REPRODUCTIVE HEALTH matters

FEATURE

Equity and women's health services for contraception, abortion and childbirth in Brazil

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Abstract: *This paper addresses equity in health and health care in Brazil, examining unjust disparities between women and men, and between women from different social strata, with a focus on services for contraception, abortion and pregnancy. In 2010 women's life expectancy was 77.6 years, men's was 69.7 years. Women are two-thirds of public hospital services users and assess their health status less positively than men. The total fertility rate was 1.8 in 2011, and contraceptive prevalence has been high among women at all income levels. The proportion of sterilizations has decreased; lower-income women are more frequently sterilized. Abortions are mostly illegal; women with more money have better access to safe abortions in private clinics. Poorer women generally self-induce abortion with misoprostol, seeking treatment of complications from public clinics. Institutional violence on the part of health professionals is reported by half of women receiving abortion care and a quarter of women during childbirth. Maternity care is virtually universal. The public sector has fewer caesarean sections, fewer low birthweight babies, and more rooming-in, but excessive episiotomies and inductions. Privacy, continuity of care and companionship during birth are more common in the private sector. To achieve equity, the health system must go beyond universal, unregulated access to technology, and move towards safe, effective and transparent care.* © 2012 Reproductive Health Matters

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Equity is one of the principles of Brazil's Unified Health System (SUS), as defined by the 1988 Constitution, together with the principles of universality (health is everyone's right and a State duty), *integralidade* (comprehensiveness, health care includes prevention, treatment and rehabilitation, and their bio-psycho-social dimensions), and control by society.[1] The concept of health equity is based on the ethical notion of distributive justice, reflecting core human rights principles.[2] To promote health equity in a population, people with different needs should be treated differently, with more investments for those who need more, in prevention, treatment or rehabilitation.

Some authors also use the concept of *health disparities*, which is different from inequity. Inequity is the result of *unjust disparities*. Some health disparities are considered inevitable – for example, people over 65 tend to have more chronic diseases than younger adults.[2] Equity in health implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential, if this disadvantage can be avoided. However, "health potential" or "health needs" vary from person to person, region to region, and time to time. The focus of a policy of equity in health is not to eliminate all health differences so that everyone has the same level and quality of health, but to reduce or eliminate the disparities arising from factors considered both preventable and unjust.[3]

According to the Pan American Health Organization, gender equity in health includes the elimination of unnecessary, unjust and avoidable differences in health status and survival; fair distribution of and access to resources (technological/

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financial/ human) according to distinct needs; that women and men contribute to health financing according to their economic capacity, not their need for services; and a just social distribution of responsibilities, power and rewards for women's and men's contribution to health production (including placing value on non-remunerated health work).[4]

Two of the most important factors considered preventable and unjust are disparities in the impact of the social determinants of health (external factors that make someone sick or healthy), and disparities in access to health services (the ability to get appropriate care when needed). The aim of this paper is to address gender equity in relation to health, considering unjust disparities between women and men, and between women from different social strata, with a focus on health care for contraception, abortion and maternity care. Data from the most recent Demographic & Health Survey (PNDS 2006),[5] the National Public Health Information System (DATASUS) and epidemiological and demographic research are analysed.

Health data are more often available from the public health sector in Brazil, for both population-based and service-based research. The lack of information from the private sector makes comparability between different social strata more difficult. Beyond vital statistics (births and deaths) and diseases with mandatory notification, information about morbidity and hospitalization in the private sector is not publicly available on a regular basis, and usually only from population-based household surveys, such as Demographic & Health Surveys.[5] In many countries, in fact, the quality and availability of information comparing public and private sector outcomes tends to be poor, scarce and biased. A recent international meta-analysis of 21 such studies concluded that, "regardless of outcomes, the quality of evidence is rated… as either low or very low".[6]

Gender, women's health and health indicators

In the last two decades since the foundation of SUS, Brazil has seen a great expansion in health services, and although huge challenges persist, economic growth and public policies for social inclusion have resulted in a decrease in poverty, income concentration and regional disparities.[1]

The Brazilian health system consists of a complex network of public and private services and providers. The public sector provides care for 75% of the population, while the private sector (for-profit and not-for-profit) is financed with private and public funds, and private health insurance. The use of private vs. public sector is strongly associated with income and educational level. While in theory, people can use the services of all sectors, in practice this depends mainly on ability to pay.[1]

In 1983, a woman-centered Comprehensive Women's Health Programme (PAISM) was created, introducing contraception and other reproductive health care into the public health services. Increased education has been closely associated with improvements in health for women themselves and their families. In Brazil, as in most countries, there has been huge social progress made by women in recent decades, with a high participation in education and the workforce. Brazilian women are currently the majority of students in all age groups and educational levels, although this does not translate into better or even equal pay in the job market.[7]

Women are also the vast majority of the health workforce: 71% at university level and 85% of technicians, but men are concentrated in the upper levels of the hierarchy.[8] Informal, unpaid care at home for people who are sick or disabled is disproportionally carried out by women.[9] This is typical for most countries: according to a damning report on gender inequity in health, health systems tend to rely on a foundation of informal health workers who are poorly paid or not paid at all, and disproportionately female.[10]

In SUS, women account for about two-thirds of outpatient consultations, including for contraception, antenatal, delivery and post-partum care, attention to symptoms of menopause, ageing, and screening and treatment for cancers such as cervical and breast cancer. This disproportion is similar in the private sector as well, and *increases* after reproductive age.[11]

Nevertheless, women have traditionally evaluated their health less positively than men of the same age. These differences between men and women present a challenge to public health, and the question of why women use services more, implying they experience more health problems than men despite living longer, has been discussed extensively.[12] Male mortality tends to be higher in all age groups. There is some evidence of female biological advantage in longevity, and women tend to be more attentive to symptoms, resulting in different health-seeking behaviour. In 2010 in Brazil, women's life expectancy was 77.6 years; men's was 69.7. More men died from all violent causes

(ten times more from homicide), and died earlier from chronic diseases.[13]

Equity, contraceptive use and ideal number of children

Between the last two PNDS surveys, contraceptive prevalence increased from 78% in 1996 to 81% in 2006 among married women aged 15–49 years, which was mostly due to increased use among more disadvantaged women; from 65% to 74% of women with the lowest incomes, and from 66% to 77% among women with the lowest educational level.[5]

Among women using contraception, there was a decrease in the proportion who had been sterilized, from 40% in 1996 to 29.1% in 2006 (but still 39% among black women). This was attributed to the increased availability of reversible methods. Male sterilization doubled from 2.5% to 5.1% (7,5% among white men) from 1996 to 2006, still low, and was mostly obtained from private clinics. In 1996, there were 16 sterilized women to one man, in 2006, this proportion was 5:1. Female sterilization has remained the most popular method among women with low income and less education. Women who are poorer, less educated, black, single, older and with a higher number of children also had a higher prevalence of unwanted births.[5]

Oral contraceptive pill use increased from 20.7% to 24.7%, and condom use among married women tripled from 4% to 12%.[5] According to the 2006 PNDS, although all methods should be available from SUS services, drugstores continue to be the main source of condoms. Hormonal methods (pills, injectables and emergency contraception) are mostly bought in drugstores, without prescription, although they are officially red label drugs requiring one.[5] In 2012, the Health Regulatory Agency (Anvisa) proposed more rigorous control of prescriptions for red label drugs, but met opposition due to the need for extra medical visits that would result, e.g. just for the 30 million pill users.

IUD use increased from 1% to 2%, and injectables from 1% to 4%. Emergency contraception was used by 23.2% of contraceptive users in 2006. SUS clinics are the main providers of IUDs and female sterilization. Diaphragms and other women-controlled barrier methods had no current users in this survey[5] due to the absence of training for providers in their use. Perhaps the transfer of provision to nurses and midwives might increase access to information and support for women who might want to use them, if they were offered.

In the last two decades, condom use has increased markedly in all population groups, as a result of the strong response in Brazil to HIV and sexually transmitted infections (STIs). The use of condoms has been more frequent among single people, and men have used condoms more frequently than women, but with a casual partner. Among those with casual partners in 2006, men's rate of condom use was 81.6%, and among women 66%; it reached 92% among youth aged 16–24 years, higher than all other age groups. However, there was a significantly lower rate of condom use among men and women with basic education (69.9%). In terms of equity, the results indicate the need for greater attention to increasing the consistent use of condoms among populations with lower educational levels and those who are more vulnerable, such as women in stable relationships, who have the lowest rate of condom use.[5]

Hormonal contraception is highly effective; it can have some non-contraceptive benefits and remains very popular, but has frequent short-term side effects, such as headaches and nausea, breast tenderness, mood changes, menstruation changes, decreased libido, and fluid retention, leading to high discontinuation rates.[14] The last nationwide data about discontinuation of reversible methods was from 1996, showing a 12-month discontinuation rate of 42.3% for pill users and 62.9% for injectables. Adverse effects and health concerns were the main causes of discontinuation.[15] Providers and women could benefit from an update on the benefits and side effects of contraceptives, and efforts made to address the high discontinuation rate.

The fertility rate in 2006 (1.8) was below replacement level. In 2001–2006, the fertility rate was 4.0 among women with no education, and 1.0 among those with more than 12 years. The fall in fertility was higher among younger, black and less educated women. For all women, the average ideal number of children was 2.1 (2.2 in the higher education quintile).[5] In Brazil, as in other Latin American countries where fertility rates were still falling in the first decade of the 21st century, there is a combination of a low fertility rate, a high number of unplanned pregnancies (and abortions), and an emerging pattern of an ideal number of children greater than the total number of children actually born. This proportion increases with increasing levels of female education in the region.[16]

Despite the high contraceptive use, 29.7% of births in the five years before the 2006 PNDS were reported as mistimed (wanted later) and 17.8%

were reported as unwanted.[5] Similar patterns are observed in other low fertility, high contracepting populations, where unwanted fertility has an important share in the total fertility rate.[14]

Inequity in abortion care

Disparities in access to safe abortion are an example of extreme inequity in Brazil, where abortion is permitted only in cases of risk to the life of the mother and rape, based on a law of 1940. In 2008, there were 3,230 legal abortions (provided only by SUS),[17] but an estimated one million abortions yearly (21 abortions per 1,000 women per year). According to a national survey in urban areas in 2010, 22% of women aged 35–39 years have had an induced abortion in their lifetimes. Illegality of abortion makes it difficult to know how accurate this is; it is likely to be an underestimation.[18]

Illegality in Brazil makes most abortions less safe, a major cause of morbidity, and the main cause of mortality in some regions. Safe abortions are only provided in the private sector illegally; they are prohibitively expensive for poorer women but affordable for those with a higher income.[17] Women with lower income tend to use more affordable methods, such as misoprostol (again, illegally, from the black market), turning to public services for treatment when there are problems. In 2008, there were 215,000 hospitalizations in SUS for complications of abortion (or miscarriage), especially from haemorrhage and infection.[17]

Complications of induced or spontaneous abortion can be prevented by proper and timely attention. The lack of information about abortion care among women with higher incomes makes comparisons between the different social strata very difficult. A recent study evaluated the quality of abortion care for women admitted to public hospitals in three state capitals (Salvador, Recife and São Luís). It included 2,807 women, hospitalized in 19 hospitals in 2010. In the three cities, care provided was far below the standards set by the Brazilian government, and pain management was frequently inappropriate.[19] As observed in other Latin American countries, sharp curettage (D&C) was the method used in almost all cases, which requires analgesia or deep sedation, hospital admission, longer waits for treatment and an overnight stay of at least 24 hours. In addition, there is a greater risk of complications.[19] WHO's *Safe Abortion: Technical and Policy Guidance for Health Systems,* both in 2003 and in the newly updated, revised 2012 edition (http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf) recommend replacing D&C with vacuum aspiration or medical abortion, both for abortion and post-abortion care. Maintaining this outdated practice violates the principle of integrity and the aim of replacing less safe interventions with safer ones. The study also found other forms of discrimination, such as the postponement of curettage until night shifts. Continuity of care and provision of post-abortion contraceptive information were also almost absent.[19]

Since 2012, however, the Health Ministry is working towards a harm reduction approach to abortion care, inspired by the successful experience in Uruguay.[20] This will hopefully improve abortion care substantially for women in SUS hospitals.

Equity and violence in health care

Abuse and disrespect in health care (in Brazil called institutional violence),[21] is a gender issue because it reflects sexist prejudices against women, expressed in the way care is organized and provided.[22] It received much attention in 2011, with the publication of the Perseu Abramo Institute report, based on interviews with 2,365 women and 1,181 men in urban and rural areas in all Brazilian states. Among women who were hospitalized for complications of abortion, 53% reported some form of violence from health care providers (men and women), including refusal of information, failure to obtain consent, delay and neglect in assistance, being threatened with prison, and verbal abuse. Among women asked about such violence during childbirth, 25% reported some form of violence (27% in the public sector and 16% in the private sector), including verbal abuse and abuses such as refusal of pain relief and painful, repeated vaginal manipulation. Women at the top of the social hierarchy (white, married, with higher education) were less vulnerable to but not free from such violence.[9] Less is know about men's experience of institutional violence in health care, but their resistance to attending health services may be due to unfriendliness towards men, and being placed in a subordinate position, which men would resist more than women.[23]

Privacy is a basic human right, a key element in quality of care, and highly valued by women. It is usually neglected in the public sector, where the pre-SUS culture of treating patients as "indigent" survives, for example, in collective maternity wards with many beds and no chance of privacy.

Having their privacy violated at a moment of intense vulnerability, whether in relation to abortion, miscarriage or childbirth, is an unjust disparity faced by women in the SUS system.[22] Equity issues in relation to autonomy and informed choice are complicated by an implicit culture among health professionals of granting autonomy to private patients while expecting those seen in the public sector to let the doctor decide.[24]

Indifferent, rude treatment is associated with patients feeling unable to speak up on their own behalf, which has implications for safety.[25] Freedom from violence, and humane treatment, including the offer of means of comfort and pain relief, continuity of care and privacy, should not be considered a privilege, restricted to those in the private sector, but part of minimum standards of quality and safety in all women's health care.[22]

Equity and maternity care

Women who have children experience unjust disparities, such as the undervaluation of their paid work because of family responsibilities, lack of recognition of their caring for others at home, the double shift, and shortage of childcare.[9] These drawbacks affect women with lower income and education more harshly than others as they have little or no ability to pay for practical help, even when they have post-partum morbidity, such as a surgical wound following episiotomy, perineal trauma or caesarean section.

Maternal mortality in Brazil was estimated to be 77 per 100,000 live births in 2007, making it unlikely that Brazil will reach the Millennium Development Goal of a 75% reduction by 2015.[17] Efforts to reduce maternal deaths have plateaued in the last 15 years. The majority occur disproportionately among black, low income, unmarried and young women, and the number of near-miss cases, which may result in serious and chronic morbidity, is high.[17] This is despite the fact that in Brazil maternity care is virtually universal during pregnancy (81% of women have six or more antenatal visits) and childbirth (98.7% deliver in a health service setting with a trained provider, 88.7% of those with a physician).[5]

Although wealthier women tend to receive better health care, studies indicate that in some circumstances women with lower income and less education may get safer and more effective maternity care. A 2005 study of equity in maternity care in São Paulo found that some indicators of quality of care, such as HIV and STI testing, the quality of antenatal records, vaginal birth rate, and rooming-in with the newborn, tended to be more frequent in low-income patients and in the public sector, although women in the higher income groups had more medical consultations and initiated antenatal care earlier.[26]

Access to appropriate – safe and effective – interventions in maternity care can save lives and promote health, but inappropriate interventions can lead to adverse outcomes for women and newborns.[27] Recent studies indicate that the historical trend in inequity – of wealthier women having better neonatal outcomes – is being reversed. From 1995 to 2007, a higher level of low birthweight rates was seen in Brazil in the more developed compared to the less developed regions.[28] This is an "inversion of the expected disparity". Worsening outcomes demand more technology to compensate for them. Neonatal intensive care units are concentrated in wealthier areas.[29] The stabilization of infant mortality rates in the last decade, when they would have been expected to fall, is likely to be due to an excess of interventions during pregnancy and delivery.[17,30] Overtreatment in childbirth has been subjected to little regulation in both sectors, and adverse events are not systematically reported or researched.

The protection of women's bodily integrity in childbirth should be a key indicator of quality of care, reflecting the change in the understanding of the birth process brought about by evidence-based health care.[31] In Brazil there is considerable neglect of this aspect of care in both public and private sectors. Elective caesarean sections, as many as 84% in the private sector and 52% of total births in 2010, may provide some benefits, such as decreased urinary incontinence at three months and decreased perineal pain in comparison with those having a vaginal delivery. But it is also associated with a higher risk of maternal and neonatal mortality and severe morbidity, including hysterectomy, abdominal pain, neonatal respiratory morbidity, fetal death, placenta praevia, and uterine rupture in future pregnancies.[32]

In the public sector, the rates of episiotomy and perineal lacerations[31] are also unacceptably high and should also be treated as an unjust disparity, with poorer women (SUS users) disproportionately affected. Reflecting the neglect of women's genital integrity, data on episiotomy and perineal outcomes are not available from the SUS information system (DATASUS), but depend upon PNDS studies,[5] available only every ten years.

Spontaneous birth in a woman-centred environment is presently a rare privilege of the upper classes, as a small but increasing number of wealthy women are choosing home birth with private practitioners. This can be seen as a case of inverse equity in which, following the introduction of a "new" intervention (breastfeeding promotion, in the classic example, spontaneous birth, in this case), health inequalities, measured in terms of relative differences in outcome rates, will initially tend to increase, as advantaged populations are the first to benefit.[33]

Greater investment in midwifery care would be highly beneficial in Brazil.[34] Social movements such as the Network for the Humanization of Childbirth (Rehuna) and others are campaigning for safer, women-centered care, to prevent the abuses against women described here, and as a direct form of social control over health services – one of the SUS principles.[35] This has met strong resistance and a confrontation between these social movements and some parts of the medical establishment. In July 2012, the Medical Council of Rio de Janeiro passed a resolution that would prohibit women in hospitals and maternity wards having any assistance from university-trained midwives, or from *doulas* (who offer emotional and practical support during and after childbirth) and a second resolution that would prohibit any doctor participating in an out-of-hospital birth or providing second-level care for women transferred to hospital from birth centres or after a home birth. These resolutions led to legal action and street demonstrations by the movements concerned to preserve the legality of midwifery, *doulas* and home births, and protect medical doctors who join professional teams to attend out-of-hospital births.[36]

Women's health and equity: improving information systems and outcomes

Services such as condom provision, contraceptive information and support, vacuum aspiration and medical abortion for post-abortion care, screening for antenatal syphilis and other STIs/HIV, midwifery care and companions at birth, are safe and effective and tend to produce positive outcomes. Expanding access to them so as to benefit all women is desirable. Use of outdated technology such as D&C for any abortion, inappropriate pain relief, elective caesarean section before labour begins, routine episiotomy, liberal induction or augmentation of labour, fundal pressure, and deprivation of companions and of privacy, tend to produce adverse outcomes that may outweigh the good effects of beneficial interventions. For most potentially harmful interventions, few data are routinely collected by the SUS information system. Hence, prevalence and trends are difficult to track or do anything about.

The inclusion of these rights-based health indicators:

- numbers of safe as well as unsafe abortions;
- complications of unsafe abortions and type of treatment;
- contraceptive methods provided, including post-abortion;
- reasons for contraceptive discontinuation and replacement methods provided;
- numbers of women with post-partum genital integrity;
- numbers of spontaneous births after 39 completed weeks of pregnancy; and
- satisfaction with health care

would benefit women at least as much as process indicators such as number of antenatal visits, access to surgery, tests and medicines. The latter are good for measuring health system efficacy in delivering technology, but not necessarily in measuring health outcomes. To evaluate equity in access to appropriate *and* potentially harmful technology, transparent data from the private sector as well as the public sector should be required, to permit comparability.[22]

In the three aspects of reproductive health care for women examined in this paper, disparity in use of contraception and maternal health coverage decreased, in the context of an unregulated health care market. Socioeconomic status continues to play a major role in relation to (lack of) access to safe abortion.

Education for health literacy and informed choice related to health technology are strikingly absent in both public and private sectors in Brazil today, although women's health movements developed a rich store of educational material in the 1980s and 90s.

To achieve equity in women's health in Brazil the government and the health system must go beyond universal, unregulated access to technology, and move towards effective, safe, transparent care, based on informed choice, and respectful of the rights of women.

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Résumé

Cet article aborde l'équité dans la santé et les soins au Brésil, en examinant les disparités injustes entre hommes et femmes, et entre femmes de différentes couches sociales, dans les services de contraception, d'avortement et de maternité. En 2010, l'espérance de vie des femmes était de 77,6 ans, celle des hommes de 69,7 ans. Pourtant, les femmes représentent les deux tiers des usagers des services hospitaliers publics et évaluent leur état de santé moins positivement que les hommes. Le taux total de fécondité était de 1,8 en 2011 et la prévalence de la contraception est élevée chez les femmes de tous les niveaux de revenu. La proportion de stérilisations a diminué ; les femmes à faible revenu sont plus fréquemment stérilisées. Les avortements sont le plus souvent illégaux ; les femmes aisées ont davantage accès à des avortements sûrs dans des centres privés. Les femmes pauvres avortent elles-mêmes avec du misoprostol et s'adressent aux dispensaires publics en cas de complications. La moitié des femmes soignées pour un avortement et un quart des accouchées font état de violence institutionnelle des professionnels de santé. Les soins pour maternité sont presque généralisés. Le secteur public enregistre moins de césariennes et de cas d'insuffisance pondérale à la naissance et fait davantage dormir les mères avec leur nourrisson, mais il pratique un nombre excessif d'épisiotomies et de déclenchements du travail. L'intimité, la continuité des soins et l'accompagnement pendant l'accouchement sont plus fréquents dans le secteur privé. Pour parvenir à l'équité, le système de santé doit dépasser l'accès universel et non réglementé à la technologie et aller vers des soins sûrs, efficaces et transparents.

Resumen

En este artículo se trata la equidad en salud y servicios de salud en Brasil y se examinan las disparidades injustas entre mujeres y hombres y entre mujeres de diferentes estratos sociales, con un enfoque en servicios de anticoncepción, aborto y embarazo. En 2010, la esperanza de vida de las mujeres era de 77.6 años; la de los hombres, de 69.7 años. Sin embargo, las mujeres constituyen dos terceras partes de los usuarios de servicios de hospitales públicos y evalúan su estado de salud de manera menos positiva que los hombres. La tasa de fertilidad total fue de 1.8 en 2011 y la prevalencia del uso de anticonceptivos es alta entre mujeres en todos los niveles de ingreso. La proporción de esterilizaciones ha disminuido; la esterilización es más común entre mujeres de ingresos más bajos. El aborto es principalmente ilegal; las mujeres más adineradas tienen mejor acceso a servicios de aborto seguro en clínicas privadas. Las mujeres más pobres generalmente autoinducen el aborto con misoprostol y buscan tratamiento de las complicaciones en clínicas públicas. La mitad de las mujeres que reciben servicios de aborto y una cuarta parte de las mujeres durante el parto informan haber sufrido violencia institucional por parte de profesionales de la salud. Los servicios de maternidad son virtualmente universales. El sector público tiene menos cesáreas, menos bebés con bajo peso al nacer y más internación conjunta madre-hijo, pero excesivas episiotomías e inducciones. La privacidad, continuación de los servicios y acompañamiento durante el parto son más comunes en el sector privado. Para lograr equidad, el sistema de salud debe ir trascender el acceso universal no regulado a la tecnología y ofrecer servicios seguros, eficaces y transparentes.