Institute of
Social Studies

FROM PAISM (PROGRAMME OF INTEGRAL ASSISTANCE ON WOMEN'S HEALTH) TO CAIRO: THE RELATION BETWEEN THE STATE AND THE WOMEN'S MOVEMENT IN BRAZIL

A Research Paper presented by

Lenise Santana Borges

(Brazil)

In Partial Fulfilment of the Requirements for Obtaining the Degree of

MASTER OF ARTS IN WOMEN AND DEVELOPMENT

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Members of the Examining Committee

Dr. I. van Halsema
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TABLE OF CONTENTS

Chapter 1

1.1 Introduction:

The Brazilian women's movement began asserting its political presence by the early 1980s, when the more liberal Brazilian regime endorsed the declaration of the UN Women's Decade. This made it possible for women who had been concerned with gender inequality in Brazilian society to organize publicly for the first time. A more flexible political environment allowed for a wider range of issues and perspectives with women providing the gender perspective to the struggle against the military regime (Alvarez 1990:83). One consequence of the organized and articulated feminist lobbying is the achievements reached in the drafting of the 1988 Federal Constitution, which recognizes rights such as (to name a few): female rural workers' rights to welfare benefits, four-month maternity leave and five-day paternity leave, equal pay for equal work, social security for domestic workers, family planning as a constitutional right, and land rights for women, irrespective of their marital status etc.

Within the Brazilian women's movement, the women's health movement has been actively working on issues related to women's health such as reproductive health-rights and sexuality, and has become an active and respected player in policy-making both at the national and international level (Barroso 1995). The position held by the Brazilian government at the Cairo Population and Development International Conference in 1994 was strongly in favor of women's reproductive rights, the need of sexual education for adolescents and a flexible vision in relation to the concept of family and can be attributed to the acknowledgment of the importance and expertise of this large and strong movement. However, this development has to be contextualised in the long history of struggle between the women's movement and the state. Despite the undeniable fact that the women's movement has transformed and influenced state policies on the discourse level, these political gains in the area of

reproductive health-rights have not been materialized into a process of implementation and accountability for the majority of women.

1.2 Statement of the problem:

Although the Brazilian Constitution (1988) recognizes the women's right to plan and manage their fertility and to have access to efficient health services, the women's movement has not been effective in translating at the level of policy implementation the political gains achieved in the level of policy formulation regarding the issue of fertility control. My own experience both as a feminist and a health worker with PAISM (Program of Integral Assistance on Women's Health) created in 1983 has shown me how the feminist perspective embedded in the PAISM is not enough to guarantee its implementation. The situation in state of Goias, where the program was first implemented, illustrates the gaps between these goals and real achievements in the field of sexual reproductive health and rights policies. The Goias Constitution stipulates that the state should guarantee integral assistance for women in all phases of their lives, including the right to maternity, pre-natal assistance, to delivery and post-partum, through programs developed, implemented and controlled by the participation of representative women's organization. Despite this, Goias has not been able to provide these guaranteed services in the majority of the hospitals and health centers in its system.

1.3 Locating myself within the discussion:

My entrance to feminism was through sexuality which is interwoven with the issue of fertility control. I did not find a conducive space to clarify these doubts and address my concerns on the issue, although I was encouraged by the discovery that this was not only my interest. The sexuality workshops in an International Feminist Meeting in Bertioga and a course on sexuality provided by a Brazilian research institution called "Fundacao Carlos Chagas", represented for me an opportunity to reflect on this issue.

Through my work and activism I have observed that this is an important subject for many women too.

I have been following the evolution of the debates surrounding reproductive health and rights and directly involved in its implementation due to my work at the Health Secretary in Goias since 1984. Simultaneously I have also been involved in imparting gender training to health professionals, creating educational material, and participated in a project aimed at public school teachers called 'Sexual Education - A Non Sexist Approach' as part of my work since 1987 as a feminist in a women's group in Goiania called "Grupo Transas do Corpo - Acoes Educativas em Saude e Sexualidade" of which I am a founding member. The formation of "Transas do Corpo" is partly related to the frustration and dissatisfaction felt at the state health secretariat, which was strongly affected by structural adjustment policies, resulting in cuts in its budget and leading to the privatization of health services. We were also motivated by the desire to work in an organization which provided us mobility, freedom to decide with who, what and how we were going to approach an issue, and a space for ourselves to discuss our own problems within a feminist perspective and practice.

My need to understand the complex relation between the women's movement and the state, probably is driven by my desire that the state acts as a real provider of services which does not treat women merely as reproducers, but as one which places women at the center of health and sexual concerns.

I am aware that the contributions of feminist academics and activists working in this area are enormous. My aim is to determine the factors that made it possible for the women's movement to achieve the transformation of the discourses around the issue of reproductive health and rights, but also to analyze the main reasons for the lack of implementation, by considering the

following research questions.

1.4 Research Question:

What are the dynamics that explain the difficulties faced by the Women's Brazilian Movement to transform the political gains in the area of reproductive health-rights into effective policies?

Sub research questions:
a- What discourses surround the issue of fertility control?
b- What was the performance of the Brazilian Women's Movement in the area of Reproductive Rights from 1983 to 1995, both in relation to the state and civil society?
c- What strategies were used by the Women's Movement to influence reproductive health and rights policies in Brazil?

1.5 Methodology and Organization of the Paper:

Answering this research question first requires an understanding of the main concepts derived from the two approaches along with a critical examination of their limits and potentialities (Chapter 2). Two approaches - the women centred and the population control approach - provide the basis of an analysis of women's needs and interests. These approaches are also critically discussed in terms of their main concepts, their limits and potentialities. I will argue that Brazilian policies related to fertility control can be used to comprehend the broader issue of women's fertility control, including how it is theorized and practiced.

But these approaches do not exist in a vacuum; they exist under specific contexts and are addressed by specific social actors. In the case of Brazil I will argue that in the context of the shift in the regime - from military to democracy - two social actors - the women's movement (mainly the health women's movement) and the state - played a central role on shaping the concept of fertility control, with the catholic church and the population control lobby playing a peripheral role. There are many theories which address

the relation between state and civil society. However, it is beyond the scope of this research to go into these theories in depth. Instead of theorizing about civil society and state I will introduce these two concepts in Chapter 3 as tools to analyze how the Brazilian state dealt with the issue of fertility control vis a vis the women's movement in the context of a shift in the political regime. I will focus on the field of policy formulation, utilizing the concepts dealt in Chapter 2, to look at the state's health policies related to fertility control. I will also review the strategies used by the women's movement pressing the state for a more women centered perspective on health issues.

In Chapter 4 I will move to the field of implementation of health policies, looking specifically to health policies which places women's well being as central to its conceptualization. The PAISM in its objectives is an example of an program, containing the specific attention of reproductive health-rights and sexuality elaborated in the previous chapters. The case study will illustrate the gap between the policy formulation stage and the actual practice of fertility control policies in Brazil, highlighting different factors which contributed to the lack of operationalization. As it is an exploratory study, the methodology chosen in not oriented toward gathering and testing data, but rather is meant to serve as an initial study to reflect on the actual implementation of PAISM in Goiania. More details about the methodology itself will be addressed in Chapter 4. At this stage I wish to point out the unavailability of sufficient data on PAISM. The problematic areas were related to quantitative date such as resource allocation, number of health services providing the program, number of PAISM routines performed by the health providers. This has restricted a quantitative evaluation of the program in Goiania. Despite these limitations, qualitative indicators such as the content of the trainings can be used as crucial indicators to assess the actual state of the services being provided by PAISM. The trainings are one of the important enabling

factors for the implementation of PAISM, which I believe will enrich the debate invalidating all other considerations.

1.6 The scope and limitations of the study:

This study intends to be an exploratory one, which seeks to analyze the diverse factors influential in the making of health policies in Brazil, focusing on the formulation and implementation of reproductive health and rights policies. This is a paper where there will be no final answer for the problem I am willing to analyze. There will be factors that will be covered, but it will be limited because of the complexity of the subject and also given the limitations of the research context and duration. This research does not cover aspects related to the structure of the health system in Brazil and its organization. The case study (Chapter 4) will be restricted to the metropolitan area of Goiania, and, although, quantitative data on the PAISM in Goiania is limited I believe that this work will contribute to fill the gap between the achievements in terms of discourse and the implementation of services in the area of reproductive health-rights and enhance my future contributions in this area.

Chapter 2

Fertility control: Approaches and Concepts

2.1 Introduction:

This last decade has been marked by heated debates related to the issue of fertility control. The arena within which these debates occur, is acknowledged as the place where diverse approaches such as the women centred approach, the population control approach, and approaches of the state, the women's movement, church etc., have been influencing and shaping the meaning of fertility control. Due to the limit of this paper my analysis is focussed on the perspectives presented by two approaches - the population control and the women centred - about women's fertility. This chapter will analyze the discourses[1] underlying each approach and the actions derived from them regarding the issue of fertility control. It provides an overview of the main concepts, how they have evolved in the last two decades, and how the ideas underlying each approach are linked to distinct perspectives about women's fertility, leading to different practices and policies related to fertility control.

The two approaches are largely responsible for shaping concepts in this field such as family planning, reproductive rights, reproductive health and reproductive health and rights which I will also elaborate. The conceptualization of these terms will form the basic foundation for my analysis, helping me to uncover the perspective embedded in the Brazilian policies related to fertility control. Ultimately in discussing the limits of each concept I will evolve a more holistic approach regarding the issue of fertility

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[1]Discourse: The term developed by Foucault stress that discourse is not a language or a text but a historically, socially and institutionally specific structure of statements, terms, categories, and beliefs. According to Foucault discourse transcends language and pervades through institutions and organizations, all of which constitute a body of knowledge which compete with one another for authority and legitimation (Scott 1988:35).

control. The state and the women's movement as relevant social actors involved in this debate will be addressed more in depth in Chapter 3. The approaches and the actors presented respectively in Chapters 2 and 3 will form the basis to understand the difficulties faced by the women's movement in transforming the political gains in the area of reproductive health-rights into effective polices. My standpoint is embedded in a feminist perspective which acknowledges women's rights and needs not just as mothers, but emphasizes the need of women's autonomy in terms of reproduction and sexuality.

Traditionally the two approaches - women centred and population control - present distinct understandings and practices about women's fertility. The population control ideologues advocate state intervention to regulate women's fertility as a strategy to foster development. On the other hand those who advocate a women centred approach differ in emphasizing women's own needs on sexuality, reproduction, and inequalities in power as central to discussions of fertility control. The latter approach presents a strong critique of "states and markets attempts to use science and technology to control women's bodies, and challenges the economic and demographic theories used to justify population policies that are harmful to women" (Correa 1994:4).

Another striking difference between the two approaches is in how they perceive the interconnections between population growth and development, and the respective policies that are undertaken in response to these perceptions. The women centred approach may be indifferent to the population question and sees no connection between population growth and development. Its emphasis lies rather in the need to protect women against population control intervention which instrumentalise women to reach population demographic goals. The theoretical dispute consists of whether there is a population problem, and if so, what is its nature? (Mandami 1972, Simon 1981, Demeney 1988, World Bank 1984, Harrison

1992, Cassen 1994). The controversy over population issues is not entirely solved and the debate is still the order of the day as we will see from the forthcoming discussion.

2.2 The Population Control approach:

The population control approach is based on the premise that the major development problem is the current growth rate of world population and proposes as a solution implementation of programs to reduce the birth rate. In order to achieve this aim, the strategies prescribed may include coercion and manipulation, financial incentives and disincentives, forced sterilization and abortion, etc... (Warwick 1990:21, Correa&Petchesky 1994:3).

The population control approach works upon the assumption that overpopulation is the cause of poverty. Malthus was the first to make the interconnection between population growth and development. He argued that if population was not restrained it would outpace the growth in food supplies, resulting in starvation, illness and death. Although he later revised his theories, his earlier writings were influential, eventually giving rise to neo Malthusian population control ideas according to which population growth should be curbed through artificial methods of fertility control, with specific attention to the poor, to achieve development and progress (Cassen 1994:1, Correa&Petchesky1994:10).

Until the World Population Conference of Bucharest (1974) the definition supported by U.S. demographers was that "rapid population growth creates strong barriers to economic development" (Leibenstein 1954; Coale and Hoover 1958 cited in Warwick 1990:21).The solution proposed by them was family planning services (provision of artificial contraception) as the only strategy to reduce fertility. As Warwick points out "this view became a form of intellectual orthodoxy within the United States and was promoted by donor agencies such as the Population Council, the Agency for International Development, and the World Bank" (Warwick 1982 ch.4

cited in Warwick 1990:22).

The priority for the United Nations (Population Division) is essentially family planning, demonstrated in one of their writings as "Whereas such factors as age at marriage, breast-feeding and induced abortion play significant but minor roles in influencing fertility and population growth, family planning programs are one of the most important determinants of fertility levels and trends, hence of population growth" (United Nations 1993:30). Instead of family planning being a component of a health program it becomes the entire objective of the program, reducing women's needs only to services around pregnancy, excluding other health services.

As regards fertility control the fundamental goal of the population control approach is to contain population growth. It advocates reduction of fertility rates particularly of certain groups (poor and minority populations) not taking into consideration women's specific needs and interests. It is certainly not interested in developing individual women to control their own fertility or sexuality. On the contrary the control is exercised from a external agency, whether national governments, church, international agencies etc... . This perspective has resulted in policies which are anti-natalist or pro-natalist (mainly anti) depending on the economic or political interest involved (Berer 1993:7).

Another characteristic of this approach is that it has little to say about women's sexuality, emphasizing only women's responsibility on reproduction. Women are treated as ignorant breeders, with no control over their sexual desires, while men are dismissed on being a active participant on the same issue. But why is sexuality important for the discussion about fertility control? First because it is an important issue where power inequalities between men and women prevail. As Elvira Lutz (an Uruguaian feminist) states: "the expression of sexuality in our societies is the mirror in which women's subordinate status is most

reflected" (Lutz cited in Berer 1993:10). The continued silence on sexuality makes it fertile ground for prejudice and guilt. Sexuality is viewed under the assumption that all women are heterosexual. Women who do not fit into these sexual norms (divorced, unmarried, prostitutes, lesbians) are marginalized and their particular needs are neglected[2].

In the population control approach, sexuality is legitimate only as an instrument of fertility and does not exist independent of it. By not addressing sexuality, and refusing to separate it from women's reproduction, procreation becomes synonymous with women's sexuality. The silence around women's sexuality acts as a powerful weapon which alienates women from themselves and makes them susceptible to control. My own view is that subsuming sexuality under procreation, women's knowledge about their own body is marginalized transforming it into a technical and forbidden issue, subjected only to the scrutiny of experts. In the population control approach there is no interest in changing inequalities between men and women, classes or races, on the contrary it aims to preserve the existing order, its hierarchies and its inequalities (Barbieri 1993:87).

In the arena surrounding the population control debate the following actors have to be addressed: the population control establishment, which includes demographers, population agencies, and most recently environmentalists; the women's movement mainly

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[2] Teresita Barbieri provides interesting insights on this issue, in her paper on gender and sexuality within population policies (Gender and Population Policies: Some Reflections, Reproductive Health Matters, No.1, May, 1993:89)

For example a lesbian woman may desire a child but she may have questions very particular to her sexual orientation. The population control approach in designing its program, does not accommodate these elements.

represented by the women's health movement, and the church followed by its allies, with their strong opposition to artificial contraceptives methods, abortion, or sexual education. The population control agents treats women's bodies as means to reduce the number of births, in which women do not have a say. They are seen as baby producers who should be grateful for the provision of artificial contraceptive methods.

Concerning to population control issue the Church has always presented a complicated attitude. It has always voiced a consistent and outspoken opposition to artificial contraception. It condemns any kind of outside intervention such as proposed by the population control approach. But on the other hand, it opposes women's rights to decide about their own fertility, negating the possibility of women as agents. Their opposition has its grounds on the premise that decisions cannot be taken by women outside the family framework. It is considered immorality to separate sexual intercourse from procreation. They are against women's control over their sexuality and fertility, as means to maintain the "order" of the family. The church views women only as asexual passive reproducers and guardians of the family. The church's desires to maintain ignorance of women about their sexuality, so they will be easily subjected to patriarchal control. They consider all artificial contraceptive methods unacceptable, and endorse only the natural ones. Therefore, the church's attitude can be considered very much alike the population control attitude: anti woman self determination.

The women's health movement advocates women's control over sexuality and fertility, supporting women's autonomy and self determination within a broader agenda in terms of sustainable and human development.

Although there has been a change in the population control discourse, conferring more emphasis on women's needs, even using

terms like women's empowerment in their proposals, it is more to serve their own agendas than from being a women centered perspective.

2.3 The Women Centred Approach:

The women centred approach as the name implies places women at the center of health, fertility and sexual concerns. It looks at women's experiences, values, issues, and information from the point of view of women whose lives are affected. In terms of fertility control it means that this approach acknowledges that as women are most affected by decisions on having or not having children, these decisions should be made independent of political, economic or population considerations. It stresses women's autonomy and decision making and is very critical about family planning programs which are meant only to lower fertility rates without taking into consideration the safety of the methods. Most of all it takes into account the inequalities of power between men and women, stressing the need to alter these social inequalities (Berer 1993:5).

The women centred approach challenges the church and other fundamentalist forces view of the family as a natural unit. It proposes women's rights to self determination on their sexual and health needs, and that women's rights should be treated as human rights. Additional to that, knowledge about sexuality is viewed as an important element to empower women which can not be dissociated from their health needs. So this approach goes much different than the population control.

The concept of empowerment plays a crucial role in this approach. It implies that women are active agents, not passive objects in terms of reproductive decisions. It supports the idea that women need to change their status in society, becoming powerful in terms of control over resources, knowledge and decision making not only as individuals but as a collective. So, the women centred approach interest is not only to prevent abuses from the population control

programs, but its agenda is also to empower women so that they can make informed decisions about fertility, childbearing, child-rearing, gynecological health, and sexual activity as well as to their public lives (Batliwala 1994:129-132).

Southern and Northern feminist support this approach. They advocate the right to choose, i.e. women's right to decide whether, when, and how to have children. They emphasize that in order to exercise this right women should have the power to make decisions about their reproductive and sexual life along with resources to carry out these decisions safely and effectively. They understand that the right to decide is inseparable from transforming the economic and gender inequities of societies, which determine the conditions that constrain women's reproductive and sexual decisions (Correa&Petchesky 1994:5).

There is no doubt that the women centred approach integrates fundamental aspects such as fertility control, sexuality, power inequalities, social inequalities, knowledge, etc., in its debate. It stimulates women's voices and power, not forgetting the need to alter social relations and inequalities. Although the discourse and the language of this approach is very challenging, the manner in which the approach can be operationalized has received little attention. The ideology within this approach is very threatening for conservative structures like the State and the Church. When women rights are claimed as a human right within policies, and power starts to be questioned, these structures react strongly obstructing any attempt in this direction. My concern about this integrated approach is the lack of clarity on how changes in women's position in society can be accomplished and not remain at the level of utopia.

Many women's health groups advocate the theory that the core of the world's problems is not centred around population growth, although they recognize that high fertility is a serious problem for women.

They identify poverty as the crux of the problem and advocate that the elimination of poverty would automatically lead to reduction in population growth (Berer 1993:5). Adherents of this view perceive population growth as a structural problem as opposed to placing the onus on women to solve the population problem.

Women's Groups mainly from the South have repeatedly sustained that the implied correlation between growth, poverty and environment is far too simplistic. They argue that inequitable distribution of resources is the major problem, and that we can not look at the underdevelopment of countries in the south without looking at the overdevelopment of the countries in the north. As Correa&Petchesky have written, "Exploitative economic systems, militarism, displacement of peasants and indigenous peoples by urbanization and agribusiness, and the vastly disproportionate consumption by Northern industrialized countries of the earth's resources most assuredly play a bigger role in wreaking environmental and economic havoc in the South than do population growth rates" (Correa&Petchesky 1994:2).

Feminists have been working intensively trying not only to be critical, but also to influence the population control approach and their limited view about family planning about the urgent need of policies based on women's rights, needs, and interests (Hartmann 1993:2). They have been confronting the Population Control agents, the Vatican and its allies on their naturalized view about family and sexuality arguing that these concepts are socially constructed, therefore susceptible to changes (Correa and Petchesky 1994:16).

2.4 The two approaches in the international context:

During the last two decades these two positions were strongly present at the World Population Conferences. In 1974, at the Bucharest Conference most governments in the developing world argued that the reasons of the development problem was not high fertility, but poverty and the inequitable distribution of

resources between North and South, reacting strongly against the Northern Governments position that family planning should be the primary means to achieve population control. In 1984 at the Mexico World Population Conference, the same countries which supported this position were then arguing that family planning should be an important part of any development program (Godfrey 1990, Sen&Germain&Chen 1994, Cassen 1994). In 1994 at the Cairo International Conference on Population and Development the debate was at stake again with the population control establishment predicting a global economic and environmental disaster if population growth was not drastically curbed, and on the other side the Vatican and its allies arguing emphatically against abortion, artificial contraception, and all forms of sexual behavior outside their dogmas (Correa&Petchesky 1994:1). At the Cairo Conference the women's movement achieved an enormous step. It was able to convey a message through the Cairo Conference Official document very much in tune with the ideas contained within the women centered approach. Concepts addressed in this document such as women's empowerment, universal access to contraception and comprehensive reproduction health services, reproductive and sexual rights, became internationally known, being adopted by 170 countries. The next stop of this unterminated debate is Beijing (September 95), where the 4th World Conference on Women was held[3].

2.5 Main Concepts: Definitions and Limits

As I already mentioned there are different approaches which address the issue of fertility control. Over the last two decades concepts like family planning, reproductive rights, reproductive health, and sexual reproductive health and rights were part of the main discourses around the issue of fertility control. In the 1970s the concept adopted by the women's movement was family planning to

[3]Unfortunately the results from the Beijing World Conference on women could not be included in this research due to the restriction of time.

distinguish it from population control used by their representatives. The concepts of reproductive rights, reproductive health and sexual reproductive health and rights are more recent (1980s, 1990s) and evolved as a response to the use of the concept of family planning as an instrument for controlling women's sexual and reproductive lives. It also aimed to integrate other aspects of women's lives to the issue of women's health and reproduction. An interesting factor in all these diverse debates is that they derived impetus from the women's movement emphasis for greater autonomy for women.

The concept of Family Planning:

The concept of Family Planning as opposed to natural fertility is based on artificial means to regulate it. Consequently, family planning policy refers to a population policy which attempts to provide means to reach fertility control. Family planning services provide the availability of contraception for couples to regulate reproduction - a need-orientation. But it also can be used as a means to reach demographic goals which can include coercion and persuasion, financial incentive and disincentive, pressures on individuals, couples, etc.. - fertility control orientation (Hardon 1993:1, Warwick 1990, Keysers 1989). So, the term Family Planning has a different meaning depending on which perspective (population control or women centered) and in which context it is being used. Family planning specially in developing countries aims to reduce population growth and is generally funded by international donors (Hardon 1993, Demeny 1988).

Some critiques on how family planning is conceptualized within the population control approach:

Family Planning services are mainly meant to be targeted at women. Men are rarely called upon to control their fertility. The prevailing idea is that women should take care of fertility control, it is their responsibility and they should not interfere with men's sexuality. Men are not included as co-participant in the

reproduction role, leaving all the burden to women.

Sexuality within family planning practice is not addressed. The language of family planning is entirely desexualized, reinforcing the prevailing assumption that there is no sexual action, or sexual beings involved in decision of having or not children. Women are treated in this approach which is based on numbers, graphics, projections, as merely figures, which makes it very technical and with very little human content to it (Demeney 1988).

Family planning programs concentrate their actions on married, fertile women in their reproductive years, leaving women from other ages unassisted. The term family planning implies decision within families, neglecting those who do not fit into this system, leaving them without information and services. Moreover its emphasis on fertility control neglects other health needs like STDs prevention, AIDs, sexual education, and access to safe abortion.

Usually family planning programs are elaborated abroad by international agencies and implemented in a vertical and target-oriented manner, not taking into account the diverse cultural population which affects the level of acceptance of the services (Hardon 1993, Sen 1994, Berger 1993). Another concern is its abusive feature of the programs and the careless attitude with respect to the safety of the methods propagated - Norplant, Anti-Pregnancy Vaccines, etc... (Hardon:1992)

The Concept of Reproductive Rights

According to Correa, the International Campaign on Abortion, Sterilization and Contraception founded in Europe in 1978 might have been the first to formalize a concept that many women's organizations around the world had come to designate as reproductive rights, which was defined as: "women's right to decide whether, when and how to have children - regardless of nationality, class, religion, disability, sexuality or marital status. Later

the definition evolved to a more holistic approach including social, economic and political conditions that make such decisions possible" (Correa 1994:61).

The definition of Reproductive Rights according to WGNRR[4] "include full information about sexuality; reproduction; and the benefits and risks of drugs, devices, medical treatments, and interventions. They also include good-quality comprehensive reproductive health services that meet women's needs; safe, effective contraception and sterilization; safe, legal abortion, safe pregnancy and childbirth; prevention of and safe, effective treatment for the causes of infertility; and freedom from "population policies and social codes that pressure some women to have children and others not to" (cited in Moreno&Claro 1994:58).

The limits and some concerns about the concept:
The concept of reproductive rights has been questioned particularly because of the term 'rights', and the legalist and western nature of its origins. The emphasis on issues like contraception, abortion, infertility, have also been under attack because it reinforces the view of women only as child bearers, not allowing space for other women's needs. The abstract nature of the rights language tends to dehumanize and desexualize the issue of reproductive rights, negating the subject - women, who belong to a specific environment with needs that go far beyond the reproductive role.

In terms of decision making the discourse of rights also assumes that decisions are made in a vacuum which is not true. Reproductive rights can not be isolated from larger social conditions - which are the multiple social, economic and cultural conditions framing a women's decision about whether to have or not have a child or her sexual life (Correa and Petchesky 1993:109-112).

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[4]WGNRR-Women's Global Network for Reproductive Rights.

Another limitation about the term reproductive rights is that it does not encompass aspects related to health such as sexually transmitted diseases, for example AIDS. In addition to that it also fails to address the aspects related to sexuality[5].

All of these limitations do not imply abandoning the rights discourse, but that it should be more inclusive and incorporate other spheres related to reproduction such as health, sexual and social needs. Correa and Petchesky (1994:109-120) make a very elaborated critique on the discourse of rights in the context of reproduction. They call for radical redefinition of the classical liberal rights model. According to them the discourse fails due to its indeterminate language, its individual bias, its presumption of universality, and its dichotomization of 'public' and 'private'. Despite the limits of the rights discourse they call for a more integrated concept which includes rights, health and development.

It is important to note that the concept of reproductive rights has no universal meaning, and varies considerably both in its conceptions as well as practices from one country to another. The scope varies from a very narrow focus on fertility control to address broader issues such as reproductive health and sexuality or even enabling conditions (economical, political and social) to fulfill reproductive rights. It's scope allows it to be adopted by religious fundamentalists as well as proponents of human rights in general. It also has been coopted by the population establishment whose primary concern is neither women's health nor their empowerment (Correa&Petchesky 1994:107).

The Concept of Reproductive Health:

Reproductive Health had its origin in the broad agenda of the

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[5]Although this is a general critique, the definition of the concept of reproductive rights presented by WGNRR does include the aspect of sexuality.

Women's movement from the South represented by the Women's health movement. The women's health movement has been working on redefining the narrow understanding that view women as means to an ends of fertility control and child health, therefore concentrating their actions towards maternal and child health. They have been very critical of narrow family planning programs aimed at fertility reduction through delivery of modern contraceptives and sterilization for married women. These interventions target and control women undermines women's ability to make their own decisions, subordinating them to top down external programs (Claro&Moreno 1994:47).

Another major concern is with the medicalization of women's bodies, used as targets to limit or increase population growth. The chief complaint is that women's agency is ignored; their multiple reproductive health needs are neglected and to add insult to injury the services are poor. It also emphasizes the necessity of empowering women to achieve reproductive health (Sen&Germain&Chen 1994:8-9).

From the foregoing discussion we may conclude that in principle Reproductive Health refers to women's needs not only as child bearers but includes complete information about sexuality, reproduction (either aiming to avoid pregnancies or to have them), accompanied by good quality comprehensive reproductive health services which means effective and safe services to procreate and to exercise contraception, safe abortion, as well as other needs (Sexual Transmitted Diseases, violence against women, sex education, etc...). It also stresses the necessity to include programs to encourage male responsibility for fertility regulation, disease prevention, and child-rearing and to include women of all ages. Another priority is to include representatives of women serving in all levels and aspects of decision making (Germain& Norwrojee&Pyne 1994:29). The proposal to achieve reproductive health is through the comprehensive reproductive and sexual health

services for women.

Some reservations about the concept of Reproductive Health:
The rational of reproductive health sometimes makes explicit reference to women's health needs and forgets the dimension of rights, fundamental to achieve a healthy life. In addition, issues of sexuality and gender power relationships have not been addressed as central to reproductive rights nor health. If health is understood as a human right, reproductive health is also inalienable and inseparable form basic rights such as the right to food, shelter, health, security, livelihood, education, and political empowerment. This argument was made apparent in an excerpt from the declaration produced in the Reproductive Health and Justice: International Women's Health Conference for Cairo '94, which states that "Better health services are one element of women's rights" (cited in Correa 1994:66). In my view the major problem with this concept is that it can be used primarily as provision of contraception and other health needs. The risk implied on this narrow application is that by not addressing women's rights it does not challenge power structures, not contributing for women's autonomy and enhancement. It becomes just a program based on health technicalities.

Sexual Reproductive Health and Rights:
The dilemma posited by these two previous approaches is that they can not be addressed in a dissociated form. It is crucial to develop an approach where there is no separation of the two concepts (health and rights) and so they are integrated. As Correa reminds us (1994:68-73) there are issues such as abortion and AIDS which are placed in this intersection of this two rationales which makes them rights and health issues.

The framework developed by DAWN (Development Alternatives with Women for a New Era), views reproductive health as inseparable from women's human rights. According to Correa it

> "incorporates attention to women's economically productive and cultural roles in addition to their biological reproductive functions. And in the biological context, DAWN's definition of reproductive health services includes not only access to contraceptive information and methods and legal abortion, but also STD and cancer prevention, prenatal care and mental health services, all within the context of comprehensive preventive health services. A further element of the DAWN perspective on reproductive health is respect for traditional health knowledge, much of which is gradually being destroyed by imposed medical technologies" (Correa 1994:58).

Another aspect defended by these researches is the inclusion of sexuality and gender issues in the context of the services. I believe that what is important for a more integrated framework is this holistic perspective which takes into account fundamental dimensions such as sexuality, rights and health of peoples's lives. The women's health movement has been working hard on pressuring the population control establishment to acknowledge this holistic framework. A successful example of this acknowledgement is the final document produced at the Cairo International Conference of Population and Development (1994) integrating health, rights and development agendas (Correa 1994:67).

2.6 Concepts as elements of particular discourses:

In the terrain of concepts we have to be aware of the multiple and sometimes contradictory perspectives on concepts above discussed and make the linkages with the social actors in question.

The great challenge when we discuss concepts is that they belong to the slippery terrain of language which means that they are not absolute, i.e., they are susceptible to shifts in their meaning. They can vary depending on history, period, location, and the protagonist who is addressing the concept. The concepts reflect the conditions in which they were produced and if one wants to understand a concept, the specific context in which it was produced should also be taken into account.

The theory of Poststructuralism is the one where we find some elements to understand this discursive field. Foucault shows that there is an implicit relation between power and knowledge. Using the concept of discourse he provides us with a useful tool of analysis specially regarding what constitute the terrain of construction of social meanings. According to Scott, "Foucault suggests that the elaboration of meanings involves conflict and power, that meanings are locally contested within discursive 'fields of force'" (Scott 1988:35). The insights brought by this theory are very helpful to analyze the discourses that shape the field of fertility control.

One of the struggles that the women's movement has imbibed is related to the reinterpretation of the concept of family planning (discursive field) mentioned earlier. It is undeniable that there have been enormous shifts in the discourse, reflecting changes in fertility control policy and practice due to the dynamic interaction and negotiation between the women's movement and the population control field. However, the impact of the shifts on the discourse have been put into question by a part of the women's movement which views with suspicion the appropriation of reproductive rights and health language by the population control establishment (Hartmann 1993:2).

As Hartmann points out "on public platforms spokes people of the population lobby are sounding more feminist than ever, embracing reproductive health as an important concern" (Hartmann 1993:2). She is concerned about the fact that it is almost impossible to differentiate between the women's health movement and the population control agencies discourses.

In my opinion, the actual challenge goes beyond the language discussion it refers to the ability in translating the framework of Sexual Reproductive Rights and Health into policies which are derived from the concerns and priorities of women and not as merely

means to achieve population control purposes. The ability that feminist have acquired to negotiate with the population agencies both in international and national level is strongly dependent on political conditions (Correa 1994:63). The political terrain where policies are made, implemented, changed and how political systems affect the outcome of polices will be the focus of chapters 3 and 4, with a focus in Brazil.

Chapter 3

Reassessing the relationship between the Brazilian Women's movement and the State - from an authoritarian to a more democratic regime

3.1 Introduction:

In this chapter I will deal with the role played by the Brazilian state and the women's movement in the context of redemocratization in Brazil. I address the issue of women's fertility control. In the first part of the chapter I will discuss the population policies addressed by the state. While the second part will focus on how the women's movement evolved within this political transition and how it redefined its relation with the state. The third part will consist specifically on the strategies developed by the women's movement towards influencing the state for a sexual reproductive health and rights approach.

Both the State and the Women's Movement have a major role in shaping reproductive health and rights policies in Brazil. The state is avowedly a site of health regulation and provision, while the government is in charge of policy making and implementation. The state and the government are very important on setting the policy agenda but they are not alone in this political arena. There are also groups of interest (population control agents, women's movement, etc.), which try to influence and set their interests in the government policy agenda. The population control lobby has been an influential interest group in pressuring governments to introduce population policies, mainly translated as family planning in their health agendas. Among the contestants striving for a position on the government's policy agenda, the women's movement, is another interest group trying to persuade the government to advance its priorities. Reaping the benefits from the opening of the regime and because of their recognized expertise and legitimacy in the area of women's health, the women's movement was able to shift from a category of an outsider as a pressure group to a category of a pressure group with inside status (Barroso 1990:52).

3.2 Population policies in the transitional Brazilian State:

A great deal has been written about the state. The classical theories about the state generally had little to say directly about gender[6]. Despite the fact that the issue of gender was formally excluded from the state theory, it was present under the surface (Connel 1990:511). The state is treated by some of these theories as separated from the social and political relations in which they are embedded, considering it as a neutral element within society.

Connell (1990:535) argues that the state is not inherently patriarchal, but it is rather historically constructed as patriarchal which produces gendered outcomes. Due to the its central role in the institutionalization of power, and in the regulation and constitution of gender relations, the state can not be dismissed in challenging patriarchy .

According to Goetz (1995:2) instititutions are not value neutral, they are gendered. According to her an example of gendered feature of the state is "the way states both assumed and construed women's identity for public policy as being conditioned by their social relationships as dependents of men" (Goetz 1995:2).

Only with the entry of feminist scholars, the state came to be studied as a place of power relations where gender relations are constructed inside and outside the state. According to Waylen (1995:86) the state participates dialecticaly in the process of gender construction, partly reflecting and partly creating forms of gender relations and gender inequality. This conceptualization of the state provided feminists an entry point to forge alliances with

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[6]Gender is this paper means the social construction of relations, i.e. how men and women differ from each other in terms of power, access to and control over resources, prestige. In terms of fertility control means that gender plays an important role on women's autonomy, control over their sexuality and reproduction (Barbieri 1993:85).

the state. They started to work upon the assumption that the nature of the state is not fixed but fluid[7], therefore a site where alliances should be pursued. According to Waylen "the state is not an unitary structure but a differentiated set of institutions and agencies, the product of a particular historical and political conjuncture" (Waylen 1995:86).

If the state is recognized as a central and susceptible actor, there is space where battles over gender relations can be fought. The case of Brazil is a good illustration on how the shift of the regime from military to democracy enabled new channels for civilian participation, where new questions and issues were introduced in the political arena. During the military regime the state was entirely distrusted and dismissed by the women's movement. After the transition the women's movement could not ignore the avenues offered by the state and so the space to manoeuver outside and inside it. As a result there was women's engagement in many areas of policy making in Brazil, specially pushing the state towards reproductive and health policies.

Brazilian politics have been marked by two important periods. The one ruled by authoritarian governments which lasted from 1930 until 1946, and the second one from 1964 until 1975, and the period marked by the redemocratization which started in the late 1970s and is still on. The type of model of development and policies adopted by each of these governments reflected on the quality of health services and affected directly women's access to them.

Prior to 1979 there was no explicit initiative taken by then state to intervene specifically on behalf of women's health. Also as late as this period there was no population policy elaborated by the

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[7]Lycklama a Nijeholt (1986) in her paper Women, Development, the State: a case study of concerted action, also argue about the non monolithic nature of the state.

Brazilian government. The state provided only the medical services related to biological reproduction while the other health care needs were completely neglected. According to Barroso (1985:53) the only services available in the health care system, were the ones closely related to antenatal and childbirth, which did not offer any guarantee of quality. The government lack of policy reflected their preoccupation with motherhood and was sustained by a passive pro-natalist approach. This position was in accordance with the strategy of development adopted by the Brazilian government which perceived development as equal to modernization, with occupation of empty spaces and with more people to work. The development paradigm followed by the Brazilian state stressed on growth first and then distribution, based on the 'trickle-down' philosophy. While indeed this growth occurred women's needs received almost no attention. This government policy resulted in deepening the inequality of access of health services for women of different social classes, with the poor women suffering the highest costs (Barroso 1991:53). The 'laisser-faire' position adopted by the Brazilian government facilitated the entrance of international population control agents as well as their family planning services. With no protection from the state, women became easy targets to 'family planning' services being subjected to all kind of abuses[8].

Taking advantage of the ambiguity of the Brazilian government in 1965 one of these international agencies (International Planned Parenthood Federation - IPPF), created a private institution, Society for the Welfare of the Family (BEMFAM, Sociedade Civil Bem Estar Familiar no Brasil), which was in charge of providing free family planning services. Until then, the state had entirely

[8]Notorious cases of abuse in Brazil are introduction of norplant (injectable contraceptive) which was in an experimental phase, and the lack of contraceptive choice leading to the use of either pill or sterilization.

neglected to support policies regarding fertility control leaving BEMFAM to make their own propaganda. An approach which was highly neo-malthusian - linking the economic problems of the country with the high birth rate (Barroso&Bruschini 1985:6-7). In 1974 the Brazilian government gave its first sign of changing its position during the International Population Conference in Bucharest. According to Barroso&Bruschini (1985:5) "in 1974, Brazil's statement at the UN conference, although still favoring population growth, recognized the government's responsibility for providing the information and means of birth control demanded by low-income families". Although at the level of discourse the government acknowledged its responsibility, in practice it remained favoring pro-natalism on the policy level, meanwhile it left BEMFAM operating freely in the country. In reality the Brazilian government was remiss in not having a concerted official policy towards fertility control. The ambiguity manifested by the Brazilian government at the Bucharest Conference is related to competing perspectives within the authoritarian regime about the population issue, with government factions favoring state intervention and others opposing state population control, resulting in obstruction of any continued population policy. The reasons underlying either faction of the state demonstrated that they actually were not related to women's needs or interests, but grounded in advancing their own political and economic agendas.

It was only in 1980 that the Brazilian State explicitly addressed the issue of family planning in a government project entitled PREV-SAUDE (Preventive-Healthcare). According to Alvarez (1990:182) this health program "included an extensive section of family planning under the rubric of "maternal-infant care," aimed exclusively at the distribution of birth control pills to fertile women (ages 15-49). This project was criticized by the women's health movement which found it very top down (ISIS International 1985:28). The women's health movement critiques were based on the arguments that they did not have a share in the process of elaborating the

program. Also it was not aligned with the perspective advocated by feminists, that all women should have the right to control their fertility and finally that the reproductive function should not be isolated from other women's health issues.

In 1982-1983 subjected by the debt crisis and adoption of structural adjustment policies, the Brazilian government was pressured by international lenders such as the International Monetary Fund (IMF) to meet some conditionalities related to population policies. According to Barroso (1990:59) in 1983 the State came up with a national family planning program to curb population growth elaborated by sectors of military and private family planning organizations. The content of this program was also very malthusian, which would have evoked strong reactions from the women's movement. Instead of just opposing the family planning program, the Health Minister presented a different alternative. Using the contribution of two feminists the Health Ministry elaborated the Program for Integral Assistance to Women's Health - PAISM. The lack of consensus in the area of policy formulation by the federal government is again revealed in this episode, were competing perspectives on the "population problem" voiced by different segments of the regime, were trying to foster their own interests and agenda. The program proposed by the Health Ministry in its discourse included aspects of women's health very much aligned with the feminist claims, favoring for the first time the women's movement collaboration in the process of formulation of the program.

It is important to point out that the role of the state in Brazil has always been very authoritarian and patriarchal in relation to women's issues. This patriarchal feature has its premises that to control women's bodies - with a natalist or a anti natalist policy - is a duty of the state and women are privileged to be protected by them. The programs delivered by the state concerning family planning usually recognize them as mothers but not as women who

have rights and needs as a woman. The feminist perspective implied political confrontation and disagreement with the church and the state's views about women (Avila 1994:17).

The shift in the government's position (more open towards women's movement influence) can be understood as a result of its conflicting interests in terms of population policies. In this process of transition the Health Ministry served as a facilitator in which the Brazilian women's movement could influence the state. Additionally, with the economic and political crises the opposition became stronger and the government displayed greater sensitivity (its legitimacy was highly contested) and was more susceptible towards interest groups such as the women's movement, which had acquired recognition for its expertise and legitimacy.

Although all ambiguity displayed by the Brazilian State, Brazil is considered a country where population control programs were applied successfully. Population growth fell from 2.9 percent in the 1960s to 1.8 percent in the 1980s. Despite of that Brazil remains a country where poverty continues unabated and where the outcomes of development reached just few. The figures reveal that in 1981, the richest 10 percent accounted for 46.6 percent of total wealth; in 1989, this had swelled to 53.2 percent (De Oliveira 1993:11).

In terms of the prevalence of contraception in Brazil, studies revealed that pills, sterilization, and clandestine abortion were becoming more and more spread. In 1986 a survey about nationwide coverage for contraception showed that, among married women, 25 percent were taking the pill and 27 per cent had been sterilized (BEMFAM 1986 cited in Barroso 1990:58). Two other studies carried out in the 1990s, one in the Northeast-1991, and the other in the city of Sao Paulo-1992, confirmed the same trend pointed out by the study of 1986. The situation of contraception usage in Brazil was limited to pill or sterilization of women (Berquo 1993:664).

The scenario of population polices in the Brazil for the 1990s is concurrent with the logic of the neoliberal structural adjustment programs imposed upon the impoverished and indebted Southern countries by the IMF and World Bank. The main strategies proposed by them to lower government deficit are privatization, trade regulation and liberalization, cutbacks in public spending on education and health. As a consequence of these cutbacks the health condition of the majority of the population has been aggravated, with particular impact on women. The structural adjustment policies have enormously eroded social services, including educational and health services rendered by the state on which women are largely dependent on (Melo 1993:4). All of this has brought enormous hazards specially for women's health, due to the limited access to medical assistance resulted from the neoliberal policies. The right to choose is linked with the availability of resources, i.e., the enabling conditions necessary to exercise reproductive decisions. According to Correa and Petchesky (1994:112) these enabling conditions " ...include material and infrastructural factors, such as reliable transportation, child care, financial subsidies, or income supports, as well as comprehensive services that are accessible, humane, and well staffed ...They also include cultural and political factors, such as access to education, earnings, self-esteem, and the channels of decision making".

3.3 Women's Movements within the Redemocratization process:

Most of the literature written about women's movement in Brazil considers 1970 onwards as the period of its contemporary manifestations. The history of feminism in Brazil does not start with redemocratization - the transition from military regime to the democratic, it has a long history which escapes the scope of this research[9].

[9]Feminist mobilization have been recorded in connection with the abolition of slavery in the last century, and also in the beginning of this century with the campaigns for women's suffrage (Sarti 1989:76).

Political forces emerged within society to confront the authoritarian regime bringing into the picture a new political and social phenomena called new social movements[10] (Scobar and Alvarez 1992:2). The women's movement was one of them to claim its demands, posing itself as an important social actor in this new power context.

The concept of women's movement far from being a homogeneous constituency refers to a plural, historical and dynamic concept formed by a collection of diverse groups with different patterns of organization and different goals (Jaquette 1989:185). Feminism with its ideological foundations was one of expressive aspects of this movement[11].

The Brazilian women's movement reflects a complex and unequal society were profound differences between women from the middle and poor class shaped their distinct discourses and practices between two type of struggles, one called the general and the other the specific struggle. The general struggle was placed more in terms of

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[10]New Social Movement - One of their characteristics is that rather than acting around the logic of interest, develop the politics of identity not towards any totalizing dream of a different society, but theirs is "an implicit demand for a radically open and indeterminate view of society (Laclay, E. quoted by Slater David 1985:5).

First they appeared in the form of the human rights movement, then later other came to claim their demands like the movement for democratization of trade unions, neighborhood movement, student movement, the rural workers movement, women's movement, black, gay and environment movement, just to cite some.

[11]I am using the term feminism as a part of the women's movement which places the struggle against gender subordination as its major objective. The women's movement is a more general and broader term which encompasses issues related to women, such as day-care centers, rising cost of life, but in general do not challenge the subordination of women. For the purpose of this paper I will refer to the women's movement as a general term which can challenge existing gender power arrangements and/or is organized to protect women's ascribed roles.

the class struggle dealing with issues like the rising of the cost living, the problems related to lack of social services and infrastructure, the unfair income distribution, etc., while the specific was pointing out the importance of the politics of the private sphere - the politics of family and reproduction (Alvarez 1989:34). One side was portrayed as struggling for equity and change in the state structures - voiced by the women from the grassroots - while the feminists were portrayed as only having abstract concerns. Feminism was considered by the Marxist parties and the church an abominable word. They were afraid that the specific issues raised by the feminists would divide the struggle and would divert attention from the "real" issue of class conflict (Hahner 1990:194). These differences were a cause of much tension and division within the movement. Although these differences seemed abýsmal and impossible to be overcome, Brazilian women's movement was able to integrate the two dimensions of women's struggle, not loosing the thread between the grassroots and the middle class feminist movement. The realization that there were limits to both discourses and that solidarity was vital to strengthen women's position brought a more unified position within the women's movement, although with different emphasis on the issues addressed. The Catholic church was the only one which remained immutable on its position regarding issues of family and reproductive rights. Consequently, the relation between the women's movement and the church became more and more difficult. As the period of transition advanced the Brazilian feminist movement more integrated gained vitality and legitimacy.

Alongside the struggle against the authoritarian regime the women's movement was responsible for including a new dimension to the political agenda and expanding the concept of democracy - i.e. the gender dimension. Gender interest became a core concept and a political goal for Brazilian feminists. According to Molyneux gender interests refer to "those interests that women (or men, for that matter) may develop by virtue of their social positioning

through gender attributes" (Molyneux cited in Alvarez 1989:28). The incorporation of gender to the struggle for democracy and the improvement of social conditions had also reflections on how the Brazilian feminism approaches the issue of fertility control. As Correa says: "Brazilian feminism has approached the reproductive rights in a broader perspective that linked reproductive needs to basic economical and political rights (Correa 1989:2).

The external scenario in which the women's movement developed was marked by dramatic political and economic changes which shaped and intensified its actions during these last two decades. A little about this political and economic trajectory is worth mention. The Brazilian military regime started to show signs of weakness in the mid 1970s and opened space for the reemergence of the participation of civil society where the women's movement had a important and active role.

The transition called "abertura" (political opening) took place from 1974 onwards when the authoritarian regime's foundation project began to falter. It is important to note that 'abertura' did not mean the end of the military's repressive measures, but it did permit more space and more explicit opposition to be voiced in civil society. The project of democracy followed by Brazil is a 'liberal democracy', a project advocated by dissident elements of the authoritarian regime coalition and conservative sectors of the opposition (Alvarez 1992:196).

Due to the process of "abertura" Brazil was constituted again with a multi party system, presidential system and civil society which includes a number of associations, NGOs, and social movements. The first civilian administration was installed in Brazil in 1985 after a long period of authoritarian regime. Nowadays each state in Brazil has its own legislative, executive, and judiciary body and national decisions are taken at the federal level. Two important notions were emphasized on the promotion of democratic practices

and processes in the new Brazil, the notions of right and citizenship. The major frame which guided the work of a large number of the social movements was to work towards creation of democratic structures and processes in the societies, institutions, organizations, families and lives, and not merely in the representative or formal sense, but also in the sense of daily practices and processes. The women's movement also inspired by these principles included the issue of gender addressing issues associated with day to day life - the rising cost of living, equal pay for equal work, the inadequate living conditions, reproductive rights, violence against women, expanding largely the concept of democracy.

Additionally the political climate the economy was also passing through enormous changes. First at the military regime there was the so called "economic miracle" (1967 to 1973) where the country experienced a rapid economic growth. This economic boom affected women belonging to different racial groups and social classes in distinct ways (Alvarez 1990:9). Moreover the oil crisis (1973) followed by the structural adjustment policies with a series of economic packages led the country as whole into a very deep recession. The economic and political crises faced by the authoritarian regime made the government assume a more "popular" and "democratic" facade, sometimes appropriating opposition discourses while appearing to respond to societal demands (Alvarez 1990:178).

3.4 The Women's movement and the State: scope for transformation?

During the authoritarian regime the attitude of the women's movement towards the state was one of antagonism. The state was considered an enemy and with whom no interaction should be pursued. The women's movement as an interest group soon perceived the importance of developing a different attitude, to influence the government and the state in order to achieve changes in the position of women. With the abertura and the reemergence of the

parties, feminists realized the importance of contributing on programs and platforms in order to attain political gains regarding female citizenship (Pitanguy 1994:110). On the other side, the state realizing its weaker position and the growth of social movements sought to integrate them to the general apparatus of the state.

Although this understanding was not unanimous in the women's movement, a part of it concerned with the unsatisfactory responses given from the private and public institutions, decided to develop strategies to change the patriarchal nature of the state. Taking advantage of the women's movement accumulated expertise and legitimacy, they started to build inroads to participate into the government (Barroso 1990:52).

After 1985 in Brazil many organizations started to view participation in formal processes of representative democracy as a complementary means for furthering the goals of social empowerment and meaningful citizenship. This would be pursued alongside continuing efforts to promote economic justice and redistribution, critical consciousness (conscientizacao), and community participation and mobilization. Subsequently, many groups turned their efforts towards influencing the drafting of the 1988 Federal Constitution through expansion of citizenship and representative democracy. One of their important actions was to pressure the legislative power to create mechanisms that would ensure citizen input and participation in the drafting of the Constitution. The strategies developed to achieve these purposes varied (Alvarez 1992:199).

Only with the redemocratization process and with the mobilization of women's organizations, was it possible to bring women's issues into public debate, ensuring the inclusion of gender at this new moment in history.

Women's organizations used different strategies to influence Brazilian state. One of the strategies was influencing political parties in order to include women's issues to their platforms or to support representatives sympathetic to women's interests.

Another strategy that proved relatively successful after 1983 was the creation of new "women's institutions" at the state and federal levels, these would theoretically supersede political parties and establish direct links between women's movements and the State. These women's spaces were meant to ensure further progress towards the eradication of gender inequality (Alvarez 1990:241). Indeed, during this period there was a great progress in terms of innovative public policies which encompassed the democratization of both public and private life. The National Council for Women's Rights (CNDM), State and Municipal Councils for Women's Rights, and Special Police Station to Attend Women Victims of Sexual or Domestic Violence are examples of "women's spaces" created as spaces to improve women's legal and social condition. The National Council (created in August 1985) served as an effective channel for women's lobby during the drafting of the new Constitution, introducing gender-specific issues that might never have been considered by the Constituent Assembly, and also lobbying key legislators throughout the constitutional debates. In November 1985 the Council launched a nationwide campaign called "Constituinte Pra Valer, Tem que Ter Palavra de Mulher" (For the Constitution to count, women must be heard). In 1986, CNDM organized a national conference on Women and the Constitution, in which a "Letter from women to the Constituent Assembly" was approved and largely distributed to legislators and women's movement organizations. This document was endorsed by a broad spectrum of women's groups and included proposals to ensure women constitutional rights in areas like: labor legislation, family law, health care, as well proposals that would elevate struggles for the transformation of gender power arrangements to the status of fundamental rights and constitutional imperatives (Alvarez 1990:251).

Also autonomous women's organization presented popular amendments to the Constituent Assembly. Alvarez cites **Uniao de Mulheres de Sao Paulo, Coletivo Feminista Sexualidade e Saude** and **Grupo de Saude Nos Mulheres de Rio**, as an example of an attempt to support women's health interests. The amendment gathered 33,338 signatures and "called for women's absolute freedom and women's right to conceive, avoid contraception, or interrupt and unwanted pregnancy up to 90 days after contraception" (Alvarez 1990:254).

As a result of intense women's lobby mainly forward by the National Council on Women's Rights, Brazil's 1988 Constitution reflects much more accurately women's demand for official mechanisms to combat violence in the home, female rural worker's rights to welfare benefits, employee's rights to employer - provided daycare facilities, four months maternity leave and five day paternity leave, equal pay for equal work, social security for domestic workers, reproductive health and rights as a constitutional right, land rights for women irrespective of their marital status.

These are remarkable gains showing that it is possible to impact the State policy arenas when there is a favorable environment to forward women's interests. But it is also true that with a more conservative political conjuncture, much of these political gains can be mitigated. The Women's Council itself is an example of how with a shift to the political right disempowered entirely its constituency, resulting in a loss of one possible channel to foster feminist interests[12].

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[12]The Women's Council started to face opposition from the Ministry of Justice to which it was attached in 1988. In 1989 with a more conservative Ministry of Justice, many actions to cut down its agency was taken, until the entire collective resignation of all Women's Council members (Pitanguy forthcoming: 17).

Alvarez calls attention for the risk of using just one strategy to foster women's interest, she suggests that multidimensional feminist strategy should be pursued, within,

3.5 PAISM: a possible strategy for reproductive health and rights policy in Brazil:

In 1983 faced with the emergence of a plan elaborated by the federal government together with private family planing organizations, the women's movement promptly realized the imperative need to respond to this coercive state policy attempt. With the collaboration of two feminists the PAISM (Program of Integral Assistance to Women's Health) was created in 1983.

The program included at policy formulation level: prenatal care, delivery and post-partum care, family planning , breast and cervical cancer screening, diagnosis and treatment of sexually transmitted diseases, and infertility services, as well as occupational and mental health services. It also expanded coverage to include adolescents and post-menopausal women rather than only women of reproductive age. PAISM emphasized that women need access to preventive as well as curative care, and to information about their bodies and their health. An important aspect PAISM does not address is the provision of safe abortion by the state, irrespective of the circumstances whether due to rape or risk of life, which is still one of the struggles carried on by the Brazilian women's movement.

The component of education was considered the chief motor of the program. It was assumed that information about their bodies and health would enable women to take control of their health, and this knowledge should be empowering to women. Alongside the provision of health care service, imparting of training and creation of educational material and technical guidelines to be used with health workers (doctors, nurses, health assistants, etc.) were crucial elements for the success PAISM. In order to achieve changes on the health system it was necessary to update technical skills

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outside the State and with the party system (Alvarez 1990:256,273).

and discuss attitudes and values presented on their day to day practices about women as clients. The group dynamics stressed respect for differences of opinion among group members which proved to be very helpful to improve relations at the work place (Barroso 1990:60-62).

Additionally the issue of sexuality became an important key element of the training programs through sex education. How could it be possible to teach a woman to use a diaphragm if she had never seen herself in a mirror or touched her vagina? Sex education starts with basic notions of the body and provides spaces to discuss how women are taught to fear and feel shame for their own bodies. As most of health professionals in Brazil are women these educational programs serve two different and important purposes. One is to increase their own self-awareness in relation to their attitude towards themselves (their lack of information, prejudice attitudes etc.), and second to develop a "new" attitude towards their client (women), which should be respected as an autonomous human being in charge of their own health and reproductive decisions (Barroso 1990:61-62).

The context in which PAISM was elaborated and legitimized has to be understood in the light of the 1983-84 period. During this years the women's movement was highly productive in terms of the discussion about women's health in Brazil. Feminists intensified their meetings culminating in the First National Meeting on Women's Health - November 1984 - (Isis International 1985:27). The First National Meeting on Women's Health, was held in the city of Itapecirica where participants elaborated a document called The Itapecerica letter (Carta de Itapecerica) containing important resolutions about PAISM to be addressed to federal and state government level. The Itapecerica letter contained a diagnostic about the health system crisis and the women's health situation in Brazil (Coletivo 1985:10-11). Also included a call for "the participation of women's groups in the elaboration, execution and

monitoring of women's health programs, sex education for all the population, the reclaiming of popular and feminist wisdom against the excessive medicalization [of women's health] and a revalorization of natural forms of life and health" (Alvarez 1990:194).

These discussions contributed largely to consolidate the women's movement position to the state's proposal. And in 1984 the women's health groups were invited by state services to evaluate and train the professionals in charge of the PAISM (Coletivo 1985:27).

The content of the program was aligned with a set of principles that the women's movement had been formulating in the previous years. Women's self-determination and no dissociation of reproduction from sexuality. It carried in its proposal a very important shift in approach, from fertility control to reproductive health care.

An outcome of this intense debate is that women's movement was able on the policy formulation level to bring forward the gender dimension to state's health policy. In theory there was an agreement between the state and the women's movement in the content of the PAISM, but as the political agenda changed it turned to be more rethoric than a committed collaboration. According to Alvarez (1990:249) the PAISM was obstructed after mid-1986. Facing an internal political-economic crisis, the Sarney government pressured by its debt rescheduling negotiations with international banks, announced the creation of an Interministerial Commission on Family Planning, and demanded the immediate implementation of a national family planning policy. It entirely deauthorized PAISM and excluded the National Council on Women's Rights (Conselho Nacional do Direitos da Mulher)from policy deliberations (Alvarez 1990:249,250). The discussion on the policy implementation level will be taken in Chapter 4.

3.6 Keeping the gender thrust at the level of policy formulation and implementation

During the period of 1983-1984 the women's movement concentrated its efforts on consolidating the feminist position regarding formulation and implementation of PAISM. It was able to organize strong opposition against factions of the state who advocated controlist solutions. Through external pressure the PAISM was kept at least on the level of policy formulation very much in tune with a women centred perspective (Alvarez 1990:194).

Another major achievement of the feminist movement has been the creation of a Committee on Reproductive Rights (1987) at the Ministry of Health, where women's health movement and specialists from different disciplines (including demographers, sociologists and gynecologists) discuss specific policies regarding reproduction. Important issues that have been discussed are: research in new contraceptives, the use of IUDs, sterilization abuse and therapeutic abortion (Barroso 1990:62).

In order to provide quicker information to the movement and to increase political power of alliances, the National Feminist Network for Reproductive Health and Rights was founded in 1991, which has 65 organizational members from all over the country (Claro&Moreno 1994:49).

The women's movement in Brazil is also responsible for creating alternative approaches to health care towards women. One example of that is the Health Feminist Collective in Sao Paulo. They provide Gynecologic and Psychological services, including information on the full range of reproductive health issues; train health care professionals, conduct workshops for women on topics such AIDS, menopause, and sexuality, and elaborate training materials. Alongside with the Health Feminist Collective there are many other groups in Brazil developing interesting work in the area of women's health. The capacity for lobbying has been increasing a lot these

last years. They have been campaigning for decriminalization of abortion, sex education in schools, to decrease maternal rates, against sterilization abuse, against contraceptive experimentation (Claro&Moreno 1994:49,58).

The women's movement was also instrumental in the elaboration of articles for the Constitution of 1988. The premisses defended by the movement were that: health is a right of all and provision of adequate health care a duty of the state, and that women have the right to health care delivered under a comprehensive and integral perspective, independent of their role as childbeares. Last but not least the movement has been very active on discussing reproductive health and rights issues in international conferences like the International Conference on Women and Development (ICPD) and in the World Conference on Women -Beijing 95. The position taken by the Brazilian government in Cairo is the result of an intense process of negotiation between the women's movement and the Brazilian state. The position held in Cairo was strongly in favor of women's reproductive rights, the need of sexual education for adolescents and a flexible vision in relation to the concept of family. The women's movement and the state's unified position on women's reproductive health and rights at the Cairo Conference defeating the Vatican's position which did not endorse or commit itself to these points was considered a landmark in the history of the relationship between these actors.

3.7 Conclusions

It is undeniable that the relation between the women's movement and the state went through deep changes. From a position of enemy the state became an important ally on carrying feminist interests during the political transition. Taking advantage of the regime transition, the women's movement was able to access the heart of policy formulation, influencing on the creation and consolidation of PAISM. It established within the realm of the patriarchal state a proposal based on a feminist approach of population policy,

changing the conceptualization of fertility control (from population control to reproductive health). Although the women's movement has garnered access to important entry points to the state policy arena, the development of the relationship between the women's movement and the state did not occur without problems. It has been a relationship that goes through ups and downs and very much subjected to the fluctuation of the political regime and political conjuncture.

Despite of that, the women's movement definitely had a major role on bringing gender interest on the political agenda expanding the scope of the struggle for democracy. Although this was a big step achieved by the women's movement, this in itself is not enough. It is necessary to sustain the interest for gender, which is not the agenda of the state. In the absence of a sustained pressure by the feminist movement on gender issues policies and programs will compromise women's needs. In the following chapter I will exam the PAISM form this critical perspective, shifting my from policy formulation to implementation.

Chapter 4

Exploratory study on the implementation of a women centred policy at a regional level

4.1 Introduction

In this chapter I wish to move from the field of policy making to the field of implementation of newly conceptualized health policies, i.e. policies that place women at the center of health concerns. I will take the case of Goias[13], where the PAISM was chosen to be implemented as a pilot project on February 1984. The PAISM health program central focus was on reproductive health, sexuality and in addition family planning as one of its activities. The main distinction of PAISM from a general health program is that it incorporates concerns brought by the women's health movement acknowledging women's individual specific needs and interests independent of their child bearing role.

4.2 Methodology

For the purpose of my analysis I will highlight some crucial features for understanding the process of implementation of PAISM in Goias. I will present these features taking as reference three distinct periods of its implementation: 1984-1985 - the beginning of the program, 1987 - the year affected by a shift in the state health policy, and 1994-1995 - the present situation of the program.

The methodology used to analyze PAISM implementation is based on available literature and on data collection from the state health secretariat. The limitations which restricted my analysis of the program are the following: insufficient literature about PAISM implementation with most of it focussing on policy formulation.

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[13]Goias is a state in the central west part of Brazil with a population of 4.012.562 (census of 1991), with 232 municipalities in 1993. The capital of the state is the city of Goiania.

Added to this the monitoring capacity of the program has also proved to be very weak. Since 1984 the PAISM in Goias has never been subjected to a detailed evaluation including its procedures and services. The only compiled data refers to a research regarding the character of the clientele, carried out in 1985. Only now (1995) under the aegis of a new coordinator, the coordination team acknowledged the urgent need to verify the quality of health services provided under the auspices of the program. The objective of the evaluation was to diagnose the existing situation and through the results reinstall the state's responsibility in providing a comprehensive health care to its clientele in all the state's public health units. This evaluation is still being processed and until now there is no final conclusions or recommendations. The on going evaluation is restricted to the services offered in the city of Goiania.

In order to substantiate my analysis and facilitate my understanding about the process of implementation of PAISM in Goias in its initial phase and its current situation, I formulated a questionnaire which was forwarded to the Goias State Health Secretary (Carlos Mendes) . The questionnaire contained questions such as: number of professionals in the coordination team, number of units offering the program, activities implemented during the two periods, and how it was being conducted - partum, pre-natal, family planing, cancer prevention, gynecological consultancy), number of training performed, financial resources used for the program (nationally and in Goias), the process of decision making, relation of the PAISM with the Women's Movement. Also some questions about the clientele were formulated, such as main problems in terms of women's health in the context of reproductive health and rights, opinion of the clientele about the PAISM etc...

I based my analysis on the Women's Health Coordination[14] answers to the questionnaire. They also supplied information about an evaluation carried out in 1985 regarding the quality of care being provided in terms of the routines addressed by the PAISM. This evaluation was carried out towards the end of 1985 by the coordination team. In actual fact, the information presented to me was in the form of transparencies. The actual methodology adopted in conducting the study, its basic premises and discussion on the findings were absent. These figures could be interpreted only by the professional(s) who was(were) in charge of the evaluation . An example of this conundrum is one of the transparencies shows irregularities in terms of the professionals following the routines. The conclusion arrived at was, the assistance given was found to be under the classification of unsatisfactory assistance level III, with no reference to this classification explaining what it meant.

The foregoing illustration shows that the program has an inherent problem of implementation related to the record of its data. The only sources I could elicit information was basically through personal communication with some members from the coordination and from my own knowledge as somebody who was indirectly involved with the PAISM since 1984.

Given these limitations of insufficient quantitative data, my analysis about the implementation of PAISM in Goiania will be restricted to qualitative indicators such as the content of training. The provision and the quality of training provided are the conditions to enable the health providers to conduct the program. I will use the information about the training as parameters to evaluate the actual services provided in Goiania since 1984.

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[14]Kemle S. Costa and Eliane Goncalves provided much of the information used in this case study as well as comments.

4.3 PAISM in Goiania, an Overview

The PAISM was first implemented as a pilot project in February 1984 in the city of Goiania, after a year of intense discussions and debates around women's demands in the area of health and reproduction. Feminists, health professionals and society were involved in this debate. The Program had its regulation and legislation carried out by the Health Ministry, and its execution conveyed by the state secretariats.

The coordinator of the program in Goias was a feminist doctor who was involved in the elaboration of the plan in the Health Ministry, identified by the Health Minister and entrusted with the responsibility. The first measure taken by the coordinator to support the implementation, was to form a central coordinator team. The coordination called Operational Unity for Woman's Health (Unidade Operacional de Saude da Mulher) was formed by thirteen health professionals, with a few having previous exposure and participation in the women's movement and with all having specialization in Public Health. Its composition in terms of professional background was: five nurses, four doctors (three women, one man) and four nutritionists. The group developed actions on women's and child's health.

Alongside the creation of the team, they were given a series of internal and external training to get them acquainted with the principles of the PAISM. During the period between 1984 to 1986 the entire state of Goias was trained both in the routines of the program, as well as its ideological contents. This means that each municipality with a state health unit which could be a hospital or health post received a training. Quantitatively it meant that at least one training was performed in each municipality, totaling 244 training in all. It was not possible to retrieve the exact number of training during this period due to the non existence of any data compiled by the coordination unit.

In terms of the organization of these training they were conducted by the coordination team and sometimes with the help of feminists from the women's movement either from Goias or outside. They were designed in such a form that they covered the technical aspects of the program as well as the general trends. The technical aspects were discussed with each category involved, but a general training was given to all professionals. This general training usually took 40 hours and it covered the crucial issues for the program such as gender, sexuality, relationship between health professional and women. An important outcome for Goias as a pioneer on developing the program was that its coordination team was often invited to conduct training in other Brazilian states. The educational material such as booklets, pamphlets, video, and texts were supplied by the Ministry of Health. From 1987 onwards the coordination of the program in Goias started to develop its own educational material.

The routines implemented were: partum, pre natal, gynecological assistance, family planning, cancer prevention and educational activities. Emphasis was much more on the educational part of the program with the professionals involved with the execution, given specific training on issues of sexuality and gender. The educational practices were considered the mainstay of the program. These practices were inspired in dynamics developed by the women's movement which acknowledged women's knowledge and worked towards the enhancement of women's control over their bodies. Relying on the help of the women's movement and feminist sex educational material, the emphasis of the training were - on women's role in society, the relationship between health professional and client, and sexuality as an important component that could not be separated from reproductive health and rights. The spirit of these trainings

is captured in a speech by Ana Costa[15] stated as follows: " We have introduced educational activities into routine health activities, and that is where the change in the position of professionals come from. In group discussions, medical care is called into question and reclaiming our bodies is considered, a space for women in medical consultancy. Contraception is talked of as a right. It is for this reason that doctors have begun to complain, saying women are talking too much" (Isis International 1985:37). The success of the program depended greatly on the sensitization of professionals towards women's autonomy and the incorporation of a more participative process in various health practices. There is no doubt that the discourse and policy formulation of PAISM was very much in tune with the women's movement demands of reproductive health and rights.

The program was funded by financial sources from the Health Ministry, the United Nations, National Bank for Economic and Social Development, and Pathfinder Fund[16] (personal information - Kemle). There is almost no information in the literature about the amount designated to the program at the national level, and at the local level (state secretariat) it was impossible to retrieve this information. The majority of the resources were designated for

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[15]Ana Costa collaborated with the elaboration of PAISM at the Health Ministry and was in charge of the implementation of the program is Goias.

[16]Pathfinder Fund is an american population control agency. In Brazil it funds ABEPF - **Associacao Brasileira de entidades de planejamento familiar** (Brazilian Association for family planning entities), in which BEMFAM is one of its associates.

Kemle S. Costa is a member of the Operational Unity for Women and Child since 1984 and also an associated of Grupo Transas do Corpo. According to her because of feminist principles the financial support sent by Pathfinder was refused, it was accepted only educational material such as pamphlets, and demonstrative kits with contraception.

trainings, elaboration of educational material and the provision of anti conceptive methods guaranteed by the Health Ministry.

The clientele benefiting from the program was composed of women in the fertile age including adolescents and older women. The study performed in 1985 showed that 50% of the population studied (total of 385 women) were between 21 and 30 years old. Some 75% of the population studied was Catholic, but only 24% were regularly practitioners. Great part of them (37.7%) came from cities in the interior of Goias state with an income lower than the minimum wage. Most of them (68%) had not completed elementary school. Although the study pointed out that 45% of them started their sexual lives during adolescence, 37% of the women interviewed denied receiving any information about sexuality. In terms of contraceptive methods, 40% of them were sterilized and 29% made use of pills (Goias State Health Secretariat 1985). These data confirmed the lack of alternatives of contraceptive methods women were subjected, mainly poor women. It also point out strongly on need of sex education as means to increase women's control over their sexual and reproductive lives enabling women resist from the risk of coercive population control programs. With this evaluation the PAISM had proved in its local level the urgent need for its implementation and continuance.

Coming back to program itself, after a period of great support and activity the program in Goias started to loose its momentum. From 1987 on the coordination unit, lost most of its prestige within the secretariat and remained without a coordinator throughout 1993. According to one of the coordination members after 1987 there was a shift in the state health policy. This shift can be understood as a reflection of the "new" government population policy established in the beginning of 1987. As already mentioned in chapter three the government headed by President Sarney announced a population control plan, entirely dismissing PAISM and excluding feminists from policy deliberations. Although there were numerous reactions

from the women's movement against the government controlist plan and in defense of the PAISM, it lost most of its support from the federal government.

Parallel to this "new" federal political agenda, the Goias state government started to emphasize the expansion of the health system, building new units, contracting more professionals on temporary contracts, and freezing the wages of the permanent workers. The most affected part of the program was the training which was at the heart of the program. With all kinds of difficulties to sustain the training like lack of transportation provision, lack of daily allowance and lack of basic means to pursue the training, the coordination team decided to concentrate their efforts in the elaboration of educational material. As a consequence of the difficulties in pursuing the training, the contact between the coordination and units was lost, resulting on a generalized loss of control over the implementation process in the health units.

Probably this inertia by the state was one of the motives that drove some health professionals (like me) from the state secretary to form a non governmental organization (NGO)[17] in the beginning of 1987. This organization[18] has as one of its objective to train health professionals with the educational contents prioritized by PAISM.

Besides the stalemate of the training another part of the program

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[17]Non Governmental Organizations (NGOs) emerged in Brazil in the 1980s, it coincides with the deepening of the debt crisis and with the cuts in public government investments on social policies. These organizations were thought as an alternative to the collapse in terms of accountability of the government. The same trend applies to women's organizations.

[18]Grupo Transas do Corpo a non governmental organization was created in 1987 and has as founders members three professionals working at the health state secretariat.

greatly affected was the availability of contraceptives methods. The Health Ministry from 1984 until 1992 supplied state secretariats with contraceptive methods to fulfill the family planning activity. From 1992 onwards the provision of contraceptives became the state and the municipality's responsibility. During the entire year of 1992 the program did not offer pills, spermicide jelly or condoms, only diaphragms and Intra Uterine Devices (IUD) were available.

The availability of diaphragms in the absence of other alternatives could probably be attributed to lack of information from the clientele as a result of the doctors negligence[19] in prescribing diaphragms as one of possible ways of contraception. The non provision contradicted one of the articles of the Goias State Constitution, which states that it is a role of the state guarantee integral assistance for women in all phases of their lives. The major reason cited by the state government for not providing contraceptives was 'lack of resources'. Under this explanation one can come up with the conclusion that PAISM was not a priority anymore and that the professed importance to assist women comprehensively remained only at the level of discourse.

In 1995 the picture of the program is as follows: the coordination team has been reduced to 7 health professionals (three nurses, 2 social workers, two nutritionists and a doctor who is the current coordinator. This team is responsible for the activities related to women's health, besides this there are two more teams, one in charge of child and the other in charge of adolescent health. During the period between 1994 to 1995 thirteen training were accomplished (seven in 94 and six until September 95).

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[19]With the change on the labor contracts the doctors started to be paid upon productivity. A report from a health worker says that in one hour a doctor would assist 40 women, which does not favor the prescription of diaphragms, because instruction on its use is more time consuming.

The program has planned an evaluation for this year (1995) but until now, there has been only one service with the conclusion of one pilot. Some of the findings of this pilot evaluation reveal that the procedures recommended by the program are not being followed at all. Some of the reasons for this vary, from negligence in filling out the women's data sheet or even opening a new one for her, to the lack of instruments like blood pressure gauge or others to execute the routines.

The actual state of the program is far from the approach of reproductive health and rights outlined in chapter 2. The health history of these women do not exist not because they do not have one, but because they are not considered by the professionals as subjects possessing valuable knowledge which should be recorded.

4.4 PAISM and its repercussions in Goiania

The reactions against the program came from diverse parts. In 1984 a feminist group from Goiania (Eva de Novo) compiled a document containing concerns and critiques about PAISM. They criticized its authoritarian formulation and the possible interventionist tendencies it contained. It also declared that it was not against family planning in total, but they felt that structural changes in Brazilian society had to be effected before family planing could be instituted. In late 1984 the group altered its position, despite their reservations they decided to work towards implementation of PAISM, promoting women's reflection groups in the hospitals of Goiania and following the implementation process (Isis International 1985:34). The shift of the group's position is related to the imperative need to prevent possible abuses by the state, as well as based on the premise that the women's movement should monitor the implementation of PAISM.

Another focus of resistance was the church which had never accepted the use of artificial contraceptives included in the program. The church was also against the content of the educational material

considered immoral by them. In 1986 all the educational material used for the program (booklets, folders, etc...) was prohibited, confiscated and burnt. This measure was taken by the federal level by the right wing allied to the church. All the material were to be replaced by new booklets that preferred natural birth control methods and where family planning was portrayed as a method of adjusting working-class family budgets and combatting poverty (Alvarez 1990:250). The church frequently used the media to echo its protests against the program. Their main opposition was related to the program's emphasis on the right of women to choose, which was interpreted as against the family and women's natural role - to bear children. According to them natural methods were the only permissible means of avoiding pregnancies.

The opposition by the church was mainly against availability of artificial methods such IUDs, which were considered abortive by them. The program in Goias had always been criticized by the church and conservative sectors of the government for its liberal character. The inclusion of sexuality as a crucial issue debated by health professional was interpreted as an act of permissiveness.

Although there were these reactions against the program, PAISM in Goias is considered internationally a successful experience of a women's centred approach mostly in its initial years (Claro and Moreno 1994:50). Indeed in its first years much was achieved in terms of spreading this new conception on women's health care, which was not followed in the subsequent years.

4.5 Concurrent factors on the stalemate on PAISM

Although PAISM in terms of policy formulation contained most of the holistic principles contained in a women centered approach, it is in its implementation the program has been called to prove its viability. The stalemate of the program at the state level can be attributed to a combination of factors, from the shift of the national policy which occurred from 1987 onwards, to the

bureaucratic and administrative inertia at the federal and state level. It is important to note that one of the enable conditions for the PAISM to work was the Sanitary Reform. This reform would bring important modifications in the Health System. The sanitary reform[20] was envisaged as the medium through which the program could be operationalised. In terms of law it established a unified and decentralized health system. The reform has been facing enormous opposition from particularly the so called "private sector of the INAMPS (National Institute for Social Security and Medical Assistance) contracted network[21] and as well as some segments of the government which refuse to accept the sanitary reform. These opposition forces have been acting on obstructing the reform implementation. A detailed assessment of why the sanitary reform has been stalled is beyond the scope of this research, but it certainly can be pointed as one of the causes of the political, administrative and financial uncertainties of PAISM.

There is a notable difference between the program in its beginning (1984 to 1986) and at the present situation (1995) in Goias. Although the evaluation of the program is not concluded we can already perceive chaos in terms of routines and general content as compared to the situation in the first years of implementation. The training, the chief motor of the program is running very slowly. As a result the perspective of a holistic program based in a women centered approach in which women are treated as autonomous human

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[20]In 1987 a presidential decree established the SUDS, "unified and decentralized health system. It became law by the 1988 Constitution, and it was based on free access of health services to the entire population and to the decentralization of power decision-making from federal to state and local levels (World Bank 1990:100).

[21]INAMPS was a program created during the military regime, and it sought to provide medical care specially curative medical services. INAMPS delivered services through its own facilities and privately contracted suppliers of hospital and ambulatory services, the so-called "contracted network (World Bank 1990:13).

being in control of their health and reproductive life, has become a distant and memorable past.

In general one may conclude from the foregoing analysis that the monitoring system of the program both at the national and state level, has been a very weak point not providing reliable feedback about the quality of service being provided. The basic data has not been recorded, making it very difficult to assess the program. Additionally the process of decision-making has remained highly centralized and with almost no transparency on the major decisions about the program.

While there were resources and a political will to implement the program, it indeed occurred. On the other side when the program began to loose its political support (1987 onwards) and consequently financial resources, these greatly affected the process of implementation. It is interesting to note that the external factors already cited earlier were the major reasons for the slowing down of the PAISM. These factors are a complex net from multi level perspectives, including social, cultural, economic and political factors. Despite this the coordination team in its majority remained cohesive and staunchly defended the program under enormous assault and pressure faced during all these years. The attempt of this evaluation might be a sign that there is still a chance to revive the program and rejuvenate it.

Chapter 5
Synthesis of the insights gained from the foregoing analysis

This paper examines the dynamics and difficulties faced by the Brazilian women's movement in transforming political gains accomplished at the policy making arena, into effective policies at the level of implementation. The paper demonstrated that at the level of discourse the women's movement was very influential and successful in achieving important political gains in the area of labor legislation and reproductive rights, in the 1988 Constitution. Through its facility for mobilization, it circumvented further setbacks in terms of regressive policies advocated by conservative lobbies, which would have been detrimental to gender interests. The Brazilian women's movement was able to strategize, lobby, and negotiate within the democratic spaces provided during the political transition, becoming an active participant within the state bureaucracy pushing for gender specific demands in the realm of state policy. The women's health program (PAISM), represents an important victory for women's movement in terms of policy formulation, introducing for the first time a gender - specific dimension to the Brazilian pro-natalist and anti-natalist debate.

With the achievement of influencing the policy formulation arena the women's movement increased its political strength and became respected voices. The Brazilian trajectory of the women's movement has shown that these political gains resulted on the continuity of other achievements at the level of policy formulation as seen in the Cairo Population and Development International Conference. On one side the successful initiatives taken by the women's movement in relation to gender policy formulation are undeniable, but despite this in the field of implementation the women's movement has met with frustration and disappointment. This has been the case of important policies and programs such as the women's health program (PAISM), where the women's movement was unable to avoid the

program stagnation and its stalemate.

The foregoing analysis has enabled me to arrive at three crucial insights on the difficulties faced by the women's movement in dealing specially with the implementation process of gender policies. The stalemate of PAISM could be attributed to the fact that it was based on a women centred perspective (elaborated in Chapter 2). The threat that women's self-determination and autonomy poses to the Catholic church and conservative segments of Brazilian society has to be addressed and cannot be summarily dismissed. During the last decades the women's movement has been constantly struggling to counteract the increasing mobilization of these conservative forces, which are in essence anti-women forces. The political arena where the issue of fertility control is posited is a complex web of forces and interests, which can not be analyzed in isolation. It is an arena where other political actors such as the state and the Catholic church have played a major role. Given this context, the Brazilian women's movement has to carefully gauge these actors. The discourses of the actors and their mechanisms of functioning have to be understood. This course of action will facilitate the movements ability to advance its interests. It is important to remember that the holistic proposal addressed by PAISM emphasizing reproductive choice and sexuality predates the discourse was discourse of sexual reproductive health and rights (1990s) advocated by DAWN. This reveals how important it is to keep on insisting on the PAISM implementation, it is an unique experience on more than 10 years of practice of what now is being internationally recommended as an gender sensitive health policy.

Another important fact is that the structure of the health system in Brazil (very centralized and uneven) posited an obstacle to the operationalization of health programs such as PAISM. The health system as a whole required indispensable changes such as the Sanitary Reform as mentioned in Chapter 4 to be able to implement specific programs . Moreover the economic and political crisis

faced by the health system on these last decades is intrinsically related to the structural adjustment policies which has affected greatly the poorest strata of the Brazilian population.

A conducive political environment, i.e. an environment receptive for political participation of civil society, has to be considered as crucial for civil society to influence state policies. In Brazil the democratic opening established in the early and mid-eighties opened new channels for the women's movement involvement in state policy making. The political context in which the new republic evolved was marked by constant backlashes, and constant shifts on the political agenda affected the implementation of the program. The priorities of the program are dependent on the agendas of the particular government in power. These result in constant changes in the Health Ministry from 1985 to 1990, the Health Ministry had its minister changed four times. Consequently with each new nomination new priorities would be drawn, affecting the implementation of programs. It was during this period that there was a policy shift by the state, a clear attempt to establish a controlist policy under the aegis of international pressure.

My involvement as a health worker and as a feminist in both levels (state and NGO) stimulated my interest on retracing the women's movement performance and unravelling the difficulties faced by at the level of policy implementation. I approached the issue of policy formulation and implementation in Brazil from a perspective of somebody who at the beginning of the research believed that the answers for the difficulties of implementation should be imputed solely to one social actor - the women's movement. My research question reveals my partial and bias perspective on trying to answer this question by only assessing the women's movement trajectory.

But this research endeavor has shown me that, the women's movement cannot be blamed for the lack of implementation of policies in

Brazil. An analysis which takes into account only one social actor would be a overestimation of the role of the women's movement and a underestimation of the other actors. By accessing only the women's movement performance we would fall into inaccuracy. By doing so we do not take into consideration the role of the other actors, as well as the political context and the structures where these polices are formulated. With the PAISM an specific health program which placed women well being as its central principle, a new dilemma was faced by the women's movement, i.e. how best to approach the local level. The implementation of policies seems to be the great challenge at this stage in Brazil. But the experience with PAISM has shown that the women's movement has also to improve its capacity of monitoring as well as civil society has to be strong to make the state accountable to its policies and programs.

As my final conclusion I should say that a better understanding of the difficulties on moving from formulation to implementation would require further studies on the discourses and practices developed by the actors involved as well as the political conjuncture in which they are involved.

Bibliography

Alvarez, E.S. 1990. Engendering Democracy in Brazil: Women's Movement in Transition Politics, Princeton University Press, New Jersey.

Avila, M.B. 1993. 'PAISM um programa de saude para o bem estar de genero', SOS CORPO, mimeo.

Avila, M.B. 1993. 'Modernidade e Cidadania Reprodutiva' in Direitos Reprodutivos: Uma Questao de Cidadania, Revista Estudos Feministas, Vol.1 N.2/93 do CIE/ECO/UFRJ.

Barroso, C. 1991. 'The Women's Movement, the State and Health Policies in Brazil' in Geertje Lycklama a Nijeholt (ed.), Towards Women's Strategies in the 1990s, Challenging Government and the State, Institute of Social Studies, The Hague.

Barroso C. and Bruschini C. 1985. 'Building politics from personal lives' in Chandra Mohanty, Ann Russo and Lourdes Torres (eds) Colonization and Resistance, Indiana University Press, Bloomington.

Barroso, C. and Sen G. 1995. 'The Women's Movement and Reproductive Health Policies' mimeo.

Batliwala, S. 1994. 'The Meaning of Women's Empowerment: New Concepts from Action', in Gita Sen, Adrienne Germain & Lincoln C. Chen, (eds), Population Policies Reconsidered: Health, Empowerment, and Rights, Harvard University Press, Boston, pp. 127-138.

Berer, M. 1993. 'Population and family planning policies: women-centered perspectives' in Reproductive Health Matters, no.1, May.

Berquo, E. 1993. 'Brasil, Um Caso Exemplar-anticoncepcao e parto cirugicos - a espera de um acao exemplar' in Direitos Reprodutivos: Uma Questao de Cidadania, Revista Estudos Feministas, Vol.1 N.2/93 do CIE/ECO/UFRJ.

Cassen, R. 1994. 'Population and Development: Old Debates, New Conclusions', in Robert Cassen and contributors (eds), Population and Development: Old Debated, New Conclusions, Transaction, New Brunswick.

Connel, R.W. 1990. 'The State, Gender and Sexual Politics:Theory and Appraisal, in Theory and Society, no. 19, pp. 507-544.

Correa S. and Petcthhesky R. 1994. 'Reproductive and Sexual Rights: A Feminist Perspective' in Gita Sen, Adrienne Germain & Lincoln C. Chen (eds), Population Policies Reconsidered: Health, Empowerment, and Rights, Harvard University Press, Boston, pp. 107-123.

Correa S. and Petchesky, R. 1994. 'Exposing the Numbers Game' in

Ms., Sept/Oct.

Costa, A.M. 1985. 'Saude da Mulher: Estorias e Inquietacoes', Cadernos da UFMG, Nucleo de Estudos e Pesquisas sobre a Mulher, Universidade Faderal de Minas Gerais.

Costa, A.M. 1992. 'O PAISM: Uma politica de assistencia integral a saude da mulher a ser resgatada, Comissao de Cidadania e Reproducao, Brasilia.

De Barbieri, T. 1993. 'Gender and population policies: some reflections' in Reproductive Health Matters, no.1, May.

Demeney, P. 1988. 'Social Science and Population Policy', Population and Development Review, vol.14, no.3, pp. 451-79.

Goetz, A.M. 1995. 'Institutionalizing Women's Interests and Accountability in Development', in IDS Bulletin, vol.26, no. 3, July 1995, pp. 1-11.

Fathalla, M.F. 1994. 'Fertility Control Technology: a Women-Centered Approach to Research', in Gita Sen, Adrienne Germain, and L.C. Chen (eds), Population Policies Reconsidered: health, empowerment, and rights, Harvard University Press, Boston, pp. 223-234.

Godfrey, R. 1990. Population Policy: Contemporary Issues, Praeger, London.

Gomes, A. 1994. 'Women, Population, and Development', in Women's Health Journal, no. 1, 1994, Isis International, Chile.

GRHPP 1995. 'Gender, Reproductive Health and Population Policies', vol.1, April, INDRA, Amsterdam.

Hahner, J.E. 1990. Emancipating the Female Sex: The Struggle for Women's Rights in Brazil, 1850-1940, Duke University Press, Durham.

Hanmer, J. 1993. 'Women and Reproduction', in Diane Richardson and Victoria Robinson (eds), Introducing Women's Studies: Feminist theory and practice, MACMILLAN, London.

Hardon, A. 1992. 'Contraceptive research: women's perspectives in Mintzes, B. (ed.), A question of control: women's perspectives on the development and use of contraceptive technologies, WEMOS and HAI, Amsterdam, pp. 7-16.

Hardon, A. 1993. 'Anti-pregnancy vaccines: conflicting views on their safety and acceptability', paper presented at the Conference on Global Immunization, Iowa, USA.

Harrison P. 1992. The Third Revolution: Population, Environment

and, a sustainable world, Penguin Books, England.

Hartman, B. 1993. 'Population Control in the New Order', in Rosiska D. Oliveira and Thais Corral (eds), Planeta Femea, Brazilian Women's Coalition, Rio de Janeiro.

Hartman, B. 1993. 'The present politics of population and reproductive rights', in Women's Global Network for Reproductive Rights, Newsletter 43, April-June.

Hockey, J. 1993. 'Women and Health' in Diane Richardson and Victoria Robinson (eds), Introducing Women's Studies: Feminist Theory and Practice, MACMILLAN, London.

Instituto de la Mujer 1993. Mulheres Latinoamericanas em Dados: Brasil, Instituto de la Mujer, FLACSO, Madrid.

Isis International 1985. 'Women and Health: the Brazilian Experience, International Reflections and Actions', in Isis International, Women's Journal no.3, Santiago

Jaquette, S.J. 1989. 'Women and the New Democratic Politics', in Jane S. Jaquete (ed.), The Women's Movement in Latin America: Feminism and the Transition to Democracy, UNWIN HYMAN, Boston.

Keysers, L. and Smith I. 1989. 'Family Planning: More than Fertility Control', Working Paper 198, Michigan State University.

Lycklama 'a Nijeholt, G. 1986. 'Women, Development, the State: a case study of concerted action', paper presented at the XI World Congress of Sociology, New Dely, India.

Mamdani, M. 1972. The Myth of Population Control: Family, Caste and Class in an Indian Village, Monthly Review Press, New York.

Ministerio da Saude 1984. 'Assistencia Integral a Saude da Mulher: Bases de Acao Programatica', Brasilia, Centro de Documentacao, Ministerio da Saude.

Mello, V. F. 1993. 'Trends in Population Policies in the 1990s', in Women's Global Network for Reproductive Rights, Newsletter 43, April-June.

Moreno, G.C. and Claro, A. 1994. 'Challenges from the Women's Health Movement: Women's Rights versus Population Control' in Gita Sen, Adrienne Germain & Lincoln C. Chen (eds), Population Policies Reconsidered: Health, Empowerment, and Rights, Harvard University Press, Boston, pp. 47-61.

Nowrojee, S. 1993. 'Speaking Out for Sexual and Reproductive Health', in Diva, vol. 4, June/August.

Nowrojee, S. and Pyne, H.H. 1994. 'Setting a New Agenda: Sexual and Reproductive Health and Rights', in Gita Sen, Adrienne Germain & Lincoln C. Chen (eds), Population Policies Reconsidered: Health, Empowerment, and Rights, Harvard University Press, Boston, pp. 27-46.

Pimentel, S. 1993. Direitos Reprodutivos e Ordenamento Juridico Brasileiro: Subsidios a Uma Acao Politico-Juridica Transformadora,Caderno 2, Comissao de Cidadania e Reproducao-CCR.

Pine N. R. 1993. 'Achieving Public Health Objectives through Family Planning Services', in Reproductive Health Matters, no. 2, November.

Pitanguy, J. 1994. 'Feminist Politics and Reproductive Rights: The Case of Brazil' in Gita Sen and Rachel C. Snow (eds), Power and Decision: The Social Control of Reproduction, Harvard Press, pp.101-122.

Pitanguy, J. forthcoming. 'The Women's Movement and Public Policy in Brazil' in Lycklama a Nijeholt, Geertje & Virginia Vargas & Saskia Wieringa (eds), The Triangle of Empowerment: Strategies and Policies Related to Women's Issues.

Sarti, C. 1989. 'The Panorama of Feminism in Brazil', in New Left Review 173: 75-91.

Schmink, M. 1981. 'Women in Brazilian Politics', in SIGNS, vol.7, no. 1, pp. 115-135.

Sen, G. 1994. 'Reproduction: Policies and Politics', in Gita Sen and Rachel C. Snow (eds), Power and Decision: The Social Control of Reproduction, Harvard Press, England.

Sen, G. and Germain A. and Chen, C.L. 1994. 'Reconsidering Population Policies: Ethics, Development, and Strategies for Change', in Gita Sen, Adrienne Germain, and Lincoln C. Chen (eds), Population Policies Reconsidered: Health, Empowerment, and Rights, Harvard University Press, Boston, pp. 3-12.

Simon, J.L. 1981. The ultimate resource, Martin Roberstson, Oxford.

Slater, D. 1985. New Social Movements and the State in Latin America, CEDLA, Amsterdam.

United Nations 1993. Dept. of Economic and Social Information and Policy Analysis, Population Policies and Programmes, Proceedings of the U.N. Expert Group Meeting on Population Policies and Programmes, Cairo, Egypt, 12-16, April 1992.

United Nations 1994. 'Draft Final Document of the Conference',

A/CONF. 171/PC/5, Program of Action of the Conference, note by the Secretary-General, 24 January.

Van Haselma, I. 1995. 'Femocrats in Brazil in the Eighties: Feminists or Technocrats?' paper presented in the International CEDLA Workshop Technocrats and the Politics of Expertise in Latin America, September, Amsterdam.

Vivaldi, M.I.M. 1994. 'Cairo: A leap forward in our empowerment', in Women's Global Network for Reproductive Rights, Newsletter 48.

Walt, G. 1994. Health Policy: An Introduction to Process and Power, Zed Books, London.

Waylen, G. 1995. 'The State and Democratization in Chile', in IDS Bulletin, vol 26, no. 3, July.

Women's Global Network for Reproductive Rights 1993. 'Population and Development Policies: Report on the International Conference "Reinforcing Reproductive Rights"', Newsletter 43.

World Bank 1984. World Development Report, Oxford University Press, New York.

Young, K. 1989. 'Not the Church, not the State' in Young (ed.), Serving Two Masters, Routledge, London, pp.101-127.