomplete abortions seek help from the public health system. Humane treatment may improve their trust in the system, so that it becomes a gateway for other health services, including contraception assistance.

Contraception assistance

"Family planning is the most difficult task. The prenatal, childbirth, and cancer care needs will inevitably flow into SUS, making the system respond, whether adequately or not. But contraception is dealt with at the drugstore, or in the case of ligation, by the physicians themselves. It is not a demand that puts pressure on the system, so it is unlikely to become a priority on the agendas adopted by the managers—whether at the central or local levels—who decide on the allocation of scarce resources."

Dr. Elcylene Leocádio, Women's Health Specialist, Ministry of Health

In December 1995, the National Congress approved the family planning legislation enabling the 1988 constitutional provisions that had been debated in Congress since 1992 (see Box 9). In December 1995, it was approved by the Senate and sent for presidential ratification. But politics and religion delayed approval of the law until August 1997.

The study found that the passage of the law had very diverse impacts on the states, municipalities, and services surveyed. Only in São Paulo did women contact the services looking for sterilization, and unit directors contacted the state health department asking what to do. These demands triggered the preparation of state regulations and strategies, including accreditation criteria for hospitals performing male or female sterilization. Two hospitals have been accredited in the city of São Paulo. Jabaquara Hospital is also offering tubal ligation and vasectomy services, following the criteria established by law.

In Ceará, the state has taken no specific action to disseminate the information systematically to the service network and accreditation system. In Pernambuco, the state health department had already issued a directive in January 1996, and six hospitals were accredited in 1997, among them CISAM and HAM. However, in May 1998, there was still much variation in the amount of information and understanding of the technical implications of the law. CISAM and the Cabo Municipal Department of Health were following the new criteria, but HAM and one of Recife's municipal maternity units were not.

There were also increased efforts to make reversible contraception methods available in the SUS system. From 1994 to 1997, the Ministry purchased contraceptives, but in 1997, the Ministry directed the states and

Box 9

Family Planning Law Provisions

- Right to surgical sterilization for both men and women over age 25 and for persons at least 21 years old who already have two living children
- Access to fertility regulation services, including counseling by a multidisciplinary team, to discourage untimely sterilization
- Prohibition of surgical sterilization of women in labor, immediately after labor, or postabortion. Exceptions allowed in cases of need due to health reasons and a history of successive previous Caesareans
- Approval of the partner is required for either male or female sterilization
- Mandatory reporting to SUS administration of all surgical sterilizations
- The inducement or instigation of individuals or groups to undergo surgical sterilization is prohibited, as is requiring sterilization certificates or pregnancy tests for any purpose
- The Ministry of Health will register, inspect, and control all institutions and services that operate or do research in the area of family planning to ensure that institutions authorized to conduct surgical sterilizations offer all options of reversible contraception means and methods
- Penalties will be established for physicians who do not comply with the law

Box 10

Recife and Cabo: Contraception Assistance in the Family Health Program (PSF)

Three PSF units were visited: Maruim and Caçaria, in Cabo, and Alto da Brasileira, in the Casa Amarela district of Recife. All three PSF teams (doctors and nurses) had been trained in family planning. Contraception activities are integrated with prenatal and postnatal activities, STD incidence, cervical cancer prevention, hypertension control, and nutrition. The most frequent problems encountered by the PSF teams are the high incidence of STDs (trichonomiasis, gardenerella, and syphilis), and male resistance to contraceptive usage. In two areas, male HIV/AIDS cases were identified (two in Alto da Brasileira and one in Caçaria). The Maruim team detected domestic violence as a major problem in the area.

In Alto da Brasileira and Reservatório, two teams covered 540 homes in monthly visits. Each team had at least one physician and one nurse, and 11 health agents operating in both areas.

- Contraception needs are discussed at individual gynecological appointments (10 appointments per week). The most frequently requested methods are pills and condoms. Male and female teenagers meet in a weekly educational group to discuss sexuality.
- Adolescents who are pregnant or have just given birth are seen monthly in their homes for counseling on breastfeeding and contraception.

The Cabo teams found a high incidence of tubal ligation, lack of information, and lack of access to reversible methods.

- Both teams hold weekly meetings on contraception and see an increasing demand for condoms and IUDs.
- The greatest challenge is keeping mothers from interfering in the visits with adolescents and invading their children's privacy.
- Adolescent mothers are monitored monthly. Their contraceptive usage is actively checked. Results have been positive: "They remain emotionally connected to us and to the agents, and thus absorb the information and counseling better."

municipalities to purchase contraceptives. The managers and local coordinators of the Women's Health Team objected that the directive could not be enforced because the Ministry no longer offers reversible methods. As a result, the Women's Health team in the Ministry of Health has been preparing a transition strategy so the network does not find itself entirely unprepared.

The Ceará experience demonstrates that when the methods are actually available, impacts are evident. Despite problems in logistics and supply over the past five years, the contraceptive options offered by the system have expanded, and sterilization rates leveled off at 35 percent (for married women) between 1991 and 1996. Most importantly, the study found that when managers are made aware, the investment is always made with either state and municipal funds or with PAB funds.

The São Paulo State Health Department bought 20,000 intrauterine devices (IUDs) with its own funds to meet the demand of the municipalities. Jabaquara Hospital has also developed a contraception assistance program with information and educational activities targeted to men, women, and adolescents in two health units connected to the hospital.

In Pernambuco, the state health department secured a supply of condoms, working jointly with the AIDS program. But the cities of Recife and Cabo are adding reversible methods to the distribution network without major difficulties. In both cities, contraceptive assistance has been incorporated within the Family Health Program, a benefit for poor women and adolescents. Cabo has made contraception assistance a priority.

The Pernambuco experience shows that basic care programs are strategic to expanding reversible contraception activities. However, the three units are faced daily with the "culture of sterilization." In Cabo, when women wishing to undergo sterilization learn that they have to undergo counseling, waiting periods, and other requirements, some start looking for other services where ligation can be carried out "without complications." In Alto da Brasileira, the number of requests for physician pre-approvals of sterilization multiplied between March and June, influenced by the electoral campaign.

Health Spending in Brazil: Volume and Composition

Conservative estimates set total health expenditures (public and private) in Brazil at around R$ 50 billion, representing almost 7 percent of gross domestic product (GDP) and R$ 320.00 per capita. (One Real equals roughly US$1.) In 1995, the public sector invested the equivalent of R$ 21.7 billion in health, approximately 3.3 percent of GDP, a per capita disbursement of R$ 140.00. The federal government is responsible for 63 percent of public expenditures in health; the states and the capital contribute 21 percent; and the remaining 16 percent are generated locally by the 5,506 Brazilian municipalities.

Expenditures on reproductive health

Accurately calculating Brazilian spending on reproductive health is difficult because of the diverse sources of information and the difficulty in segregating different categories of spending. Currently, only federal government expenditures can be analyzed in this way. Thus, reproductive health expenditures covered here refer exclusively to those funded by the federal government, including hospital and outpatient expenditures on reproductive health, federal expenditures on contraceptive methods, cost of STD/AIDS medicines, and Women's Health coordinating costs.

Growth in total federal spending on reproductive health

Between 1995 and 1997, total federal spending on reproductive health grew by 34 percent, rising from R$ 834 million to R$ 1.119 billion. However, this growth was due almost entirely to the increase in the cost of supplying STD/AIDS medications (see Table 1). In percentage terms, reproductive health expenditures amounted to 14 percent of the Ministry of Health's hospital and outpatient

Table 1

Consolidated expenditures on reproductive health at SUS (federal funds), 1995 to 1997 (in R$ 1,000.00 of December 1997[1])

DESCRIPTION	1995	1996	1997
Outpatient expenditures	134,073	149,021	157,070
Hospital expenditures[2]	694,263	715,419	716,576
Women's health coordination	5,315	4,785	3,059
Medications (STDs/AIDS)		41,148	242,790
Condoms	598	2,308	
Total reproductive health	834,249	912,681	1,119,495
Total outpatient expenditures	3,804,308	4,088,639	4,364,554
Total hospital expenditures	3,659,491	3,830,812	3,831,955
Total Ministry of Health expenditures	18,506,000	15,855,000	19,036,000
Reproductive health as percent of:			
Outpatient and hospital expenditures	11.2	11.5	13.6
Total Ministry of Health costs	4.5	5.7	5.9

Source: CD ROM DATASUS and DATASUS Internet

Notes:

1 To calculate amount in dollars, use exchange rate of US$1 = R$1.1156.

2 Includes procedures related to male reproductive health of R$ 26.2 million in 1995, and of R$ 24.9 million in 1996. For 1997, the amount of hospital expenditures was estimated based on the percentage observed in 1996.

Table 2

SUS : Growth of expenditures on selected outpatient procedures of women's reproductive health, Brazil, 1995 to 1997 (in R$1,000 of December 1997[1])

PROCEDURES	1995	1996	1997	PERCENT 1997	PERCENT INCREASE/ DECREASE FROM 1995 TO 1997
Total outpatient expenditures	3,804,308	4,088,639	4,364,554		14.7
Reproductive health expenditures	134,073	149,021	157,070	100	17.2
Control of gynecological pathologies[2]	77,905	83,342	83,772	53.3	7.5
Cancer prevention	40,131	45,560	51,587	32.8	28.5
Prenatal assistance	15,024	19,000	20,684	13.2	37.7
Family planning	499	577	573	0.4	14.8
Maternity and postmaternity	514	542	454	0.3	-11.7
Percentage in reproductive health	3.52	3.64	3.60		

Source: CD ROM DATASUS and DATASUS InterNet

1 To calculate amounts in dollars, use exchange rate of US$1 = R$ 1.1156.

2 In SUS terminology, gynecological procedures are included as control of gynecological pathologies.

expenditures in 1997, and 6 percent of its total expenditures. In per capita terms, total Ministry of Health expenditures were R$ 94 in 1996, of which those devoted to reproductive health were about R$ 10.

Growth in outpatient expenditures in reproductive health

Federal outpatient spending on reproductive health experienced real growth of 17.2 percent from 1995 to 1997, rising from R$ 134 million to R$ 157 million (see Table 2 p. 19). However, these expenditures amounted to only 4 percent of total outpatient expenditures. The main cost item in 1997 was control of gynecological pathologies (53.3 percent of the total). The groups of expenditures showing the highest growth were prenatal assistance and cancer prevention, at 37.7 percent and 28.5 percent, respectively.

Growth in specific reproductive health services has been significant. For example, from 1995 to 1997 prenatal appointments grew by 57 percent, mammograms increased 43 percent, and breast echograms increased 50 percent.

Growth of hospital spending in reproductive health

Hospital spending for reproductive health amounts to approximately R$ 700 million per year, which is more than 18 percent of total hospital expenditures covered by federal funds. Birth services accounted for 70 percent of these expenditures.

Allocation of funds at the local level: federal, state, and local expenditures

Distribution of federal health care funds to the three states studied was fairly equal (R$ 55-66 per capita), but total expenditures were different because each state and municipality contributed its own funds in varying amounts. The amount of state funds was highest in São Paulo. São Paulo spent more than R$ 100 per capita on health, Ceará spent R$ 27 per capita, and Pernambuco spent about $R 23 per capita.

In 1996, federal per capita expenditures on reproductive health were R$ 9.00 in São Paulo, R$ 11.70 in Ceará, and R$ 11.80 in Pernambuco. Expenditures were higher in Pernambuco and Ceará because the public system is the main provider of services in these states. São Paulo, a more affluent state, can afford higher contributions for health (see Box 11).

International funds

In 1996, US$ 28 million were invested in activities related to reproductive health in Brazil. Although reduced, these funds have been essential to the support of local initiatives, as demonstrated by the state of Ceará. Box 12 provides information on total amounts invested in different areas related to the ICPD agenda.

Box 11

Examples of Investments in Reproductive Health by States and Municipalities

- Between 1996 and 1997, São Paulo invested R$ 12 million to improve obstetric services, and R$ 160,000 for purchasing IUDs.
- Between 1993 and 1996, Ceará invested R$ 1.6 million in the *Viva Mulher* program.
- Between January and July 1998, Cabo invested R$ 1.1 million in primary care programs (Family Health and Community Health Agents) to meet primarily the needs of women and children. R$ 140,000 were applied exclusively to reproductive health (maternity restructuring, training, and contraceptive methods).

Box 12

International Funds: Projects and Programs Related to ICPD, 1996

- US$ 12.4 million for STD/AIDS prevention, much of it from a World Bank loan
- US$ 5.5 million, originating from UNFPA and the U.S. Agency for International Development (USAID), for reproductive health services and family planning
- US$ 3.3 million for information, advocacy, and sex education, through programs developed primarily by NGOs
- US$ 3.3 million for research on policies and population data, provided primarily by multilateral and bilateral organizations and NGOs
- US$ 1.5 million for programs offering contraceptive methods
- US$ 2.0 million for gender equity and women's empowerment

The Brazilian Experience: Lessons and Insights

The 10 years that have passed since the PAISM was implemented demonstrates that the time between the formulation of a new policy and its actual implementation is necessarily long. The implementation process involves political and institutional dynamics, divergent interests, and financial considerations. Thus, the time elapsed since the Cairo conference (five years from 1994 to 1999) is too short to fully evaluate ICPD impacts. However, the developments related to the Cairo and Beijing conferences had a positive impact on the Brazilian policy scene, by adding new light to clarify old problems.

Reproductive health and health system reform

The Brazilian experience is an example of the challenges and dilemmas that result from trying to match the Cairo agenda to the dynamics of health system reform. For five years, implementation of PAISM was held up by the problems encountered in consolidating the Universal Health System. The Cairo and Beijing recommendations were being incorporated at the same time that the system's funding problems were being resolved and the decentralization process was ongoing. These reforms encouraged local initiatives that gave priority to reproductive health activities. Success was possible only because of the inherent characteristics of the SUS: public investments, universality, thorough planning, and recent prioritization of basic health care. However, these favorable conditions do not eliminate the challenges.

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To incorporate the ICPD agenda into the SUS, it was necessary to overcome a vertically-oriented reproductive health program that contains all the components set forth in paragraph 7.3 of ICPD Programme of Action. The Brazilian experience suggests that integration of all reproductive health actions (beyond family planning) is necessary, but not sufficient. Reproductive health must be made a "system priority." São Paulo's experience in adopting a new assistance model shows that service restructuring that focuses exclusively on individual users' points of view may compromise the quality of public health interventions. This situation is undesirable where health conditions require systematic vigilance and disease control actions.

A second challenge is to recognize that reproductive health services and supplies are not provided exclusively through the public health system. Even when SUS is universal, as in the Brazilian case, many people use the private sector for contraceptive services and methods. Hence, the system must also take into account private sector supply and demand.

Financial resources

The Brazilian case is unique with respect to the funding of reproductive health activities. Health expenditures (both public and private) are relatively high in comparison with other developing countries. However, the amounts invested by the federal government in reproductive health are relatively low compared with total expenditures. When they are invested wisely—as a result of decentralization—their impact can be positive in terms of meeting women's needs. But total spending on reproductive health is still low. Experience shows that when the system is structured properly, any additional investment has an enormous impact on women's quality of life.

Enabling factors

The following factors can be seen as "enabling" the implementation of a comprehensive reproductive health approach.

- **Political scenario.** Democratic conditions and consolidation; public debate on the ICPD agenda; and the creation and revival of institutions that support the Cairo and Beijing recommendations at the federal level (macro-level policy).
- **The SUS consolidation.** Decentralization allows local managers to become decision-makers and brings the system and services closer to the public. Expansion of basic health care programs supports the horizontal integration of reproductive health activities and allows outreach to population groups that have difficulty accessing other levels of the system. Social accountability mechanisms promote the systematic support of health policies at all levels.
- **Women's organizations.** These groups were essential in exerting pressure on the health system (convincing managers, sensitizing and training health professionals) and indispensable for mobilizing public support, creating coalitions, stimulating public debate, and systematically monitoring policies.

Disabling factors

A number of factors can also be identified as hindering the implementation of ICPD recommendations related to reproductive health.

- Political-institutional instabilities (especially at the Ministry of Health).
- Activities of groups hostile to the Cairo Programme of Action, especially groups with access to political power.
- Budgetary constraints that delayed SUS consolidation and affected social policies. The lack of systematic policies to correct inequalities flooded the health system with demands that are often related to poverty rather than health.

> Between 1995 and 1998, progress [in contraceptive assistance] was observed in four areas: the passage of a family planning law; expansion of reversible contraception services in the public system, especially in basic care programs; limits on the number of Caesarean sections conducted in SUS hospitals; and efforts to regulate the contraceptives market.

Abortion: legislation and services

The Brazilian case shows that it is possible to expand access to abortion services even if legislation is restrictive and there are opposing forces. Success depended on combining gradual strategies with proposals to broaden the legislation. Public debate regarding abortion contributed to the Cairo and Beijing agendas, but only because the advocacy community made abortion a priority and developed effective communication strategies.

Contraception assistance

Since the 1980s, contraception has posed the greatest obstacle to an effective public health system. However, between 1995 and 1998, progress was observed in four areas: the passage of a family planning law; expansion of reversible contraception services in the public system, especially in basic care programs; limits on the number of Caesarean sections conducted in SUS hospitals; and efforts to regulate the contraceptives market. There are still problems in the logistics of supplying contraceptive methods and in convincing local managers of the importance of investing in reversible contraception. Measures to solve these problems must include a massive effort to improve the quality of care for incomplete abortions so that women coming to SUS for help with incomplete abortions will feel comfortable returning for other reproductive health services, including contraception.

References

1. V. Faria, "Políticas de Governo e Regulação da Fecundidade," *Ciências Sociais Hoje* (São Paulo:Vértice Editora, 1989).
2. J.A. Carvalho and L. Wong, *Window for Opportunity: Some Demographic and Socieconomic Implications of the Rapid Fertility Decline in Brazil,* discussion paper no. 19 (Belo Horizonte: CEDEPLAR, October 1995).
3. E. Barros, S. Piola, and S. Vianna, *Política de Saúde no Brasil: Diagnósticos e Perspectivas,* discussion paper no. 401 (Brasília: IPEA, 1996).
4. B. Ávila and R. Barbosa, "Contracepção: mulheres e instituições," (Recife: SOS Corpo, 1985); C. Barroso, "Direitos Reprodutivos: a Realidade Social e o Debate Político," *Cadernos de Pesquisa* 62 (São Paulo: Fundação Carlos Chagas, August 1987); S. Corrêa, "Uma Recusa da Maternidade: Causas e Condições da Esterilização Feminina," *Os Direitos Reprodutivos e a Condição Feminina* (Recife: SOS Corpo, 1989); S. Corrêa and B. Ávila, "O Movimento de Saúde e Direitos Reprodutivos no Brasil: Revisitando Percursos," (Campinas, Brazil: The Population Council, 1998).
5. A. Costa, "O PAISM, Uma política de Assistência Integral a Saúde da Mulher a ser Resgatada" (São Paulo: Comissão de Cidadania e Reprodução, 1992).
6. RedeSaúde, "A Saúde das Mulheres no Contexto Sócio-político Brasileiro–Seguimento do Programa de Ação da Conferência Mundial da ONU sobre População e Desenvolvimento, Cairo/1994," preliminary version (1997); RedeSaúde, *Jornal da RedeSaúde* 15 (1998); Informativo da Rede Nacional Feminista de Saúde e Direitos Reprodutivos (São Paulo, May).
7. J.E. Potter, "The Dark Side of Diffusion: Increasing Returns and the Persistence of Outmoded Contraceptive Regimes" (University of Texas, unpublished, January 1998).
8. E. Berquó, "Anticoncepção e partos cirúrgicos – A espera de uma ação exemplar," *Estudos Feministas* (Rio de Janeiro: Ciec-ECO-UFRJ, 1993).
9. T. Gouveia, "Monitorando as Conferências do Cairo e de Pequim: Inciativas das ONGs de Mulheres," *Observatório da Cidadania* 2 (Rio de Janeiro: IBASE, 1998).
10. S. Corrêa and A. Freitas, "Atualizando os Dados sobre a Interrupção Voluntária da Gravidez," *Estudos Feministas,* vol. 5, no. 2/97 (Rio de Janeiro: Ciec-ECO-UFRJ, 1997).

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Appendix 1

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Appendix 2

Tables and Boxes

Table 1

Estimated number of induced abortions, Brazil and main regions, 1994, 1995, and 1996

REGIONS	HOSPITALIZATIONS DUE TO ABORTIONS (DATASUS)			INDUCED ABORTIONS (estimated)		
	1994	1995	1996	1994	1995	1996
North	19,889	18,936	16,459	84,000	80,000	69,500
Northeast	121,406	105,285	94,752	512,100	444,000	399,900
Southeast	127,332	113,969	101,732	537,800	481,000	429,400
South	26,551	22,227	19,247	112,100	93,800	81,200
Midwest	16,638	14,281	14,170	70,400	60,200	59,800
TOTAL	**331,861**	**274,698**	**246,370**	**1,316,400**	**1,159,400**	**1,039,900**

Source: S. Corrêa and A. Freitas, *Revista Estudos Feministas*, January 1998.

Table 2

Contraceptive use among married women, Brazil, 1986 and 1996

METHOD	1986 (percent of married women)	% (of methods used)	1996 (percent of married women)	% (of methods used)	VAR.%
Modern	**56.5**	**100**	**70.6**	**100**	**25.0**
Pill	25.2	44.6	20.7	29.3	-17.9
Tubal ligation (sterilization)	26.9	47.6	40.1	56.8	49.1
Condom	1.7	3.0	4.4	6.2	158.8
IUD	0.6	1.1	1.1	1.6	83.3
Diaphragm*	0.7	1.2	0.1	0.1	-85.7
Injectables	0.5	0.9	1.2	1.7	140.0
Vasectomy	0.8	1.4	2.6	3.7	225.0
Traditional	**9.3**	**100**	**6.1**	**100**	**-34.4**
Rhythm/abstinence	4.3		3		-30.2
Withdrawal	5		3.1		-38.0
TOTAL	**65.8**		**76.7**		**16.6**

* Including spermicides

Source: BEMFAM, *National Survey on Maternal-Infant Health and Family Planning*, Brazil, 1986 (Rio de Janeiro, December 1987), and BEMFAM, *National Survey on Population and Health*, 1996 (Rio de Janeiro, March 1997).

Table 3

Sterilization among married women, by residence and education, Brazil, 1996

CHARACTERISTICS	FEMALE STERILIZATION (percent of married women)	FEMALE STERILIZATION AS PERCENT OF MODERN METHODS
Region		
Rio de Janeiro	46.3	60.8
São Paulo	33.6	47.0
South	29.0	40.0
Mideast	38.8	54.8
Northeast	43.9	70.5
North	51.3	75.3
Midwest	59.5	73.5
Area of residence		
Urban	40.6	55.9
Rural	38.0	62.1
Years of education		
None	45.7	80.7
1-3	44.9	70.5
4	40.4	58.7
5-8	36.9	49.5
9-11	38.8	51.4
12 or more	35.7	46.8

Source: E. Berquó, "Feminine Sterilization in Brazil Revisited," 1998 (mimeographed).

Table 4

Percentage distribution of sterilized women by age at time of surgery, Brazil, 1996

AGE AT STERILIZATION (years)	PERCENT OF STERILIZED WOMEN
Under 25	20.5
25-29	36.6
30-34	27.9
35-39	12.2
40-44	2.6
45-49	0.1

Source: E. Berquó, "Feminine Sterilization in Brazil Revisited," 1998 (mimeographed).

Table 5

Percentage distribution of current users of modern methods, by source, 1996

SOURCE	ANY METHOD	PILL	IUD	INJECTABLE	CONDOM	FEMALE STERILIZATION	MALE STERILIZATION
Public sector	**43.1**	**7.8**	**47.4**	**3.9**	**9.3**	**70.9**	**31.3**
Private sector	**54.1**	**90.5**	**51.5**	**94.3**	**77.1**	**27.2**	**66.9**
Family planning clinic	0.2	0.1	4.0	0.0	0.4	0.2	0.0
Drugstore	35.7	88.2	1.9	93.6	75.2	0.0	0.0
Private hospital	16.0	0.4	15.7	0.7	0.1	26.0	52.3
Other*	2.3	1.8	30.0	0.0	1.5	1.0	14.6
Other**	**2.8**	**1.7**	**1.1**	**1.8**	**13.5**	**1.9**	**1.8**
Does not know	**1.1**	**0.1**	**0.0**	**0.0**	**2.5**	**1.5**	**1.8**
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number	6,446	1,989	105	135	547	3,460	201

* Includes doctor's office/private doctor, and health unit/community agent.

** Partner, friends/relatives, and other sources.

Source: BEMFAM, *National Survey on Population and Health, 1986*, March 1987.

Box 1

Monitoring activities at the federal level

NATIONAL COMMISSION ON POPULATION AND DEVELOPMENT (CNPD)	NATIONAL COUNCIL ON WOMEN'S RIGHTS (CNDM)	INTER-SECTORIAL COMMISSION ON WOMEN'S HEALTH (CISMU)
• Document "Population and Development Guidelines" to direct UNFPA's investments in Brazil • Creation of Permanent Evaluation Committee for projects presented to UNFPA • National Essay Competition on Population and Development, including topics on reproductive health, gender, and sexuality • Actions in Congress and government offices related to legislation on family planning and abortion in cases permitted by law • Collaboration on strategies for reinstating the Intersectorial Commission on Women's Health, and participation in this National Health Council advisory commission • Diagnostic of Brazil's Youth, which resulted in an international seminar and two publications that discuss reproductive health issues: "Young People Following the Path of Public Policies" and "Young People in Brazil: National Diagnostic" • Participation in the Brazilian Official Delegation to the Annual Sessions of the U.N. Population Commission • Participation in the Latin American Regional Meeting on Adolescent Reproductive and Sexual Health. (Costa Rica , October 1997) • Participation in the Brazilian Official Delegation to the International Youth Conference. (Portugal, August 1998) • Series of seminars in the second half of 1998 conducted by CNPD to discuss the results of ICPD recommendations in Brazil; CNPD responsible for the national report to be presented to the United Nations at the Cairo+5 events	• CNDM signed two protocols with the Ministry of Health: Breast and Cervical Cancer Prevention and Family Planning. • The Cancer Protocol developed into *Viva Mulher*, the National Cervical Cancer Program • PAISM reactivation and recognition of reproductive rights were defined as priorities in the National Equality Plan, an instrument prepared by CNDM to guide the implementation of the Beijing Action Platform in Brazil. The Plan had public hearings in various states and was presented to the president in January, 1997. • CNDM fostered Beijing implementation at the local level, calling on states, municipalities, and state and municipal women's rights councils to prioritize health activities.	• The role of CISMU is to inform the National Health Council of issues relevant to women's health/reproductive health. It proposes resolutions and makes recommendations and motions that, once approved by the plenary, are presented to the Ministry and the technical areas. Between 1997 and 1998, the following recommendations made by the commission were approved: ► Require maternal deaths to be reported. ► Evaluate educational materials on women's, children's and adolescents' health. ► Coordinate institutions involved in collecting health-related information. ► Regulate the implementation in SUS of abortion services in cases permitted by law. ► Recommendation to evaluate the Assistance Teaching Center implemented by PAISM. ► Motion to provide support to PL-20/1991. • CISMU also stimulated intra-institutional dialogue at the Ministry of Health level. Between November 1996 and September 1998, it organized 10 meetings involving PAISM, the National AIDS Program, the National Adolescent Health Program (PROSAD) Family Health Program, the National Cancer Institute, areas of Planning and Human Resources of the Ministry, the Program to Combat Cervical Cancer, the Budget Commission and the Intersectorial Commission on Workers Health. It also promoted various successful local experiments in the implementation of PAISM or some of its specific components.

Box 2

Quality of care in abortion assistance

STAGES AND CIRCUMSTANCES OF SERVICE	HOSPITALS II AND III	CISAM
Treatment at the emergency unit	Waiting time varied between 10 minutes and two hours. In Hospital II, two women were seen and then told to go home and rest. A third was not seen at all, so she went to CISAM, where the procedure was finally performed. In most cases, there was no waiting at the emergency unit.	In only one case was the wait two hours, and the user had to move from the outpatient unit to the maternity unit to find a doctor.
Between the emergency unit and the procedure	One user said she believed they made her her wait in Hospital III because her "abortion had been forced."	The waiting period between the emergency unit and the actual intervention varied from one to 24 hours, either because the women required care or because there were too many people.
Communication between health workers and users	Either routine questions were asked or no questions were asked at all. Only one woman was informed about the procedure. One group of health workers questioned the patients in the emergency unit, and others performed the procedure. In the view of the users, there was no communication from one moment to the next.	Women were asked what had happened to them in an objective and methodical manner, indicating an unbiased and open attitude. The health workers explained the reasons for asking questions. Testimony shows that the first few moments of contact are essential to the patient's emotional stabiity.
Atmosphere	Two users felt openly discriminated against. One said she was well treated because she had a natural abortion (miscarriage), while another said she was made to wait because hers was a "forced" abortion. One user considered herself "brutalized." The others mentioned coldness and discrimination.	The environment was nondiscriminatory and respectful.
Procedure	The patients were given no information on the procedures and their possible consequences. The technique used was curettage under general anesthesia. When asked questions by the patient, the team did not respond. One 15-year-old user, under epidural anesthesia, was interrogated by the doctor on how and why the abortion had been forced.	The facility provided constant assistance by psychologists, social workers, nurses, and physicians. The most widely-used procedure was AMIU with local anesthesia. The patients were informed before, during, and after the intervention. There was concern about the patient's emotional condition. Many women said the "chatting" helped them withstand the pain. A user who was physically unstable had to undergo general anesthesia.

(Continued on next page)

Box 2 *(continued from page 29)*

Quality of care in abortion assistance

STAGES AND CIRCUMSTANCES OF SERVICE	HOSPITALS II AND III	CISAM
Hospitalizations	Some lasted two or three days. Attitudes were inconsistent. Patients were given no information on their clinical condition. In Hospital III, there is an infirmary for women who aborted. In Hospital II, they are put in the same infirmary as women who just gave birth or are undergoing other types of surgery. Both situations are uncomfortable, but the separate infirmary stigmatizes them and makes women feel more vulnerable and guilty. On the other hand, sharing the space with new mothers and their babies can be painful. The hospital treats all women as “mothers,” which adds to the grief of women that just had an abortion (whether abortions or miscarriages).	The use of AMIU reduced the hospital stay. Many women were able to leave the same day. Those that stayed received intensive care. There was an “interaction” between the patient and the team, not just with each segment, as in other services. There was a dialogue, and the user felt respected. Sharing space with new mothers and their babies is discomforting for women that aborted. Endearing terms like “mother, mommy” were heard everywhere. Many users mentioned the “commotion” that the presence of academics and professors caused. Many women said they felt awkward as “objects of study.”
Counseling upon hospital discharge	Generally, there is no counseling except to recommend rest and good nutrition.	In a few cases, the users referred to specific recommendations. They were not told to come back to the units except for contraceptive assistance.
Counseling on contraception	There is no contraception counseling, although both hospitals have family planning outpatient units.	During the procedure and prior to the hospitalization, the patient is counseled on contraception. The team proposes the insertion of an IUD. One woman said she considered using an IUD, but after finding out through a family planning service what the device was, she decided against it.

Appendix 3

Resource Flow of the Brazilian Health Sector

Federal Taxes

Federal Social Taxes

Social Security Budget

Social Security

Health

Social Welfare

PUBLIC SECTOR

Ministry of Health

National Health Fund

State Health Secretariat

State Taxes

State Health Fund

Municipal Health Secretariat

Municipal Taxes

Municipal Health Fund

PROVIDERS:

Hospitals
Other Institutions

Physicians

Other
Health Actions

PRIVATE SECTOR

Family Budget

Private Health Plans
and Insurance

Resources From Enterprises

Hospitals
Other Institutions

Physicians

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