

The Brazilian Political Economy of Health:  
Implications for Women's Sexual and Reproductive Rights

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## ABSTRACT

### The Brazilian Political Economy of Health: Implications for Women's Sexual and Reproductive Rights

A thesis presented to the Global Studies Program

Graduate School of Arts and Sciences  
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Citizenship in Brazil guarantees the right to the highest attainable standard of health. The shared commitment of government and civil society to human rights has mobilized coordination between policy development and implementation, resulting in the progressive improvement of national health outcomes. Despite the success of health programs in strengthening prevention and treatment services, the political economy of Brazil has compromised public health performance. The existing structural and ideological forces have intensified social inequalities and lessened opportunities for individual and collective advancement. This paper explores the formation of a unified public health system based on human rights principles and the ability of national health policies to address women's health issues. It further examines the influence of social and cultural perceptions of gender norms on women's ability to exercise sexual and reproductive health rights. The recommendations are aimed at the government to encourage it to address its responsibility to increase the availability, accessibility and

quality of health care provisions. I propose a gender-based perspective in reducing health inequity for women in relation to the economic and social disparities in Brazil. By increasing participatory processes and creating effective mechanisms to evaluate, assess, and monitor policy, improvements will be made in standards of living and the wellbeing of individuals. If these changes are implemented, Brazilian women can benefit from their citizenship and fully realize sexual and reproductive health rights.

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## **Introduction:**

The international community has recognized a universal standard of human rights. Brazil has advanced the rights of citizens and secured the right to health by establishing its Unified Health System (Sistema Unico de Saude, SUS) in 1990. The dedication to social justice exhibited by the government and civil society has provided the opportunity to improve health outcomes. Despite the advancement of health rights, the quality of management and delivery of health care provisions remains inadequate. Global standards of human rights cannot be fulfilled in Brazil without considering the complexity of local circumstances. Government efforts to maximize available resources for the fulfillment of health rights should be examined in light of the political, social, and economic dynamics specific to Brazil.

Brazil has progressed into an emerging market and has become a significant competitor in the global economy. However, the benefits of capitalism and economic growth are not consistent across different populations. The differences in income and the large percentage of the population under the poverty line exemplify the lack of government action towards the social welfare of its citizens. The legacies of colonization, ideological regimes, discrimination, as well as resource and human exploitation have hindered the country's ability to move forward.<sup>1</sup> Although Brazil transitioned from a military dictatorship to a democratic regime, the liberal ideologies are still governed by

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<sup>1</sup> Birn, Anne-Emanuelle, Yogan Pillay, and Timothy H. Holtz. Chapter 4: The Political Economy of Health. Textbook of International Health. 3rd ed. New York: Oxford UP, 2009.

authoritative practices. Neo-liberal policies, such as Structural Adjustment Programs, have cut health care services and shifted health professionals from the public sector to the private sector, increasing social inequalities especially among women and children.<sup>2</sup> The privatization of health services means an increase in out-of-pocket fees and a decrease in quality of care in the public health sector. The historical processes and existing neo-liberal reforms have contributed to the extreme poverty and social desperation seen in Brazil.

The violent and systematic exertion of structural forces on society has shaped and manifested health disparities.<sup>3</sup> Significant gaps remain in public policies directed towards women's health in Brazil. Structural violence and gender norms have especially hindered efforts to advance women's sexual and reproductive health rights. Public health initiatives need to address the inequalities present in society to guarantee equal access to health care and women's autonomy of sexual and reproductive choices. The active participation of civil society in all levels of policy formation will improve political and public awareness about social determinants of health. Participation encompasses the right to seek health-related information, to receive basic health education, to express views freely, and to transparency in the policy-making processes.<sup>4</sup> With the reduction of poverty and improvement in basic living conditions, Brazil will be able to successfully promote women's health rights.

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<sup>2</sup> Birn, Anne-Emanuelle, Yogan Pillay, and Timothy H. Holtz. Chapter 4: The Political Economy of Health. *Textbook of International Health*. 3rd ed. New York: Oxford UP, 2009.

<sup>3</sup> Farmer, Paul. "An Anthropology of Structural Violence." *Current Anthropology* 45.3 (2004): 305-323.

<sup>4</sup> Hunt, Paul and Gillian McNaughton. "Impact Assessments, Poverty, and Human Rights: A Case Study Using the Highest Attainable Standard of Health." Human Rights Centre, University of Essex, 2006, 1-26.

## Chapter One: Health as a Human Right

The right to health is a substantive right declared by the International Covenant of Economic, Social and Cultural Rights. Brazil acceded the ICESCR on January 24, 1992, legally binding the State to implement the Covenant.<sup>5</sup> The treaty instructs governments to take steps, maximize available resources and move forward in the implementation of the treaty.<sup>6</sup> The full realization of economic, social and cultural rights is not immediate, yet the State has the obligation to move as efficiently as possible to realize the right.<sup>7</sup> The government should respect, protect and fulfill rights by increasing availability, accessibility and quality of health-related goods and services. The ICESCR also holds governments responsible in ensuring procedural rights. Procedural rights include non-discrimination throughout policy implementation, civil participation in decision-making, access to information and government accountability through complaint and remedy outlets.<sup>8</sup>

Under international law, the right to health is defined as “the right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health.”<sup>9</sup> The right to health does not

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<sup>5</sup> "International Covenant on Economic, Social, and Cultural Rights." *United Nations Treaty Collection*. Office of the High Commissioner for Human Rights, 2011. <<http://treaties.un.org> >.

<sup>6</sup> Green, Maria. "What We Talk about When We Talk about Indicators: Current Approaches to Human Rights Measurement." *Human Rights Quarterly* 23.4 (2001): 1062-1097.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> The United Nations. International Covenant of Economic, Social and Cultural Rights. *The Right to the Highest Attainable Standard of Health*. Geneva, 2000.

mean the right to never get sick, as the government cannot fully protect populations from the influence of biological and socioeconomic factors. This right contains entitlement in factors such as the right to a health system providing equal access, the right to prevention and treatment, equal access to medicines and health-related information, and the participation of the population in health-related decision making at local and national levels.<sup>10</sup> Although the right to health does not mean entitlement to free health care, there are certain positive and negative obligations with regard to health care that the government should fulfill. Negative obligation means the government should not engage in actions that would negatively affect the health of a population, and positive obligation means using available resources while taking appropriate measures to maintain an appropriate level of health.<sup>11</sup>

The duty to respect the right to health means the government should not actively deprive citizens of this guaranteed right. The duty to protect the right to health means the government should regulate and pass laws preventing harm done by third parties. This would concern private actors such as corporations and businesses lobbying for their own interests. The duty to fulfill means governments should ensure that a proficient health care system is in place and good determinants of health, such as clean water, are equally accessible in order for people to realize their right to health.

Global human rights standards can be used to determine and shape developmental goals and processes. Such standards should be incorporated throughout the assessment, planning, implementation, monitoring and evaluation stages of public policy. To achieve

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<sup>10</sup> The United Nations. International Covenant of Economic, Social and Cultural Rights. *The Right to the Highest Attainable Standard of Health*. Geneva, 2000.

<sup>11</sup> Shue, Henry. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. Princeton: Princeton UP, 1980, 13-64.

good health outcomes, all available resources should be directed towards health goals on a non-discriminatory basis, paying special attention to the needs of vulnerable and marginalized populations. The government has the responsibility to reduce disparities in access to health care and reduce inequalities in the social determinants of health for all populations.

### **Sexual and Reproductive Health:**

Sexual and reproductive health was first defined at the International Conference on Population and Development in 1994.<sup>12</sup> Women have sole autonomy over their sexual and reproductive rights, “a process that involves not only a healthy reproductive system, but also the experience of sexuality in a healthy and satisfactory manner.”<sup>13</sup> It is the responsibility of the government and health care providers to respect a woman’s right to self-determination in matters of sexuality and reproduction, and to guarantee comprehensive information and participation in decisions pertaining to their health.<sup>14</sup> Women’s health initiatives should incorporate rights-based principles in all levels of national policy-making, management and service delivery.

Brazil, as a participant in international agreements on human rights and signatory of the ICESCR, has integrated the rights-based guidelines in their sexual and reproductive health policy objectives.<sup>15</sup> Universal access to the public health care system has reaffirmed the rights and citizenship of people that would otherwise be excluded due

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<sup>12</sup> Cottingham, J. C., and T. K. Ravindran. "Gender Aspects of Sexual and Reproductive Health." *World Health Organization* (2008).

<sup>13</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

<sup>14</sup> Cottingham, J. C., and T. K. Ravindran. "Gender Aspects of Sexual and Reproductive Health." *World Health Organization* (2008).

<sup>15</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

to social, cultural, and economic constraints. The United Nations' Millennium Development Goals related to reproductive and sexual health include improvements in obstetric care, family planning, legal abortion services, increase in domestic and sexual violence awareness, and prevention and treatment of sexually transmitted diseases.<sup>16</sup> These advances have not fully recognized or considered the determinants that exclude women from fully exercising their sexual and reproductive rights.

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<sup>16</sup> Ibid.

## **Chapter Two: Health Care Reform in Brazil**

The military dictatorship in Brazil, from 1964 to 1985, was characterized by rapid economic growth, a fragmented health system, and little social participation in all sectors.<sup>17</sup> Under the military regime, public health care services were concentrated in the rich areas of the South, where preferential access was granted to certain public sector employers and professionals.<sup>18</sup> The health care system consisted of private insurance, social security, and charitable institutions. The transition to democracy in the 1980's saw hyperinflation and a foreign debt crisis that increased absolute poverty. The Latin American debt crisis of 1982 was a result of excessive borrowing from international financial institutions, which exceeded the ability of Latin American countries to repay loans. This crisis required most of Brazil's financial resources to be directed towards the national debt and supporting structural adjustments.<sup>19</sup> The budget restrictions for the neo-liberal economic program (1990-1992) meant more shrinking of health resources by the federal government. The policies of international institutions such as the World Bank shaped the consequences of foreign debt. The policies increased inequalities and encouraged high-risk behaviors, such as migration and urbanization, while reducing

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<sup>17</sup> Victora et al. "Health Conditions and Health-Policy Innovations in Brazil: The Way Forward." *The Lancet* 377 (2011): 2042-2053.

<sup>18</sup> Mobarak, Ahmed, Andrew Rajkumar, and Maureen Cropper. *The Political Economy of Health Services Provision and Access in Brazil*. Working paper no. PEC2003-0001. Boulder: University of Colorado, 2003.

<sup>19</sup> Hein, Wolfgang, Sonja Bartsch, and Lars Kohlmorgen. *Global Health Governances and the Fight Against HIV/AIDS*. New York: Palgrave Macmillan, 2007.

spending on health and social services.<sup>20</sup> The political institutional crisis of the late 1980's and early 1990's negatively affected the relationship between civil society and the State, especially in the area of sexual and reproductive health.

The Sanitation Movement in Brazil resisted and overcame the neo-liberal agenda to formulate a new social agenda utilizing the language of human rights. Paulo Freire, an important scholar of Brazil during the time, developed an approach to education that linked knowledge and the identification of issues to positive action for change and development in societies.<sup>21</sup> This approach to activism influenced health workers, policy makers, academics, and managers to jumpstart a social movement advocating for health reform. Participants in the Sanitation Movement believed that the precarious health conditions of the rural populations were the main barriers to advancing the country.<sup>22</sup> They believed the right to health should be the right of citizenship in Brazil. Most health care services were implemented by physicians in private hospitals and were restricted to formal sector workers who paid payroll taxes. These provisions, which increased class inequalities in access to health services, were opposed by the movement, which promoted “universal access to publicly funded health care” and “decentralization of authority over health care to the states and municipalities.”<sup>23</sup> The movement grew in popularity during the dictatorship among leftist political parties and slowly, members took positions in the health sectors. By 1988, the Sanitation Movement opposition, along with other activist

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<sup>20</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

<sup>21</sup> "Education, Conscientization and a Pedagogy of the Oppressed." *Paulo Freire*. Freire Institute, 2011. <<http://www.freire.org/paulo-freire/>>.

<sup>22</sup> Hein, Wolfgang, Sonja Bartsch, and Lars Kohlmorgen. *Global Health Governances and the Fight Against HIV/AIDS*. New York: Palgrave Macmillan, 2007.

<sup>23</sup> Ibid.

movements, led to the creation of a democratic constitution, declaring health as a human right.

The health system in Brazil then changed from contribution-based health to a tax-financed public health system with universal coverage. The Unified Health System (Sistema Unico de Saude, SUS), created in 1990, united the principles of comprehensiveness, universal access, and participatory decision-making.<sup>24</sup> The Family Health Strategy was created to expand primary health care and focused on poorer geographical areas, especially the North and Northeast.<sup>25</sup> The SUS principles decentralized the allocation of public resources and promoted civil society participation for health provision integrity.

### **The Unified Health System**

The Brazilian Constitution of 1988 requires decentralization in the administration of public health care provisions, directed by municipal governments and supplemented with state and federal financial and technical assistance.<sup>26</sup> Decentralization transfers responsibility from federal and state spheres to local municipalities, which have generated initiatives based on the epidemiological profile of the population.<sup>27</sup> Since both basic and complex health care provisions are chosen by municipalities, these local governments would be able to target services towards the needs of the community and be held accountable for the efficient delivery of health services.

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<sup>24</sup> Galvao, Jane. "Brazil and Access to HIV/AIDS Drugs: A Question of Human Rights and Public Health." *American Journal of Public Health* 95.7 (2005): 1110-1116.

<sup>25</sup> Victora et al. "Health Conditions and Health-Policy Innovations in Brazil: The Way Forward." *The Lancet* 377 (2011): 2042-2053.

<sup>26</sup> Mobarak, Ahmed, Andrew Rajkumar, and Maureen Cropper. *The Political Economy of Health Services Provision and Access in Brazil*. Working paper no. PEC2003-0001. Boulder: University of Colorado, 2003.

<sup>27</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

The SUS is subsidized by the government to ensure the poor receive the minimum level of health services. Although the financing of SUS includes contributions from states and municipalities, 70% of the health care services provided under SUS are paid by the federal government.<sup>28</sup> Along with the public health system, there exists a private health care system funded by private health insurance plans. Many health facilities providing SUS services are privately owned but the municipal government determines which provider qualifies to participate in the SUS system and imposes limits on transfers to each licensed SUS provider in its jurisdiction.<sup>29</sup>

Today, 80% of the 190,000,000 inhabitants depend exclusively on SUS in order to have access to health care services.<sup>30</sup> According to the Ministry of Health, SUS has nearly 6,000 registered hospitals, 64,000 primary health care units and 28,000 Family Health Care Teams.<sup>31</sup> Of the 6,500 hospitals in the country available to the SUS, 48% are private hospitals with contracts with the public health system.<sup>32</sup>

### **HIV/AIDS Initiatives**

The National HIV/AIDS and STD Program was incorporated into the country's Unified Health Care System in 1985.<sup>33</sup> The Ministry of Health worked with state governments and municipalities to have 98.1% of all AIDS cases covered in a

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<sup>28</sup> Mobarak, Ahmed, Andrew Rajkumar, and Maureen Cropper. *The Political Economy of Health Services Provision and Access in Brazil*. Working paper no. PEC2003-0001. Boulder: University of Colorado, 2003.

<sup>29</sup> Ibid.

<sup>30</sup> "Unified Health System (SUS)." *Health Service*. Federal Republic of Brazil, 20 Jan. 2010. <<http://www.brasil.gov.br/sobre/health>>.

<sup>31</sup> Ibid.

<sup>32</sup> Ibid.

<sup>33</sup> Biehl, Joao. "Pharmaceuticalization: AIDS Treatment and Global Health Politics." *Anthropological Quarterly* 80.4 (2007): 1083-126. <<http://www.jstor.org/stable/30052774>>.

decentralized financing system.<sup>34</sup> Since state government no longer needed to negotiate actions with the federal government, they could set annual targets determined locally rather than on nationally set priorities. These improved response rates for the HIV/AIDS epidemic, in the form of increased treatment provisions and testing.

The World Health Organization tried to dissuade Brazilian authorities from granting universal and free AZT distribution on the grounds that there were scarce financial resources available, yet the government began distributing AZT for free starting in 1991.<sup>35</sup> Free treatment for opportunistic diseases (since 1988), the antiretroviral drug AZT (since 1991), and the antiretroviral combination therapy HAART (since 1996, shortly after its discovery) increased the gap between available free treatment and the available financial resources of the government.<sup>36</sup> The HIV/AIDS epidemic was beginning to become hard to control in terms of financial assistance. The Brazilian government decided to pursue long-term financial credit with the World Bank, which became the largest external resource for the health sector in Brazil. The World Bank credit (1994-1998) was used to reduce incidence of HIV/AIDS and enhance public and private institutions of HIV/AIDS control.<sup>37</sup>

The commitment to reducing HIV/AIDS incidence was made possible by the alliance of activists, government reformers, development agencies, and the pharmaceutical industry.<sup>38</sup> The alliance created legal interfaces to enhance public health interests at global and national levels. AIDS activism converged with state policy-

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<sup>34</sup> Hein, Wolfgang, Sonja Bartsch, and Lars Kohlmorgen. *Global Health Governances and the Fight Against HIV/AIDS*. New York: Palgrave Macmillan, 2007.

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> Biehl, Joao. "Pharmaceuticalization: AIDS Treatment and Global Health Politics." *Anthropological Quarterly* 80.4 (2007): 1083-1126. <<http://www.jstor.org/stable/30052774> .>.

making, and the public health paradigm shifted from prevention to more treatment access.<sup>39</sup> There was a stronger public voice for socially vulnerable groups over access to scarce public and medical resources. The medical and social burden of HIV/AIDS, especially among the poor, was brought to light. Civil society shifted efforts from influencing the government to implement prevention programs to pushing for, access to HIV drugs.<sup>40</sup> The social mobilization gave legal and political legitimacy to make medications available. The politics of treatment access were not only based on social mobilization and ethical principles of universal health care, but also fueled by market forces.<sup>41</sup> Pharmaceutical companies capitalized on the idea of citizen empowerment by using human rights themes in distributing their products and mobilizing patient groups to demand very expensive drugs for AIDS therapy. The increasingly market-driven State recognized the claims of organized interests groups that represent civil society, rather than actively addressing public needs.<sup>42</sup> Due to the political nature of AIDS activism, there is a huge gap between the kind of mobilization taking place and the AIDS the poor experience.<sup>43</sup> The poor are less likely to access political channels and engage in AIDS activism due to structural forces that prevent such mobilization.

Brazil's efficient response to the AIDS epidemic did not come easily. Brazil had to overcome the political power of global institutions in dictating the allocation of foreign credit and challenge the patents and pricing structures of global pharmaceutical

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<sup>39</sup> Ibid.

<sup>40</sup> Hein, Wolfgang, Sonja Bartsch, and Lars Kohlmorgen. *Global Health Governances and the Fight Against HIV/AIDS*. New York: Palgrave Macmillan, 2007.

<sup>41</sup> Biehl, Joao. "Pharmaceuticalization: AIDS Treatment and Global Health Politics." *Anthropological Quarterly* 80.4 (2007): 1083-1126. <<http://www.jstor.org/stable/30052774> .>.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

companies at the World Trade Organization.<sup>44</sup> Regardless of the successes of the national HIV/AIDS initiatives, universal health care delivery and government spending on drug treatments continue to be highly unequal. The social movements responsible for the increase in HIV/AIDS activism also contributed to awareness of women's health issues. Policy specifically prioritizing women's health has had similar successes, yet more issues arise today with the monitoring, implementing, and evaluating of women's programs.

### **Reproductive Health Initiatives**

Before the 1970's, national health policies emphasized the female role of wife and mother, supporting maternity and maternal health through prenatal and delivery services.<sup>45</sup> The stress on biological aspects of women's health meant other health issues pertaining to the female population were limited. Women's movements worked alongside the Sanitation Movement to question the health care system and the role of the State in guaranteeing health rights. Women demanded that health reforms include agendas for sexuality, birth control, sexually transmissible diseases, and inequality as the producer of disease.<sup>46</sup>

The Integral Assistance Program for Women's Health (PAISM) was implemented by the Brazilian Health Ministry in 1984.<sup>47</sup> This program promoted education in health centers, social participation, and respect for differences and cultural diversity.<sup>48</sup> The aim was to represent the interests of users of the health care system, specifically women, and to introduce a political perspective to the discussion of power relations in health services.

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<sup>44</sup> Biehl, Joao. "Pharmaceuticalization: AIDS Treatment and Global Health Politics." *Anthropological Quarterly* 80.4 (2007): 1083-126. <<http://www.jstor.org/stable/30052774> .>.

<sup>45</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

<sup>46</sup> Ibid.

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

However, the importance of incorporating basic reproductive health in a public health system had not reached the necessary level of attention. PAISM was implemented as a separately managed program within municipalities, remaining disconnected with the changes being made in the Unified Health System. Local governments created the Family Health Program and Community Health Agents Program in order to better serve their communities.<sup>49</sup> Using the PAISM framework the programs prioritized reproductive decision-making, access to information, high-quality antenatal and delivery services, reduction of female mortality rate from HIV/AIDS, and the strengthening of policy efforts to reduce gender violence and expand legal abortion services.<sup>50</sup>

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<sup>49</sup> The Population and Reproductive Health Program in Brazil: Lessons Learned. *The John D. and Catherine T. MacArthur Foundation*. 2003.

<sup>50</sup> Ibid.

## **Chapter Three: Women's Health Issues**

### **HIV/AIDS**

HIV/AIDS affected the Brazilian population differently across regions, ages and social classes. In 2006, the number of people living with HIV in Brazil was estimated at 620,000, of whom 188,000 had developed AIDS.<sup>51</sup> The current trend sees an increase in heterosexual transmissions, with greater infections of women and children. Despite all the efforts of national and civil actors, there is increasing correlation between the incidence of HIV/AIDS and social inequality. From 1995 to 2003 national AIDS mortality rates in Brazil dropped from 15.1 to 8.8 per 100,000 among men, whereas among women a reduction from 4.5 to 4.0 per 100,000 was reported in the same period.<sup>52</sup> Even though highly active antiretroviral therapy (HAART) has been available since 1996, the decline in AIDS mortality has impacted women less dramatically than men. The decline in AIDS mortality was only 38% in women as compared to 52% in men from 1995-1998.<sup>53</sup> This growing feminization of the HIV pandemic reflects women's greater social and biological vulnerability.<sup>54</sup>

The factors that contribute to HIV/AIDS among women include bio-physiological factors. With regard to HIV, women, as compared to men, were diagnosed as seropositive

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<sup>51</sup> Hein, Wolfgang, Sonja Bartsch, and Lars Kohlmorgen. *Global Health Governances and the Fight Against HIV/AIDS*. New York: Palgrave Macmillan, 2007.

<sup>52</sup> Braga, Patricia, Maria-Regina Cardoso, and Aluisio Segurado. "Gender Differences in Survival in an HIV/AIDS Cohort from São Paulo, Brazil." *AIDS Patient Care and STDs* 21 (2007): 321-28.

<sup>53</sup> Segurado, Aluisio, Shirlei Miranda, and Maria Oliveira Latorre. "Evaluation of the Care of Women Living with HIV/AIDS in São Paulo, Brazil." *AIDS PATIENT CARE and STDs* 17.2 (2003): 85-93.

<sup>54</sup> *Ibid.*

at a younger age and were admitted to the clinic at earlier stages of disease progression.<sup>55</sup> This can be attributed to early behavioral high-risk activities and women's perception that lack of female medical care (Pap smear), not the presence of sexual activity, is the predominant risk for disease.<sup>56</sup> Women are diagnosed with HIV/AIDS when they are pregnant, and since men do not get pregnant, women are subject to medical scrutiny earlier in the trajectory of their HIV/AIDS disease. Women are more susceptible than men to HIV because of hormonal changes, vaginal microbial physiology, and a higher prevalence of sexually transmitted infections, for exactly the same bio-physiological reasons.<sup>57</sup> Women do not have a complete understanding of the need for long term clinical follow up and adherence to therapy and medications. One study found that 40% to 50% of interviewed women did not understand the meaning of HIV viral load assessments and CD4 counts, even though they were periodically submitted to these laboratory monitoring tests.<sup>58</sup> Solely biological explanations for women's vulnerability to HIV/AIDS and STD's overlook the gender norms that shape attitudes towards information on sexuality and risk.

There is an increase in HIV infection among women who engage in sexually risky behavior. For instance, female crack users prostitute themselves for drugs or for money to

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<sup>55</sup> Quinn, Thomas C., and Julie Overbaugh. "HIV/AIDS in Women: An Expanding Epidemic." *Science* 308.5728 (2005). <<http://www.jstor.org/stable/3841606> .>.

<sup>56</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

<sup>57</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

<sup>58</sup> Braga, Patricia, Maria-Regina Cardoso, and Aluisio Segurado. "Gender Differences in Survival in an HIV/AIDS Cohort from São Paulo, Brazil." *AIDS Patient Care and STDs* 21 (2007): 321-328.

be used for buying drugs.<sup>59</sup> Sex workers are also engaging in unsafe sex practices with their multiple partners. The use of injection drugs is strongly associated with HIV infection, especially among sex workers using unsterilized needles. One study found 28.8% of women who used injection drugs to be HIV positive, while only 5.6% of those who did not were.<sup>60</sup> Women whose partners used injection drugs were three times more likely to be HIV positive. There was also a strong correlation between HIV and other STD's. STD's promote HIV transmission by enhancing HIV susceptibility and infection through a variety of biological mechanisms.<sup>61</sup> Women who tested positive for syphilis were 3.5 times more likely also to be HIV positive and those who tested positive for Hepatitis C were 11 times more likely.<sup>62</sup> Women are an important risk group with respect to the transmission of STD's and HIV/AIDS.

### **Family Planning:**

#### *Contraception*

Although there is universal access to family planning in Brazil, health clinics across the country are not consistent with regard to the types of contraception offered. A national study of the Brazilian Unified Health System in the area of family planning was conducted using data from 5507 municipalities (95% of the total) and after regional differences were accounted for, the findings still revealed a low quality of assistance in

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<sup>59</sup> Nappo, Solange, Zila Sanchez, and Lucio Garcia De Oliveira. "Crack, AIDS, and Women in Sao Paulo, Brazil." *ASSIA: Applied Social Sciences Index and Abstracts* 46.4 (2011): 476-485.

<sup>60</sup> Ibid.

<sup>61</sup> Wasserheit, JN. "Epidemiological Synergy: Interrelationships between Human Immunodeficiency Virus Infection and Other Sexually Transmitted Diseases." *Sexually Transmitted Diseases* 19.2 (1992): 61-77.

<sup>62</sup> Chacham et al. "Sexual and Reproductive Health Needs of Sex Workers: Two Feminist Projects in Brazil." *Reproductive Health Matters* 15.29 (2007): 108-118. <<http://www.jstor.org/stable/25475297> .>.

smaller municipalities.<sup>63</sup> The quality of family planning assistance encompasses the low availability of contraceptive methods, educational services and information offered by health centers and professionals.

The majority of contraceptive methods offered at health clinics are restricted to male condoms, distributed in 53% of municipalities, and birth control pills, distributed in 47% of municipalities.<sup>64</sup> Considering 95% of Brazilian municipalities, only 16% offer IUD, 13.5% offer injectable hormonal methods, and only 6.6% offer diaphragms.<sup>65</sup> A huge issue also is that Brazil has one of the highest rates of tubal ligation, with 40% of women in their fertile years sterilized.<sup>66</sup> The high prevalence of sterilization among low-income and less-educated women contributed to women reporting no use of condoms.<sup>67</sup> This method does not offer any protection from HIV/AIDS and other STI's, increasing women's risk of infection. Even though different forms of contraceptives are offered and used, the services seem to be directed towards prevention of pregnancy rather than protection against sexually transmitted diseases. Health professionals and national health campaigns need to emphasize the consequences of disease associated with unprotected sex so women can make informed decisions regarding contraceptive methods.

### *Maternity*

For pregnant women, quality prenatal care is vital to ensuring the safety of the mother and child. The Ministry of Health in Brazil created the Prenatal and Birth

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<sup>63</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

<sup>66</sup> Ibid.

<sup>67</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

Humanization Program in 2004 as a part of the National Pact for the Reduction of Maternal and Neonatal Mortality.<sup>68</sup> The program guidelines for prenatal care require a minimum of six consultations every four weeks through the 36<sup>th</sup> week and, every two weeks thereafter.<sup>69</sup> The basic conditions for care include early identification of pregnancy and periodic consultations, both of which require adequate human resources and equipment. Although use of prenatal services has increased, women still have difficulty accessing high-quality prenatal care and many do not have the required number of consultations. As of 2004, the average number of consultations of Brazilian women was around four during the gestational period (40 weeks), but, only 17.21% of the women who began prenatal care had the adequate number of consultations.<sup>70</sup> Two percent of Brazilian municipalities have no low-risk prenatal care, and 43% do not have minimal operational conditions to conduct high-risk prenatal follow-ups. Studies show that in 29% of the municipalities the same professionals do not accompany a woman's prenatal consultations and 65% of municipalities do not allow the presence of family members.<sup>71</sup> Also, 78% of municipalities do not employ an obstetric nurse for low-risk deliveries and 10% have no guarantee of a hospital vacancy for the delivery.<sup>72</sup> This means that a large proportion of women do not have a consistent support system in the pregnancy and delivery process. Women are entitled to quality reproductive health services in all phases of life.

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<sup>68</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> Ibid.

<sup>72</sup> Ibid.

A national study conducted in 2002 evaluated 7,332 women's deaths during their reproductive years. Nearly 6% of the women were or had been pregnant in the 12-month period before their deaths. Among these, 51.6% of the deaths were related to maternal causes.<sup>73</sup> In Brazil, the ratio of maternal mortality was 54.3 per 100,000 live births and among these deaths, 67.1% occurred specifically because of obstetric causes.<sup>74</sup> According to the International Classification of Diseases, the leading causes of registered maternal deaths in Brazil in 2007 were hypertensive disorders, sepsis, hemorrhage, complications of abortion, placental disorders, complications of labor, embolism, abnormal uterine contractions, and HIV/AIDS.<sup>75</sup> Obstetric complications are the leading cause of hospital admission for women of reproductive age, accounting for 26.7% of all admissions in 2008.<sup>76</sup> The mortality rate from direct obstetric causes is an important indicator of the quality of prenatal, delivery and postnatal care. The quality of maternal health services shows how devalued women's physical and emotional wellbeing during pregnancy is. The high number of maternal deaths should be incentive enough to mobilize resources towards improving obstetric care.

By 2010, a reproductive-age mortality survey in all state capitals estimated a maternal mortality ratio of 55 deaths per 100,000 citizens.<sup>77</sup> Political movements have tried to improve initiatives in reporting maternal mortality, including compulsory investigation and maternal mortality committees in all 27 states, yet the maternal

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<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

<sup>75</sup> Victora et al. "Maternal and Child Health in Brazil; Progress and Challenges." *The Lancet* 377.9780 (2011): 1863-1876.

<sup>76</sup> Ibid.

<sup>77</sup> Ibid.

mortality ratio remains the same. Even with under-registration and under-reporting, the ratio is five to ten times higher than in high-income countries.<sup>78</sup>

### *Adolescent Pregnancy*

Studies have shown that adolescents in Brazil are initiating sexual acts at earlier ages than in previous years, resulting in increased rates of adolescent pregnancy, accounting for 18.2% to 22% of all pregnancies in the country.<sup>79</sup> Girls who have less than four years of education are six times more likely to become young mothers than girls who have nine years of education.<sup>80</sup> Adolescent girls are vulnerable to negative reproductive health outcomes including the risk of HIV/AIDS and STD's, violence, unsafe abortions, early marriage and social isolation. The higher susceptibility of women to HIV infection is associated with social norms surrounding sexual behavior and unsafe sex practices among the younger population. Teen pregnancy and early marriage are common in poor rural areas and urban slums. Many young mothers declared they wanted their first pregnancy so they did not use condoms.<sup>81</sup> It is necessary to explore the value of pregnancy and lack of opportunities in society that influence the choices and behaviors of young women.

### *Childbirth*

The establishment of universal access to health care in Brazil has also contributed to the unnecessary increase in Caesarian sections and multiple ultrasound scans.

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<sup>78</sup> Ibid.

<sup>79</sup> Teixeira Caiaffa, Waleska. "The Urban Environment from the Health Perspective: The Case of Belo Horizonte, Brazil." *The Public Health Journal* 21.3 (2005): 958-967.

<sup>80</sup> The Population and Reproductive Health Program in Brazil: Lessons Learned. *The John D. and Catherine T. MacArthur Foundation*. 2003.

<sup>81</sup> Monteiro et al. "Sexual Diversity and Vulnerability to AIDS: the Role of Sexual Identity and Gender in the Perception of Risk by Young People (Rio De Janeiro, Brazil)." 7.4: 270-82. *Sexuality Research and Social Policy*. Oswaldo Cruz Institute/Oswaldo Cruz Foundation, 16 Nov. 2010.

Caesareans are associated with increased maternal morbidity and mortality rates. Of the 3 million births that occurred in 2007, 47% were by Caesarian section, with 35% of births in the SUS being Caesarian and 80% of births in the private sector being Caesarian.<sup>82</sup> Caesarian deliveries are more frequent among women from higher socioeconomic groups, women with more years of schooling, and white women. Although it is hard to tell whether mothers or health care professionals are pushing preference for Caesarians, studies with in-depth interviews suggest a belief that vaginal birthing is too painful. In a study in Rio de Janeiro, however, 70% of 437 women said they would prefer a vaginal birthing at the beginning of their pregnancy, yet only 10% of births were delivered vaginally.<sup>83</sup>

Government policies attempt to control the increasing number of surgical deliveries, especially since the World Health Organization recommends a limit of 15% Caesarian rate.<sup>84</sup> In 1998, the SUS put a limit of 40% for the proportion of institutional deliveries that would be reimbursed and in 2000, the limit was 30%. The effect was a decrease from 32% in 1997 to 23.9% in 2000 due to financial incentives.

In 1996, 71.6% of women in the poorest family-income quintile received care during childbirth, compared with 98.1% of women in the wealthiest quintile. In 2007, the coverage changed to 96.8% and 99.5%, respectively.<sup>85</sup> Despite the increased level of coverage, the quality of care remains low. In a study done in Pelotas, 98% of the women had ultrasound scans during antenatal visits, yet half of them did not have recommended

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<sup>82</sup> Victora et al. "Maternal and Child Health in Brazil; Progress and Challenges." *The Lancet* 377.9780 (2011): 1863-1876.

<sup>83</sup> Ibid.

<sup>84</sup> Ibid.

<sup>85</sup> Ibid.

breast or pelvic examinations. Data from a national survey showed that only 62% of women giving birth in public-sector facilities had routine HIV testing.<sup>86</sup> A gap remains in the overuse of certain services and limited use of simple and preventive measures for women's health.

### *Abortion*

The availability of safe and affordable abortion services depends on abortion laws and how they are interpreted and applied. In Brazil, the restrictive legislation on abortion allows the procedure if pregnancy was a result of rape, if the pregnancy puts the mother's life in risk, and in the case of fetal anomalies.<sup>87</sup> In the case of fetal anomalies, therapeutic abortion can only be done after the issuance of a judicial order authorizing the woman to interrupt the pregnancy.<sup>88</sup> In all other circumstances abortion is a crime.

Hospitalizations due to unsafe abortions increase the costs for the health system, and impact the financial stability of women in their most economically viable years. Abortion is the fourth most common cause of maternal mortality, resulting from 700,000 to 1 million unsafe and illegal abortions per year.<sup>89</sup> In 2008, 215,000 hospital admissions within the SUS were for abortion-related complications, of which only 3,230 were for legal abortions.<sup>90</sup> Of the 3 million births that occurred in 2008, approximately 1 in 4 pregnancies were terminated.<sup>91</sup> A variety of methods are used to induce abortion, especially drugs, available for a low cost in the black market. In a national survey of

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<sup>86</sup> Ibid.

<sup>87</sup> Guilhem, Dirce, and Anamaria Ferreira Azevedo. "Brazilian Public Policies for Reproductive Health: Family Planning, Abortion and Prenatal Care." *Developing World Bioethics* 7.2 (2007): 68-77.

<sup>88</sup> Ibid.

<sup>89</sup> The Population and Reproductive Health Program in Brazil: Lessons Learned. *The John D. and Catherine T. MacArthur Foundation*. 2003.

<sup>90</sup> Victora et al. "Maternal and Child Health in Brazil; Progress and Challenges." *The Lancet* 377.9780 (2011): 1863-1876.

<sup>91</sup> Ibid.

urban areas, drugs were used to induce 48% of all reported abortions.<sup>92</sup> The frequently used drug, Misoprostol (brand name Cytotec), is meant to prevent ulcers in people who take certain pain medication that cause ulcers.<sup>93</sup> If a pregnant woman takes Misoprostol, it can result in a miscarriage, premature labor, or birth defects. The mortality rate from abortion complications illustrates how important fully legalizing abortion is to the health of many women in Brazil.

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<sup>92</sup> Ibid.

<sup>93</sup> "Misoprostol." PubMed Health, Sept. 2008.  
<<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000886/>>.

## **Chapter Four: Political Economy of Health**

Over the years Brazil has made strides in promoting health rights for citizens, especially for women. Yet the overwhelming inequalities in Brazil undermine the progress national policies have had in promoting women's reproductive and sexual health. In order to improve population health, civil society and policy makers need to address the underlying determinants of health and recognize the role of the political economy and social relations in shaping health outcomes. The application of biomedical and behavioral interventions alone will not fix the unequal distribution of health and disease. Health should be viewed as a function and reflection of social structures and ideologies that operate at individual, household, community, and national levels.<sup>94</sup> By first identifying social inequalities, the implications for women's health in Brazil can be addressed.

### **Social Inequalities:**

There exists an important link between poverty and the right to the highest attainable standard of health. The ICESCR definition of poverty from a human rights perspective states, "poverty is a human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political

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<sup>94</sup> Birn, Anne-Emanuelle, Yogan Pillay, and Timothy H. Holtz. Chapter 4: The Political Economy of Health. Textbook of International Health. 3rd ed. New York: Oxford UP, 2009.

and social rights." <sup>95</sup> Poverty is a social determinant of health, with high levels of socioeconomic inequality correlating with worsened health outcomes for a society. Those who are of weak health are more likely to become poor due to medical costs and lack of ability to work, creating economic insecurity. Those who are poor are more vulnerable to disease due to their environment and exposures. The increasing gap between resource-rich and resource-poor populations perpetuates health disparities. The mechanisms by which poverty causes disease include the weakening of immunity and neuropsychological development due to malnutrition, the spread of disease due to dire living conditions, the impact of unstable social support networks, and exposure to environmental pollutants.<sup>96</sup> In Brazil, poverty is most visible among *favelas*, or shantytowns, which are a result of large movement of migrants onto public or private lands.<sup>97</sup> The slums are situated on the outskirts of cities and exemplify the unequal distribution of wealth among populations. These communities are deprived of basic living conditions essential to a healthy life. Improvements in health in Brazil will more likely be due to decreases in poverty than to improvements in medical care.<sup>98</sup>

The social environment influences risk of disease, independent of individual characteristics. In Brazil, few investments were made early on in infrastructure and social services directed towards the poor. These investments could have guarded those lower on the social ladder from social, behavioral and environmental risks that would compromise

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<sup>95</sup> Hunt, Paul and Gillian McNaughton. "Impact Assessments, Poverty, and Human Rights: A Case Study Using the Highest Attainable Standard of Health." Human Rights Centre, University of Essex, 2006, 1-26.

<sup>96</sup> Nguyen, Vinh-Kim, and Karine Peschard. "Anthropology, Inequality, and Disease." *Annual Review Anthropology* 32 (2003): 447-474.

<sup>97</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

<sup>98</sup> Hunt, Paul and Gillian McNaughton. "Impact Assessments, Poverty, and Human Rights: A Case Study Using the Highest Attainable Standard of Health." Human Rights Centre, University of Essex, 2006, 1-26.

their health outcomes.<sup>99</sup> Those lower in the social hierarchy are then blamed for behavior over which they have little control. The cause of disease is not based on biological factors alone and must be understood as the “embodiment of social hierarchy.”<sup>100</sup> This inequality is a form of structural violence, depriving populations of material resources and increasing risk and blame. The unhealthy behaviors adopted early in life are not purposely chosen. Poor health outcomes are a result of social exclusion.<sup>101</sup>

The increasing gap in economic disparities can affect an individual’s sense of social justice and inclusion, which leads to heightened anxiety and compromised life expectancies.<sup>102</sup> Societies with uneven income distribution have limited social support institutions and rising levels of violence and disrespect among citizens.<sup>103</sup> The perception of living in an unequal and unjust society will create more hierarchy in social relationships. If the relationships between the poor and privileged who are involved in delivering public services deteriorate, then the capacity of the poor to access, use, and benefit from health related goods and services is compromised.<sup>104</sup> This lack of mutually respectful relationships among populations can increase the burden of disease.

### **Gender Inequalities:**

Gender roles and responsibilities are socially constructed. Gender does not simply reflect cultural norms of masculinity and femininity; it also reflects the value accorded to things considered male and things considered female, which is a form of social

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<sup>99</sup> Nguyen, Vinh-Kim, and Karine Peschard. "Anthropology, Inequality, and Disease." *Annual Review Anthropology* 32 (2003): 447-474.

<sup>100</sup> Ibid.

<sup>101</sup> Ibid.

<sup>102</sup> Woolcock, Michael, and Simon Szreter. "Health by Association? Social Capital, Social Theory, and the Political Economy of Public Health." *International Journal of Epidemiology* 33 (2004): 650-667.

<sup>103</sup> Ibid.

<sup>104</sup> Ibid.

differentiation.<sup>105</sup> The different characteristics of gender shape a woman's vulnerability to exposure of disease and the outcome of that exposure. Gender inequalities also impact a woman's ability to access health information and services, her experience with health services, and the social and economic consequences of a health problem.<sup>106</sup> These patterns arise from and reflect unequal social distributions of power and control.

Gender inequalities increase women's vulnerability to social determinants of health and consequences of illness. The unequal burden of disease among women remains pervasive, even in a context where universal access to care is available. The patriarchal society in Brazil fosters gender inequalities, disempowerment, and social injustices for women.<sup>107</sup> It is necessary to assess how gender roles at an economic, social, and personal level interact with the biological characteristics of disease. Sexual and gender identity among social groups influence an individual's perception regarding risk and behavior. The analysis of these intersecting forces will offer insight necessary to improve prevention and treatment strategies for women.

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<sup>105</sup> Annandale, Ellen, and Kate Hunt. *Gender Inequalities in Health*. Buckingham: Open UP, 2000.

<sup>106</sup> Cottingham, J. C., and T. K. Ravindran. "Gender Aspects of Sexual and Reproductive Health." *World Health Organization* (2008).

<sup>107</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

## **Chapter Five: Structural Forces**

### **Social Perception of the Body:**

People perceive the functioning of their bodies and reproductive systems in different ways. The body image refers to the representations an individual entertains about the body in its relationship to the environment, including internal and external perceptions, memories, affects, cognitions, and actions.<sup>108</sup> The concept of body image encompasses the social and cultural meanings of being human and on the various threats to health, well-being, and social integration.<sup>109</sup> The cultural constructions of the body are helpful in sustaining views of society and social relations and justifying particular social values and social arrangements, which can produce structural violence.<sup>110</sup> It is important to understand the context in which images and concepts of body, sexuality and reproduction acquire meaning.

A study conducted in one of the poorest areas in Brazil, looked at the extent to which biomedical views of anatomy and physiology had been assimilated, rejected, or reinterpreted.<sup>111</sup> The male body image was described by men in reference to the view that men are always ready to have sexual intercourse and need more sexual activity. This is a

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<sup>108</sup> Victora, Ceres G., and Daniela R. Knauth. "Images of the Body and the Reproductive System among Men and Women Living in Shantytowns in Porto Alegre, Brazil." *Reproductive Health Matters* 9.18 (2001): 22-33. <<http://www.jstor.org/stable/3776146> .>.

<sup>109</sup>Ibid.

<sup>110</sup> Scheper-Hughes, Nancy, and Margaret Lock. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." 6-31.

<sup>111</sup> Victora, Ceres G., and Daniela R. Knauth. "Images of the Body and the Reproductive System among Men and Women Living in Shantytowns in Porto Alegre, Brazil." *Reproductive Health Matters* 9.18 (2001): 22-33. <<http://www.jstor.org/stable/3776146> .>.

belief used to justify men having more sexual partners outside of marriage, a common practice. The male body, as perceived by the females, was seen as strong enough to cause the contraceptive pill to fail and that the pill was the “weak” one. The reproductive functions of the body were seen as a part of the women’s world. Men saw both reproduction and contraception primarily as “*coisas de mulher*” (women’s issues or domains), since women look after the ill, take children to the doctor, get pregnant, give birth, and look after the children and family. More than 54% of men did not know how to explain the functioning of the male or female reproductive system.<sup>112</sup>

When women from the study talked about the functioning of the reproductive system, they often gave a non-biomedical explanation of what took place. Women’s common belief is that the menstrual period and fertile period coincide and, the body is “open” in the beginning or end of the period when the blood flow is low, so the perception is that they are more likely to get pregnant then. Sexual intercourse was thought to be avoided during menstruation, but “the woman runs the risk of getting a sexually transmitted disease because the body is bleeding.”<sup>113</sup>

Women most commonly drew women’s bodies, though, with the reproductive organs in the biomedical model, which meant they had seen it before where as men only drew only outside body parts.<sup>114</sup> The biomedical model drawn by the majority of the women shows that they have more contact with the health services than men, maybe due to the cultural belief that men have strong bodies and hardly get sick. The data show that even when lay people have been exposed to biomedical drawings, their own

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<sup>112</sup> Ibid.

<sup>113</sup> Ibid.

<sup>114</sup> Ibid.

representations may be informed by other notions, values, and experiences. Those who did draw the biomedical model still attached their own particular meanings to them, based on physical experience or emotional and social experiences.<sup>115</sup> Gender-related bodily experiences also shaped the meanings of these representations and understandings of the body. Women tend to individualize what happens in the female body based on personal and social experiences. This means that, for women, the biomedical model is just one way, rather than the only way, of knowing the body. Although the study was set only one region of Brazil, it offers insight on the differing perceptions of body image between men and women living in shantytown communities.

### **Patriarchal Society:**

It is important to consider gender issues and power relations that have historically affected Brazilian women and their health. Brazil's history is characterized by political corruption, unfair land practices and an unstable economy that privileged the wealthy. This structural violence created a situation in which men could not support wives and in which scarcity of male employment encouraged male mobility and made transitory sexual relationships the norm.<sup>116</sup> The development of social inequalities over time in Brazil has created a cultural perception that males do not have monogamous relationships. Women are aware of culture-related sexual double standards that tolerate extramarital male sexual activity and punish women who engage in the same behavior.<sup>117</sup>

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<sup>115</sup> Ibid.

<sup>116</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

<sup>117</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

Men's infidelity and extramarital sexual behavior are expected and accepted, so long as it did not jeopardize the wife's health.

For women, there are cultural barriers to discussing sex within either relationships or communities. At the social and reproductive level, women are traditionally seen as the health provider to the family and asking for help may affect their status within the home as primary caregiver.<sup>118</sup> In regards to an HIV diagnosis, new stresses occur including the fears of infecting their partner, losing sexual desire, and feeling less sensual within themselves. There is also fear of abandonment as a consequence of sharing their status with partners. There have been advances in drug development and regimes for HIV infections, but effective medical care depends on the ability to provide early diagnosis of infection.<sup>119</sup> The lack of supportive social networks and little decision-making power within the household and community also affect women's actions regarding health. If permission is needed from male partners, relatives, or in-laws to access services, confidentiality is jeopardized and women's safety may be put at risk.

Culturally shaped perceptions may also dictate when and with whom contraceptives are used for disease prevention. Men in general are more likely to use condoms in encounters they perceive to be more risky, than with their wives and steady partners.<sup>120</sup> Women who want to practice safer sex may not be able to for fear of being considered immoral and untrusting. Requesting condom use by male partners, for reasons

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<sup>118</sup> Vlassoff, Carol, and Lenore Manderson. "Incorporating Gender in the Anthropology of Infectious Diseases." *Tropical Medicine and International Health* 3.12 (1998): 1011-1019.

<sup>119</sup> Bell et al. "Sexual and Reproductive Health Services and HIV Testing: Perspectives and Experiences of Women and Men Living with HIV and AIDS." *Reproductive Health Matters* 15.29 (2007): 113-36. <<http://www.jstor.org/stable/25475326>>.

<sup>120</sup> Victora, Ceres G., and Daniela R. Knauth. "Images of the Body and the Reproductive System among Men and Women Living in Shantytowns in Porto Alegre, Brazil." *Reproductive Health Matters* 9.18 (2001): 22-33. <<http://www.jstor.org/stable/3776146> .>.

other than contraceptive purposes, could prompt deterioration of relationships and give an occasion for conflict, physical and emotional violence, psychological manipulation, and losing their position as a respected wife or mother.<sup>121</sup> In another study, women reported that they were unable to convince their partners to use condoms even after knowing the woman's positive HIV status. One interviewee said of her partner, "he is the kind of man who does not tolerate condoms."<sup>122</sup> This statement clearly demonstrates the relative lack of control women may have over their own bodies.

Women's health vulnerability should be analytically assessed in terms of their structural position within society and their family roles. Within a family, the husband's status is directly related to the way his wife behaves. Men expect women to be sexually and emotionally passive and available. The lack of financial opportunities among poor communities in Brazil does not change family dynamics and roles. The male figure is still seen as the sole provider for the family, regardless of whether or not the woman works.<sup>123</sup> The ideals of male authority are reinforced when women who work do not recognize or acknowledge their important contribution to the financial stability of their family.<sup>124</sup> The lower status of a woman's job compared to that of males also supports the cultural notion that the man's work is more significant. The woman symbolically stands behind the man again. This unequal social organization of gender exposes women to different standards

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<sup>121</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

<sup>122</sup> Santos, Naila, Elvira Ventura-Filipe, and Vera Paiva. "HIV Positive Women, Reproduction and Sexuality in São Paulo, Brazil." *Reproductive Health Matters*, 6.12 (1998): 31-40. 5 Feb. 2011. <<http://www.jstor.org/stable/3774936> .>.

<sup>123</sup> Victora, Ceres G., and Daniela R. Knauth. "Images of the Body and the Reproductive System among Men and Women Living in Shantytowns in Porto Alegre, Brazil." *Reproductive Health Matters* 9.18 (2001): 22-33. <<http://www.jstor.org/stable/3776146> .>.

<sup>124</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

of health. Within the structure of the family, male authority devalues a woman's autonomy and inhibits her ability to improve her wellbeing and the wellbeing of her family.

### **Adolescent Sexuality:**

Differences between genders are a consequence of social constructions of expected roles. Peer pressure to partake in sexual behaviors and actions is molded by the meaning culturally attributed to sexuality. Sexuality is expressed through personal action while encompassing the sexual culture of the peer group. The gender relations dictate that the male should not resist sexual impulses and females should control their impulses.<sup>125</sup> Sexual initiation for males is a consolidation of masculinity, a way to express the process of becoming a man.<sup>126</sup> Adolescents' expectations regarding sexual initiation are in line with the traditional gender roles pertaining to sexual behavior.

Males and females have different motivations behind sexual acts, based on gender relations that shape their identities. For women, the ideal first sexual relation will happen from trust and respect from the partner who keeps private their relation, to not put the girl's morality at risk.<sup>127</sup> From a young woman's point of view, the first sexual experience should be legitimized in a committed and affectionate relationship. Sexual initiation is seen as the first step to achieving maturity, including the ability to assume responsibility for consequences of sexual acts like pregnancy.<sup>128</sup>

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<sup>125</sup> Borges ALV, Nakamura E. Social norms of sexual initiation among adolescents and gender relations. *Rev Latino-Am Enfermagem* 2009; 17(1):94-100.

<sup>126</sup> Ibid.

<sup>127</sup> Ibid.

<sup>128</sup> Ibid.

A study was conducted among 14 to 18 year-old students from public schools in the state of Sao Paulo to examine the norms of sexual behaviors at adolescence.<sup>129</sup> When young girls were questioned about initiation of sexual relations, the relations were said to sometimes assure the partner will not look for other women to satisfy sexual needs. One interviewee said, “there’re girls who have sex only because the boyfriend wants it, there’re no guys who’d wait two months to have sex”.<sup>130</sup> It is an interplay of resistance in engaging in sex versus the risk of losing their partner. The study’s findings regarding male sexual needs were that both young men and young women understood them to be more frequent and intense than those of females.<sup>131</sup> In terms of first sexual experience, male virginity is considered a weakness. Sex for men was viewed as an instinct. Naturally, men should not deny sexual advances at any time.

In the context of HIV/AIDS and STD’s, condoms among adolescents in the study were used more with first sexual contact, and then replaced by birth control pills during relationships because condoms were reported to take away from spontaneity and pleasure.<sup>132</sup> The main consequence of unprotected vaginal sex was not understood to be AIDS but unwanted pregnancy. This is unfortunate because from a public health perspective, prevention of pregnancy should not be separated from prevention of STD’s. Avoiding pregnancy was perceived as a woman’s role, also a reason for changing protection from condoms to birth control pills.<sup>133</sup> This is yet another example of how reproduction and sexual health are perceived to be only under a woman’s domain. The

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<sup>129</sup> Ibid.

<sup>130</sup> Ibid.

<sup>131</sup> Ibid.

<sup>132</sup> Ibid.

<sup>133</sup> Ibid.

findings from this study demonstrate the lack of effective and informative sexual education in public school systems at a time when adolescents are exploring their sexuality. Educational programs need to emphasize the consequences of unsafe sex practices in light of risks of disease.

### **Maternal Identity:**

In shantytowns, changes in women's social status and their development as adult reproductive beings are defined through a cumulative process. First sexual intercourse and the birth of her first child contribute to the respected status of an adult woman. The life stages are *menina* (girl), *moçinha* (young lady) *mulher* (woman) and *mãe* (mother) and the experience of each one is necessary to accomplish the next.<sup>134</sup> For women, their health and wellbeing is influenced by their history of childbearing and their role as parents. Having children is very important for women who desire to be respected and is also seen as an opportunity to improve their status. Motherhood becomes an inherent part of their femininity. This is an example of how gender-appropriate behaviors and the values attached to them are culturally defined. Many women believe being a mother is the main reason for living and that you are not fully a woman if you don't or can't have a child.<sup>135</sup> For a woman to admit to not being able to cope with the emotional and physical demands of caring would be the equivalent to admitting to failure as a mother.<sup>136</sup>

The desire to have children exists among women living with HIV. Improvements in effective prevention of mother-to-child transmission and the provision of assisted

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<sup>134</sup> Victora, Ceres G., and Daniela R. Knauth. "Images of the Body and the Reproductive System among Men and Women Living in Shantytowns in Porto Alegre, Brazil." *Reproductive Health Matters* 9.18 (2001): 22-33. <<http://www.jstor.org/stable/3776146> .>.

<sup>135</sup> Hebling, and Hardy. "Feelings Related to Motherhood among Women Living with HIV in Brazil: a Qualitative Study." *AIDS Care*, 19.9 (2007): 1095-1100.

<sup>136</sup> Annandale, Ellen, and Kate Hunt. *Gender Inequalities in Health*. Buckingham: Open UP, 2000.

reproductive services by the universal health system have influenced HIV-infected women's decision to have children. The decision to have a child although HIV-positive meant the desire to be a mother was stronger than fear of negative outcomes. Reasons for not having a child include the fear of lack of support, feelings of guilt, and the stigmatization of their HIV-positive status extending to their children's lives.<sup>137</sup> An HIV-positive diagnosis before pregnancy discourages women from pursuing motherhood. Women who still wish to become a mother are able to reclaim this social identity, which was questioned at diagnosis.

It is not against the law in Brazil for an HIV-positive woman to have a baby but all pregnant women must be offered an HIV test to get access to AZT if they are positive. Antenatal HIV testing is often done to protect obstetricians during delivery. Such testing should be also be used in fostering informed decisions among pregnant women and to ensure women's access to antiretroviral therapy and counseling.<sup>138</sup> The availability of HIV testing during antenatal consultations will not improve any health outcomes for women if health care providers are looking after their own interests before those of their patients. HIV/AIDS and reproductive health care services should provide accurate information about risks and benefits of ART and support desires for children.

Many women lacked information about which contraceptive methods were available, the best way to get pregnant while trying to minimize the dangers of HIV infection, and the probabilities of mother-to-child transmission with and without the use

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<sup>137</sup> Santos, Naila, Elvira Ventura-Filipe, and Vera Paiva. "HIV Positive Women, Reproduction and Sexuality in São Paulo, Brazil." *Reproductive Health Matters*, 6.12 (1998): 31-40. 5 Feb. 2011. <<http://www.jstor.org/stable/3774936> .>.

<sup>138</sup> Ibid.

of AZT and other antiretroviral drugs.<sup>139</sup> The physicians also realized most had never checked on or talked about adherence to condom use, safe sex practices, and any other issues regarding reproductive health. This discussion happens frequently during antenatal care and delivery, when women are already pregnant or HIV-positive.<sup>140</sup> Pregnancy was thus associated with having ever had a gynecologist consultation. This indicates that young women tend to be included in a more structured way inside the health services only after their first pregnancy. Information regarding safe sex practices should be introduced to young women before a pregnancy.

### **Medical Discourse:**

When women do seek health services, the medical power and cultural process of discrimination and domination over women may influence how women feel during a medical examination. In one study, many women felt comfortable with how the physicians were treating them, but 35% did not feel comfortable talking about sex and sexuality with physicians.<sup>141</sup> Women expressed being embarrassed about getting undressed before physicians, especially male gynecologists. Many of the women who were HIV-positive prior to pregnancy would have preferred to talk about their sexual concerns with the clinicians of infectious disease, as the women already had frequent appointments with them and already had established a stronger relationship.<sup>142</sup>

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<sup>139</sup> Ibid.

<sup>140</sup> Ibid.

<sup>141</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

<sup>142</sup> Santos, Naila, Elvira Ventura-Filipe, and Vera Paiva. "HIV Positive Women, Reproduction and Sexuality in São Paulo, Brazil." *Reproductive Health Matters*, 6.12 (1998): 31-40. 5 Feb. 2011. <<http://www.jstor.org/stable/3774936> .>.

The social representations associated with HIV/AIDS include the issues that arise with medical treatment or advice and how it may contradict the cultural values or desires of individuals. Physicians typically perform surgical operation for HIV-positive women and vaginal birth for women on antiretroviral therapy. However, the medical recommendation may lead women to neglect their own preferences, which the women themselves considered less important. Many resigned themselves to their low status in the health system and, ultimately, the decision about how their baby was to be delivered was not up to them at all.<sup>143</sup> The baby's health is one of the determining factors for women preferring Caesarean delivery, yet these women were caught between medical prescription, institutional discourse, and personal desire. Although HIV/AIDS is more prevalent among poorer women, the rate of Caesarians is higher among richer women, which suggests delivery methods for HIV-positive women are not always Caesarian.

The fear of HIV/AIDS and the consequences within the community are reasons for women to avoid seeking preventative health care. A health care providers' lack of understanding of how gender roles affect a woman's ability to access services can lead to blaming and disrespect. Some physicians may not even be prepared or want to treat those that fall outside sexual gender norms, such as sex workers. Doctors play a huge role in quality of service and influence whether a woman will come back if additional services are needed. In another study at the time of disclosure of HIV infection, 21.6% of HIV-positive women reported negative attitudes from health care professionals such as

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<sup>143</sup> Knauth, Daniela, Regina Barbosa, and Kristine Hopkins. "Between Personal Wishes and Medical "Prescription": Mode of Delivery and Post-Partum Sterilisation among Women with HIV in Brazil." *Reproductive Health Matters* 11.22 (2003): 113-21. 5 Feb. 2011. <<http://www.jstor.org/stable/3776050> .>.

indifference, discrimination and even criticism.<sup>144</sup> For example, after the death of a child, the doctors treating a woman told her not to have any more children because it was a “crime” so they sterilized her by tubal ligation.<sup>145</sup> This relates back to the high prevalence of female sterilization in Brazil and suggests that the rates of tubal ligation include procedures done without consent. Along with medical discourse, stigma and discrimination are still barriers to quality reproductive health care for HIV-positive individuals. Patients tested at maternity wards in hospitals and private services were more likely to be discriminated against and criticized, which lends support to the idea that health professionals training should incorporate a rights-based framework.

### **Media:**

The structure of the public health system in Brazil tends to organize health promotion campaigns to satisfy political motives rather than to respond to epidemiological realities. For example, young women from the slums of Belo Horizonte reported the main source of any health information for them was the media, then school, and lastly health centers.<sup>146</sup> Current strategies are inappropriate for women because of several factors. Messages on the television and radio were said to be “too fast” and “without details.”<sup>147</sup> Although the campaigns emphasize safer sex practices, they do not address the gender inequalities that shape most sex relations between men and women. It

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<sup>144</sup> Segurado, Aluisio, Shirlei Miranda, and Maria Oliveira Latorre. "Evaluation of the Care of Women Living with HIV/AIDS in São Paulo, Brazil." *AIDS PATIENT CARE and STDs* 17.2 (2003): 85-93.

<sup>145</sup> Santos, Naila, Elvira Ventura-Filipe, and Vera Paiva. "HIV Positive Women, Reproduction and Sexuality in São Paulo, Brazil." *Reproductive Health Matters*, 6.12 (1998): 31-40. 5 Feb. 2011. <<http://www.jstor.org/stable/3774936> .>.

<sup>146</sup> Chacham, Maia, Greco, and Silva. "Autonomy and Susceptibility to HIV/AIDS among Young Women Living in a Slum in Belo Horizonte, Brazil." *AIDS Care* 19.1: 12-22.

<sup>147</sup> McCalman, Claudia Ladeira. "Barriers and Motivators for Low-Income Brazilian Women in Metropolitan Belo Horizonte: Insights for AIDS Prevention." *Health Care for Women International* (2001): 565-586.

is also difficult to address sexual relations in campaigns in the Brazilian society, where sex is publicized by the media vulgarly. The media commercializes sex rather than portraying sexuality as a domain of citizenship and freedom.<sup>148</sup> Campaigns should stress healthy behaviors by considering the socioeconomic and cultural context of target audiences.

### **Sexual Identity:**

The systems of beliefs, roles and practices that structure sexuality in different social contexts are important to women's perception of their own health. A sexuality framework provides an understanding of sexual behavior and relationships in a culture by examining the gender norms that shape attitudes toward information on sex, sexuality, sexual risk taking, and fidelity.<sup>149</sup> This framework captures structures that shape gender-based vulnerability to disease.

Gender is a factor in considering what appropriate behavior is in any cultural context. In the *favela*, sexual relationships and their social and economic implications are both central and ambiguous issues in the lives of most of the women in the community.<sup>150</sup> A good woman should remain home with her children, not venture out into the city streets alone, and should never have more than one sexual partner. There is also a gendered division between a woman's domain of the "*casa*" (the house) and the male domain of the "*rua*" (the street), dividing the moral world in Brazil.<sup>151</sup>

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<sup>148</sup> The Population and Reproductive Health Program in Brazil: Lessons Learned. *The John D. and Catherine T. MacArthur Foundation*. 2003.

<sup>149</sup> Parker, Richard, Gilbert Herdt, and Manuel Carballo. "Sexual Culture, HIV Transmission, and AIDS Research." *The Journal of Sex Research* 28.1 (1991): 77-98. <<http://www.jstor.org/stable/3812952>>.

<sup>150</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

<sup>151</sup> *Ibid.*

Women valorize traditional notions of respectability, virginity, and fidelity. Women knew the “rules” of correct behavior and knew how “good” Brazilian women should behave sexually.<sup>152</sup> A woman’s status is directly linked to her sexual purity, while a man’s honor derives from controlling that purity. Once a woman becomes sexually active, she will either assume the role of wife or that of a prostitute. A woman’s greatest asset is her respectability and a woman without a husband is not respectable. The concept of “husband” is different in shantytowns, as many women do not legally marry or later live with a man other than their legal husband.<sup>153</sup> The husband figure is the current man that is providing for the woman and her children. Only by retaining her virginity until marriage, when she transfers control of her sexuality from her parents to her husband, and by remaining faithful to that husband, can a woman achieve the proper status of wife and mother.<sup>154</sup>

### **Financial Conditions:**

Women in Brazil are constrained by these cultural expectations of female sexuality but manipulate them to meet their own needs.<sup>155</sup> When income falls short, behaviors change to compensate for family survival without much consideration given to the consequences on individual health.<sup>156</sup> Among other consequence of low economic and social status, such as malnutrition, stress and anxiety can impact an individual’s biological vulnerability. Economic dependency and limitations of financial resources prevent women from accessing and affording proper treatment. Women are less likely to

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<sup>152</sup> Ibid.

<sup>153</sup> Ibid.

<sup>154</sup> Ibid.

<sup>155</sup> Ibid.

<sup>156</sup> Annandale, Ellen, and Kate Hunt. *Gender Inequalities in Health*. Buckingham: Open UP, 2000.

mobilize family resources to cover personal medical fees, especially if basic necessities are scarce.

Mothers are forced to rely on actions which compromise health in the struggle for financial survival. Women in shantytowns are able to manipulate cultural norms to their own advantage by using sexuality as an economic resource.<sup>157</sup> Although men are perceived to have stronger sexual impulses than women, society also dictates that Brazilian women are inherently sexual and will engage in high levels of sexual activity unless controlled.<sup>158</sup> Women who use sex for survival deny that such behaviors increase risk of disease.<sup>159</sup> Although women are trying to overcome inequities in society by increasingly partaking in risky behaviors, it further validates the cultural notion of need for control over female sexuality.

**Violence:**

The risk factors for intimate partner violence include being young, alcohol use and substance abuse, inequality and power imbalance, poverty, gender inequality, lack of institutional support, social norms, and promotion of masculinity based on power and aggressiveness.<sup>160</sup> Violence directed towards women result in harmful health outcomes including permanent physical damage, chronic pain, depression, mental health problems, and sexual and reproductive health problems.<sup>161</sup>

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<sup>157</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

<sup>158</sup> Ibid.

<sup>159</sup> Ibid.

<sup>160</sup> Garcia-Moreno, Claudia, and Heidi Stockl. "Protection of Sexual and Reproductive Health Rights: Addressing Violence Against Women." *International Journal of Gynecology and Obstetrics* 106 (2009): 144-147.

<sup>161</sup> Ibid.

Violence against women impacts a person's ability to achieve the highest attainable standard of physical and mental health and impinges other human rights, specifically women's reproductive rights. Women have the right to make reproductive decisions free from discrimination, coercion, or violence, and the right to protect themselves from HIV/AIDS and STD's. The inability to request or negotiate condom use, intimidation, coercion, and the fear of violence also increase the risk of unwanted pregnancies. This form of human rights violation affects a woman's wellbeing and ability to support her children. Governments have the legal obligation to take all appropriate measures to prevent violence against women and to ensure that quality health services are available to respond to their specific needs.

**Abortion Law:**

Even though cultural, political, economic, and even religious barriers exist to having an abortion, women who have unwanted pregnancies will still engage in such acts whether or not they are safe. This risks not only their health and future fertility but also their social standing. Women from poor communities are more likely to have difficulty accessing and affording abortion services, and, consequently, to resort to unsafe procedures. Legal abortion procedures are more likely performed in private clinics and costs approximately \$1500.<sup>162</sup> The social implications of abortion on women cause both mental and physical consequences. Complications from unsafe abortion include hemorrhage, chronic pelvic infections, and infertility.<sup>163</sup> Septic abortion accounts for a disproportionate share of expenditures in transfusions, operating room costs, use of

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<sup>162</sup> Yanda, K., S.V. Smith, and A. Rosenfield. "Reproductive Health and Human Rights." *International Journal of Gynecology and Obstetrics* 82 (2003): 275-283.

<sup>163</sup> Ibid.

medication and hospitalizations.<sup>164</sup> This affects not only the women with complications but all other hospital patients due to overuse of resources.

Unlike many other pregnancy-related problems and illnesses, mortality and morbidity caused by complications from unsafe abortions are preventable. In poor settings, morbidity and mortality drain health care resources from other reproductive health services, and, because they are preventable, they should not be happening. Death and injury from complications from unsafe abortions are much lower in countries that provide legal access to abortion on broad grounds, including upon request.<sup>165</sup> Providing safe abortion services is a cost-efficient way of reducing maternal mortality and morbidity and a process that ensures the right of women to make reproductive choices.

These forms of structural violence obstruct the ability of women to benefit from sexual and reproductive health rights. Gender norms and values enforced by society and institutions contribute to early marriage and childbearing, lack of knowledge of one's body, and embarrassment and silence surrounding sexual issues.<sup>166</sup> Women delay seeking health care and are often unwilling to disclose problems to health care providers due to these issues. Improvements in women's sexual and reproductive health are possible if policies and programs consider the social and gender inequalities present in Brazilian society.

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<sup>164</sup> Ibid.

<sup>165</sup> Cottingham, J. C., and T. K. Ravindran. "Gender Aspects of Sexual and Reproductive Health." *World Health Organization* (2008).

<sup>166</sup> Ibid.

## **Chapter Six: Recommendations**

A framework using human rights language and principles will make the right to the highest attainable standard of health a reality. Development and health programs will be more aware of discrimination and inequality among populations, emphasizing government and community interaction to secure rights. It will strengthen the accountability of duty-holders (governments) while empowering right-holders (the people) to demand change. Improvements in population health, specifically the health of women, can be initiated by a politically conscious and empowered civil society and decentralized government of mutually respecting citizens.

### **Health Care System:**

Governments have the duty to respect, protect, and fulfill rights for their citizens. In order to fulfill the rights of citizens, the national government should take positive action to ensure systems are in place to attain these rights, where the government is doing what individuals cannot. Within Brazil, health care delivery has reduced inequalities in the health sector but the public health system continues to face challenges in reaching the poorest populations and addressing their specific needs.

The political nature of financial transfers from the government to the private sector undermines the funding of the SUS. The private facilities that provide SUS services are reimbursed for complex care procedures, a transfer amount determined by

political negotiations between state, municipal, and federal governments.<sup>167</sup> Private patients with certain conditions that are not covered by their insurance still use the SUS, even though their private insurance contributions are tax-deductible (while SUS is tax funded).<sup>168</sup> The tax-funded SUS only represents a 41% share of the public sector relative to total health expenditure.<sup>169</sup> With around 80% of the total population entirely dependent on the public health system, the SUS should be receiving more investments.

Municipalities that are politically connected to state legislators have more health services available due to similar party preferences and the ability to influence aid grants from state and federal governments.<sup>170</sup> More health services per capita are provided in richer municipalities that have larger health care budgets and greater allocations to both private and public clinics. People with access to these goods and services have higher household per capita income, are more likely to be educated and white, and were seeking treatment for more severe illnesses.<sup>171</sup> Although the goal of decentralizing health care provisions is to meet the specific health needs of a community, municipalities of lower income citizens with lower health care budgets do not have the resources to do so. Public health clinics have limited consultation openings and are overcrowded. The percentage of people seeking care and actually receiving care remains low. The greater the income inequality, the more poor and uninsured people are in need of public health services.

The social inequalities in Brazil increase women's vulnerability to disease.

Without a properly functioning public health system, women will encounter additional

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<sup>167</sup> Victora et al. "Health Conditions and Health-Policy Innovations in Brazil: The Way Forward." *The Lancet* 377 (2011): 2042-2053.

<sup>168</sup> Ibid.

<sup>169</sup> Ibid.

<sup>170</sup> Mobarak, Ahmed, Andrew Rajkumar, and Maureen Cropper. *The Political Economy of Health Services Provision and Access in Brazil*. Working paper no. PEC2003-0001. Boulder: University of Colorado, 2003.

<sup>171</sup> Ibid.

disparities in health care provisions. The financial restrictions and minimal supply of specialized services and human resources in the SUS mean lower quality and availability of care. Stronger regulation is needed to minimize competition among private and public sectors and to reimburse the SUS when patients with private insurance use public services. The management of SUS at municipal, state, and federal levels should not be based on political party interests. Coordination among different government levels, the private sector and the public sector should increase to reduce inequalities in the health sector. The government needs to overcome barriers to health reform that include corruption, bureaucracy, political agendas, and inadequate and unequal financial and resource allocation. The public health budget should be increased, public subsidies for private sectors should be reduced, and public investment in infrastructure should be expanded.

### **Health Care Providers:**

The government fulfills health rights by ensuring high-quality goods and services founded on just principles. A physicians' relative power in the health care system undermines the experience of disease among the poor. For example, oncologists in Recife, a poor region of Northern Brazil, never initially disclose diagnosis of cervical cancer to female individuals for fear of how patients will cope with the information.<sup>172</sup> The oncologists in Recife were also more likely to effectively treat and cure patients with private insurance, due to the perception that an impoverished woman's cancer was less likely to be cured.<sup>173</sup> By physicians not acknowledging the presence of disease, a

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<sup>172</sup> Gregg, Jessica L. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ., 2003.

<sup>173</sup> Ibid.

woman's suffering becomes insignificant. Health providers working with patients of diverse socioeconomic and cultural backgrounds should have a greater understanding of burden of disease among women. All women deserve more effective strategies for prevention, treatment, and good quality care, regardless of insurance status.

The authoritative nature of doctor-patient relationships prevents women from sharing concerns and requesting assistance. For example, care during delivery is focused more on physicians who define the procedures used to regulate a woman's needs, as perceived by physicians, than on women's needs, as defined by the women themselves. Health professionals need to create an atmosphere for individual decision-making processes in health clinics. In the case of legal abortion in Brazil, women should receive high-quality care despite the contradicting beliefs and morals regarding abortion, demonstrated by physicians and policy makers. Health professionals should respect the autonomy and dignity of an individual in order to provide appropriate medical recommendations.

The Ministry of Health provides incentives for municipalities to implement a family health approach through the provision of financial support for family health teams working in underserved areas.<sup>174</sup> Specialized training in family health is entering university curriculum, but only as a result of this Ministry initiative rather than as a curricular requirement.<sup>175</sup> Training programs and discourse in medical schools should teach health professionals how to be more gender sensitive and culturally competent, since current attitudes are interfering with quality of service.

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<sup>174</sup> Atkinson et al. "Implementation of Promotion and Prevention Activities in Decentralized Health Systems: Comparative Case Studies from Chile and Brazil." *Health Promotion International* 20.2 (2005): 167-175.

<sup>175</sup> Ibid.

## **Policy and Program:**

An essential part to realizing the right to health is poverty reduction and promotion of gender equality. Public health policy agendas need to incorporate gender into health disparity analysis. Women's sexual and reproductive health policies should focus on access to a full range of high-quality services for family planning and prevention of HIV/AIDS and STD's. Policies should advocate equal entitlement to sexual and reproductive health rights in all sections of society. Social policies on education, social security, housing and income should be enhanced and include a gender-perspective that will allow women to directly benefit from policy reform. Programs that provide training to enable individuals to negotiate safe sexual practices should include male participants in the pursuit of sexual freedom for women free from coercion and violence. Campaigns can help modify social norms and gender inequality by working with men to challenge notions of masculinity and promote shared responsibility between men and women on birth control, sexual health, and child care. These campaigns should be directed towards adolescents, since for the majority of people, sexual activity is initiated during teenage years. It will be difficult to challenge existing beliefs among members of older generations who have been subjected to these norms throughout their lives.

Health interventions need to empower women economically and provide opportunities for financial stability. Young women, especially, appear to be ignored by governmental programs that currently focus on empowering young men through vocational training and job placement.<sup>176</sup> The few programs geared towards women tend

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<sup>176</sup> Chacham, Maia, Greco, and Silva. "Autonomy and Susceptibility to HIV/AIDS among Young Women Living in a Slum in Belo Horizonte, Brazil." *AIDS Care* 19.1: 12-22.

to reproduce traditional gender roles, by promoting jobs such as manicurist or nanny.<sup>177</sup> Being a young woman out of high school with no job prospects increase the chances of early pregnancy and marriage for financial stability. Poverty in Brazil makes it difficult to provide such opportunities. Educational programs and public forums need to empower women to feel confident in becoming financially independent and that financial security is possible without a man. Adolescents should also be exposed to sensitive programs that deal with equality, respect and human rights to counteract the mixed messages of gender expectations portrayed by parents, schools, and the media. Program and policy need to challenge the structural inequalities that contribute to the burden of disease for women.

The current abortion policies in Brazil are consistent with the political and cultural environment of sexuality, but not with citizenship and human rights.<sup>178</sup> Brazil is predominantly Catholic, the moral foundation for pro-life policies. Catholicism views abortion as evil and sinful, which can also influence development of policies and conduct of health professionals. Although guidelines related to legal abortion are improving care and proper training of providers, the problem remains in the legality of the procedure. Due to the amount of social and health implications of illegal abortions, the focus should turn away from moral perspectives and move towards a focus of sexual and reproductive health rights of women. Abortion rates are not lower in places where abortion is illegal, just more unsafe. Conservative laws will only be changed with public support, political activism, and separation of church and State. Public health programs and policy makers need to develop strategies to prevent unwanted pregnancies, unsafe abortions, abortion-

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<sup>177</sup> Ibid.

<sup>178</sup> The Population and Reproductive Health Program in Brazil: Lessons Learned. *The John D. and Catherine T. MacArthur Foundation*. 2003.

related deaths, and improve treatment of abortion complications.<sup>179</sup> The legal framework surrounding abortion should slowly move towards encompassing women's autonomy in reproductive decisions.

There needs to be an organizational strategy oriented around quality. Quality of care remains low despite increase in access to health services. Women's health initiatives need to increase awareness of the importance of doctor visits for issues other than pregnancy. More comprehensive and holistic reproductive health programs are needed, that integrate family planning services and STD/HIV/AIDS prevention, encompassing screening, diagnosis, treatment and psychological support in reproductive and sexual health. Integrating services is possible if investments are made to ensure connections and communication among various agencies and organizations dedicated to sexual and reproductive health and rights that currently have contradictory guidelines and priorities.

### **Civil Participation:**

The goal of achieving the highest attainable standards in health is possible with increased dialogue among national and municipal government and civil society. Participation and involvement of civil society in the process of improving public services has had positive outcomes. A study was conducted among the poor communities in Porto Alegre (Southern Brazil), which actively began to negotiate resources in the public sphere to improve health and living conditions. The city implemented participatory budget setting as the main government policy for defining where to allocate

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<sup>179</sup> Yanda, K., S.V. Smith, and A. Rosenfield. "Reproductive Health and Human Rights." *International Journal of Gynecology and Obstetrics* 82 (2003): 275-283.

investments.<sup>180</sup> The decision-making process begins by giving power over public resource allocation to forums elected at open neighborhood meetings. Participants decide the importance of investments in the context of local necessity and delegate them to representatives. The representatives elect a Municipal Budget Council, which finalizes the budget proposals with the local government and presents it to the city legislative council for approval.<sup>181</sup> This participatory process encourages informed debate and local control over implementation of decisions, allowing for distribution of power. The participation process empowered citizens to legitimize local interests and needs.

Participation empowers community members to question their living conditions and construct strategies to improve them. It is an avenue to denounce the political, economic, and social structures that contribute to inequality. The community is able to articulate views at different political levels, increasing political consciousness, social cohesion and trust among citizens. Social participation in decision-making processes will advance health outcomes by mobilizing individuals to assertively demand change.

### **Human Rights-Based Assessment:**

In order for governments to comply with international legal obligations mechanisms for assessing policies need to be created. A health impact assessment is a combination of procedures and mechanisms that evaluate the effects of a policy or program on the health of a population and how these are distributed within the population.<sup>182</sup> Specifically, a gender impact assessment would use gender-based

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<sup>180</sup> Jovchelovitch, Sandra, and Pedrinho A. Guareschi. "Participation, Health and the Development of Community Resources in Southern Brazil." *The Journal of Health Psychology* 9.2 (1994): 311-322.

<sup>181</sup> Ibid.

<sup>182</sup> Hunt, Paul and Gillian McNaughton. "Impact Assessments, Poverty, and Human Rights: A Case Study Using the Highest Attainable Standard of Health." Human Rights Centre, University of Essex, 2006,1-26.

measures to evaluate the proposed policy.<sup>183</sup> Governments which have ratified the International Covenant of Economic, Social and Cultural Rights, of which Brazil is one, can adopt impact assessments to progressively realize human rights by using the standards at all levels of policy formation.

Improvement in assessment, evaluation, and monitoring of policies is critical if Brazil wishes to achieve higher standards of health. A study analyzed how this evaluation process has been developed in the Family Medicine Unit of a public health service organization.<sup>184</sup> Users said they had not participated in any assessment process but that there was no need for it, because they expressed satisfaction. Yet, this does not mean the care received was of high quality because the existence of social inequality in communities results in low expectations of care. Indeed, it is difficult to assess health programs and initiatives in Brazil due to the bureaucratic organization of health care provision. The quality of policies within the community cannot be evaluated when members are grateful that health services are available at all. It is important to create mechanisms that effectively and accurately measure the quality of health care services to ensure accountability at all levels of management and processes. Health care provision and efficacy of programs should be evaluated using a gender framework, to guarantee successful efforts in the realization of women's right to health.

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<sup>183</sup> Ibid.

<sup>184</sup> Pereira Da Costa et al. "Right of the Citizen and Evaluation of Health Services: Theoretical-Practical Approaches." *Revista Latino-Americana De Enfermagem* 18.5 (2010): 1013-1019.

**Conclusion:**

Globalization has increased the transfer of capital, technology, and people. This transnational phenomenon has also increased social disparities in a time of increasing wealth. The diminishing investments in public sectors deprive the poor of opportunities for upward mobility and enhance the impact of structural violence already present in society. Consequently, the ability of States to deliver public health programs effectively is limited in a neo-liberal political economy context.<sup>185</sup>

Brazil's commitment to respecting, protecting, and fulfilling the right to health has resulted in notable improvements in the wellbeing of citizens. National public policies and programs have been able to address sexual and reproductive health issues and reduce mortality and morbidity rates, especially with HIV/AIDS. This progress does not outweigh the chronic social and gender inequalities that impede the ability of all citizens to exercise health rights. The inequalities in health and medical care are interconnected with the social relations, cultural environment, and institutional systems that shape the experience of illness.<sup>186</sup> The relationship of these dimensions illustrates how structural factors associated with economic development and poverty influence social and individual vulnerability.

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<sup>185</sup> Nguyen, Vinh-Kim, and Karine Peschard. "Anthropology, Inequality, and Disease: A Review." *Annual Review Anthropology* 32 (2003): 447-474.

<sup>186</sup> Vlassoff, Carol, and Lenore Manderson. "Incorporating Gender in the Anthropology of Infectious Diseases." *Tropical Medicine and International Health* 3.12 (1998): 1011-1019.

A successful sexual and reproductive health agenda is dependent on economic growth and redistribution of resources. There needs to be heightened awareness and understanding of how poverty and inequality are linked with sexual and reproductive health and human rights. Interventions should encourage autonomy and dialogue among women to challenge power relations and structural forces. The exclusion of vulnerable populations from the global economy will continue to worsen health statuses unless effective participation in the public sphere puts pressure on governments to transform social conditions.

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