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THEME: INTEGRATED AND COMPREHENSIVE SRH SERVICES: A GLOBAL VIEW

Commentary: Reproductive health and rights in Brazil 20 years post-International Conference on Population and Development

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In 1983, during political mobilisation after the military dictatorship, feminist and public health movements in Brazil developed a Comprehensive Women's Health Programme (PAISM; Victora et al., 2011) that moved beyond existing MCH services to introduce contraception, sexual health and attention to the gender, *life cycle* and psycho-social dimensions of health and care (Diniz, d'Oliveira, & Lansky, 2012; Victora et al., 2011). Wide social movements were successful in their efforts to include the right to health care in the 1988 Constitution, along with the creation of a Public Health System (SUS) that was intended to be universal, comprehensive and equitable (Victora et al., 2011).

In 1992, the National Feminist Network on Reproductive Health (Redesaúde) was founded in time to play a strong role in the NGO Forum and intergovernmental negotiations of the 1994 International Conference on Population and Development (ICPD). In 1995, the National Commission for Population and Development was established to monitor Brazil's implementation of the ICPD Programme of Action. Despite challenges, the broader women's health movement, frequently in alliance with HIV activists and associations of other health professionals, successfully advocated for public policies at municipal, state and federal levels that increased women's access to basic health care, including sexual and reproductive health services. Redesaúde trained activists to monitor and hold government entities accountable for the implementation of health policies, and in 2004 the federal government instituted a national Comprehensive Women's Health Policy to reinvigorate implementation of the PAISM agenda (Victora et al., 2011), and to integrate that work with programmes against domestic and sexual violence.

As a result of these public policies, in addition to increased availability of contraceptive methods in the private sector, women's education and employment, and urbanisation, contraceptive use reached 81% among married women aged 15–49 years in 2006, and remain high in all income groups. Female contraceptive sterilisation (29%) and oral contraceptives (25%) are the most frequently used methods, followed by male condoms (12%) and male contraceptive sterilisation (5%; Ministério da Saúde, 2008). IUDs are used by only 2%, while diaphragms and female condoms have few or no users and are rarely available (Ministério da Saúde, 2008). The total fertility rate in 2006 was

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1.8, below replacement level, and fell to 1.0 or less for women with 12 years of education or more (Ministério da Saúde, 2008). Although overall racial, regional and income inequalities persist, younger, black and less-educated women experienced the highest declines in fertility. Age-specific *birth rate*s among women aged 15–19 years have decreased from 89.5/1000 in 1991 to 67.2/1000 in 2011 (Silva & Surita, 2012).

However, contraceptive use is far less effective than it should be. In 2006, 29.7% of births were reported as unplanned and 17.8% as unwanted (Ministério da Saúde, 2008). In 2012, a nationwide survey found that 54% of births were unplanned (do Carmo Leal et al., 2014). High rates of contraceptive discontinuation persist, most often because of health concerns (Curtis, 2012), in addition to high rates of abortion, including abortions by many women who reported that they were using contraception (Ministério da Saúde, 2008).

Abortion in Brazil is legally restricted. Access to safe, though illegal, services is limited to women with money, and many women who are eligible for induced abortion under the law cannot obtain services (Vieira, 2012). Over the last two decades, women have increasingly used misoprostol to initiate abortion, followed by medical care, mostly under the SUS (Diniz & Medeiros, 2012). This pattern has possibly contributed to the reduction in public hospital admissions for complications of unsafe abortion in recent years (Silva, Bedone, Faúndes, Fernandes, & Moura, 2010). Half of women receiving post-abortion care report violence by health professionals (Venturi & Godinho, 2013).

Although national policies have recently begun to support midwives and birthing centres (Diniz et al., 2012), in 2006, 89% of births were attended by doctors who saw high rates of episiotomies, inductions, fundal pressure and caesarean-sections (Diniz et al., 2012; Ministério da Saúde, 2008; Victora et al., 2011); it is further alarming to note that over 54% of all births in 2012 were due to caesarean-sections (Silva et al., 2010). Reaching MDG-5 to improve maternal health by 2015 is unlikely as many issues still plague reproductive health and rights in Brazil, including an increasing number of preterm births (Victora et al., 2011) and up to one-quarter of women reporting violence by health providers during *childbirth* (Venturi & Godinho, 2013). Privacy, continuity of care and companionship during delivery are provided mostly in the private sector (Diniz et al., 2012; Ministério da Saúde, 2008; Victora et al., 2011), despite PAISM's emphasis on woman-centred health care and shared decision-making. Efforts to universalize access to health care have emphasised doctors over other providers such as midwives, nurses and others, who were to be key actors under PAISM's commitment to integrated and comprehensive care (Diniz et al., 2012).

Women's rights activists must develop greater strength and secure powerful alliances to access and persuade all levels of government to implement the PAISM vision, and meet their ICPD commitments. Progress also increasingly requires skilled and sustained pressures to counter the social and religious opponents of sexual and reproductive health and rights in Brazil (Corrêa, 2014), as well as actions to address legal barriers (especially to safe abortion); expand contraceptive choices (including female barrier methods and emergency contraception, the latter available in only 40% of cities); promote comprehensive, multidisciplinary care; and reinvigorate quality assurance and accountability mechanisms for both public and private health services.

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