

*Population Policies and Health:  
the Brazilian experience in reproductive health\**

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# Population Policies and Health: the Brazilian experience in reproductive health

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Population policy has been a very sensitive issue in Brazil for a long time. To most of us from the local population community, it used to mean a family planning approach to women's health, founded on the idea of an eminent demographic chaos in the country, mainly due to high fertility levels among the population.

Today, the scenario has changed. Fertility levels have dropped sharply and rapidly, contraception has reached a high prevalence level among all social strata. The treat of a population explosion lies in the past. Apparently, there is no more reasons for the old debate between neo-malthusian and critical demographers. At the same time, institutional agencies which used to place the idea of population control in the forefront of their programs have also calmed down, and a new discourse has emerged. Reproductive health has replaced the concept of family planning, encompassing a much broader scope within a more flexible framework. Politically, this change means, among other things, that there is more room for demanding from the public and private sector a more comprehensive approach to women's health in their policies and programs. It means also that programs limited to family planning actions have had to incorporate some other dimensions to keep going. Although some have simply adopted a rhetoric of reproductive health without dismissing the old demographic targets, their family planning actions have to be accompanied by at least some other concerns with the health of women.

The purpose of this paper is to review the ways by which these changes in policy orientations occurred in Brazil, focusing on the work led by feminist groups in the country. Observations will be made on the institutional developments of this new approach, as well as on some of the challenges and possibilities for turning the discourse into concrete health policies and programs.

## **Population policies and women's needs**

The controversy over the orientation of population policies in Latin America experienced a big change from the time feminist movements entered the debate. Contraception has been for long an arena of dispute since the beginning of this Century, an issue for the women's movement in the USA and Europe (Gordon, 1992). Nevertheless, to what concerns the developing world, we can say that both the medical and the family planning communities have taken the lead. Family planning was considered for the first group as a way for the betterment of health; and for the latter, as a way to secure social and economic welfare, both at the individual and at the society levels (Canesqui, 1981 and 1982; Rocha, 1986; Berquó, 1994).

Neo-Malthusian demographers, bilateral and multilateral agencies officials, and medical professionals worked hand by hand in designing policies and programs, both public and private, in order to promote a widest as possible acceptance and compliance to contraceptive methods, specially hormonal pills and IUDs. Most often than not, those policies and programs overlooked the target population for their family planning actions, making mute ears to complains from contraceptive users about unwanted side effects and discomfort apparently associated with the methods they had been using. Very often, a minor damage argument was utilized to justify the promotion of contraceptive use, since a large family or long years of childbearing would allegedly produce worse effects on women's health than the possible side effects of contraceptive methods.

Organized women in Brazil entered the scene in the late seventies. The family planning target population started to claim for their status of a "legitimate other" in the political debate. There were two fundamental arguments for their plead. One was that women themselves should be allowed to decide what and when to do. That is to say, women claimed the right to decide the number of children they want to bear, and of making an informed decision on which contraceptive method to adopt, should they decide to postpone or end childbearing. The other was that women should be taken by policy makers as a whole being, and not as mere reproductive bodies. Which means that contraception should be considered and acted upon in public policies in the context of women's integral health. Those two principles are the core of the feminist approach to population policies in Brazil, on the basis of which women have argued for changes in the ways medical professionals and family planning missionaries have dealt with contraception (Barroso, 1984, 1986a and 1986b; Berquó, 1982, 1986; Cardoso, 1983; CECF, 1986).

It is fair to say that feminist movement in Brazil has always fought for an universal access to health assistance, considered as one of the basic social rights. The background scenario is one of a poor health service, both in terms of

coverage and of quality. This is so even in areas traditionally included in health policies, such as maternal and child care. The betterment of health assistance to women is seen as dependent on a complete redefinition of the strategies of resource allocation in the public sector, and on the widening of the scope of its policies (Barroso, 1985; Berquó, 1995). The promotion of health for women within a more global conception was established in 1983, with the Programa de Assistência Integral à Saúde da Mulher - PAISM (Program for an Integral Assistance to Women's Health).

This ambitious national program was a result of negotiations led by the women's movement with governmental authorities and family planning providing agencies. Within this Program, special emphasis was given to participatory actions, to the promotion of health education, taking the needs of women at all stages of their life cycle as a framework for policy. Family planning was, for the first time, included in an official health program. The concept of PAISM would be later inscribed in the Brazilian Constitution of 1988. However, evaluations made in the 90's revealed that only a few provinces have actually started the operations defined by the Program. Unfortunately, the discourse of universality and of integrality did not come to a reality in health services in the public sector (Costa, 1992; Araújo and Sorrentino, 1994).

As a matter of fact, despite the progress of feminist struggle and of some success in affecting policy-making, data on the status of health among Brazilian women reveal a stalemate situation. In the context of a comparative study of several Latin American countries, Berquó calls attention to the narrowing of contraceptive options for Brazilian women. Between 1986 and 1991 in the Northeastern Region of Brazil, there has been an increase in female sterilization and a decrease in the use of hormonal pills. Also, women tend to get a surgical sterilization at younger ages, with a difference of 7 years between the average age at sterilization in 1986 and 1991. Brazil rates poor in other female health indicators as well, one of them being maternal mortality (Berquó, 1994).

The notion of Reproductive Health, as it has been proposed by the World Health Organization, brought new elements to the political arena. At some point in time, the notion of family planning has been apparently deleted, and reproductive health appeared as a substitute. For some, the change in vocabulary was needed as a matter of *aggiornamento*. The discourse of population explosion had to be adapted to meet the demands of women. But, for many engaged with a real advancement in women's health, the concept represents a step forward in the definition of a broader framework for family planning programs. Still limited, if we consider *reproductive* as a restrictive qualifier in the definition of the scope of health programs for women.

However, the WHO definition makes explicit references to the various stages of a person's life, calling attention to the health needs associated with female and

male reproductive systems from birth to death. This definition has been adopted by the International Conference of Population and Development held in Cairo in 1994, constituting the basis for the continuing struggle of women within the countries. One of the more important contributions of the international women's movement to the document issued at the Conference has been to place reproductive health in the context of reproductive rights. The definition proposed by WHO contained exactly the elements feminists groups needed to facilitate the agreement reached at Cairo.

### **Sexuality and the male**

Population policies and reproductive health policies have been generally geared towards women. Women have been also the political actors responsible for the displacement from an emphasis on demographic targets towards a concern with individual and social rights. Nevertheless, feminist critique did not question -- and if it did, its implications have been extremely limited -- the fact that modern contraception excluded the male from the debate. The notion about the rights of women over their bodies did not consider the fact that *it needs to be two to dance tango*. The advancements in technologically assisted reproduction did not change the scenario from this point of view. Even if we take into account technological improvements in reproduction, the disputes over the biological byproducts of artificially produced pregnancies show that men cannot be easily eliminated from the scene (Laqueur, 1992; Ruddick, 1992). However, politically reproduction continues to be a women's issue. And for many feminist groups it is difficult to accept the idea that men are legitimate others to be considered in the debate.

Nevertheless, there is one fact against which positions tend to become more flexible. It is possible to say that, in Brazil, HIV/AIDS epidemics has challenged established views, including the one which sees the promotion of women's health as something restricted to women. HIV/AIDS helped to place men under focus, and the so-called "male question" in the agenda of policy and research funding agencies. This change is based on a sound hypothesis about the paths of the epidemic, which are recognized to coincide in some way with the roads of male sexuality and associated gender systems. Thus, sexuality and gender find recently a new space within the policy discourse. But it is important to call attention to the fact that the introduction of sexuality in the agenda occurs because there is a treat of a mortal disease, and because there is enough evidence to challenge the former idea of HIV/AIDS as a disease restricted to some risk-groups.

To better evaluate the impact of HIV/AIDS, it is enough to think that the contra culture movement of the 60's has not very much affected the political and research agendas, although it has strongly placed into question sexuality and

helped to liberalize sexual behavior. It is also true that feminism, a movement which outgrows from previous waves of social change, while has fought for the legitimacy of women's control over their bodies, and questioned their manipulation by both family planning policies and medical doctors, did not result in placing sexuality at the core of the scientific agenda or into the portfolio of advanced research. The fear of HIV did it.

As a matter of fact, HIV/AIDS epidemic has the merit -- if we could say so -- to shake other established views as well. Because of AIDS, medical professionals had to look for help from human sciences in general, psychology and anthropology in particular. They realized they knew nothing about the way people practiced sexuality. Health, and more specifically, sexual health (no matter what does it mean) became a subject to which non medical professionals had legitimately something to contribute. Multidisciplinary groups emerged, helping to amplify the scope for reflections and for action. While some women's groups maintained their strategies of communicating exclusively with women on the basis of a strict definition of women's interests, academic and health professional women engaged with finding concrete alternatives to promote women's health giving the epidemic, tend increasingly to take men into account as part of the population to be targeted.

In fact, it is right to say there is already in Brazil a HIV/AIDS community, formed by a variety of professional and non professional individuals, both working in public health institutions and in NGOs. They are all strongly committed with lessening the damage for those who happen to carry HIV. They may act sometimes in a specialized way, in the sense that some groups select that or that other segment (i.e. gay community, professional sex workers, etc.) to promote their programs. Very often, though, men and women work side by side in the development of programs of support for any HIV positive or manifested AIDS male or female person.

One example of the complexities brought about by the epidemic is the articulation of contraception and prevention of STDs and AIDS in health policies. It may be argued that the concept of reproductive health has opened the way for a more integrate approach to health programs. This is true. But beyond theories and concepts, there are very concrete challenges. Some of them comes from the institutional trajectories of programs. It is not only a matter of how to develop a more positive approach to prevention of a disease, and of an unwanted pregnancy, without hindering a search for a freer sexual life. Those involved with the definition and implementation of health programs feel the challenge in their daily work. The institutional mechanisms responsible for priority definitions and resource allocation in contraception and in HIV/AIDS prevention do not communicate. They do in fact co-exist, responding to different professional and community demands and pressures. They form two different institutional circuits, which rarely intersect each other.

This articulation is still more complex if we think that modern approaches to contraception do not consider STDs and HIV prevention. The old condom, and now the female condom, are considered to be the only available practical alternatives for a safe sex. We all recognize a need to develop acceptable means of STDs prevention which use can be controlled by women. But there is also a need to develop strategies to reach men in an independent way and not only through their women partners. Male clientele may be less accessible to health actions since men constitute a minor part of health service patients. And despite the fact that condom use depends on the willingness of men to collaborate, contraceptive methods development did not address the issue of men's needs.

### **Concluding remarks**

To approach sexuality and to integrate men's perspectives in the discussion about reproductive health seem to be two important challenges to a feminist approach.

They constitute a difficult area for a consensus. And there is not a uniform position among those involved with women's health, not even among feminist oriented women's health groups. In fact, there are still strong resistance to establishing a partnership with men, specially on issues which have been symbolically and politically central to the advancement of feminism as a social movement.

In this context, it is important to mention the work of research funding agencies, specially those committed with supporting policy-oriented research. Taking a critical position, there are obviously aspects which deserve attention, mainly their efficacy in orienting research energies towards an agenda defined outside the scientific community, the proposition of theoretical approaches which also come from non scientific needs. These are very complex issues which cannot be fully discussed here.

I would like though to call attention to the fact that these "external" demands, demands which come from designing policy approaches to health, are pushing hard in a direction which, in a way, corresponds to some theoretical developments in gender studies. There is an increasing academic interest on what some refer to as men's studies. There are some discussion among feminist oriented social scientists on the need and the ways to build a more consistent and relational gender approach, which involves to consider the male side. There are signs that a complete reformulating of ours views about strategies of promoting health for all will have to come soon.

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