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# Reproductive health and rights, and public policies in Brazil: revisiting challenges during covid-19 pandemics

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**ABSTRACT**

We revisit the debates on reproductive health and rights (RHR) and public policies in Brazil, with focus on contraception, abortion and maternity care. These were part of a broader political agenda for re-democratisation, and for health sector reform, with the creation of the Women's Integral Health Program (PAISM) in 1983, and of the Universal Health System (SUS) in 1988. The momentum created by ICPD in Cairo (1994) was essential to institutionalise the language of RHR. Not without resistance and organised activism, recent years of right-wing governments brought a disinvestment in most public policies for women's rights. Some components of the RHR agenda are more mainstreamed, such as fertility regulation, especially hormonal and long term-methods. The limited legal rights to abortion are poorly institutionalised and constantly threatened. Maternal care tends to be highly medicalised and frequently abusive. The covid-19 pandemic accelerated social and public health disruption. The article addresses notions such as reproductive justice and institutional violence, present in the early days of women's health movement, in order to highlight important premises that were diluted in the debate on reproductive rights and autonomy. The historical analysis of how these concepts evolved locally and globally can allow a better understanding of present challenges.

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## Introduction

This article faces a double challenge. In the first place, we seek to make a historical overview, with all the limitations that this type of endeavour poses, on important landmarks in the Brazilian context in the last four decades, for the construction of an agenda, negotiation and implementation of public policies in the field of what is now widely known as reproductive health and reproductive rights. Our second challenge is to examine the adaptations that these concepts have undergone as a result of political struggles and underlying historical moments.

We initially address the concept of integrality, locally forged mainly in the health field, at a time of great intellectual effervescence and political openness in the country, and which represents an important turning point in women's health care policies, until then with a strong maternal-infant focus. Next, we address the interfaces and connections with the broader international level, and the formulation of the concept of reproductive rights, a language with strong global appeal and politically very advantageous for women, based on the ideas of self-determination and reproductive autonomy.

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In reviewing the situation about contraception, abortion and maternal care, we argue that even with all the intense post-Cairo activism, with the institutionalisation of reproductive health and rights came a narrow interpretation of these concepts, with the prioritisation of some themes in the public policy agenda. This diluted version was in contradiction with the necessary intersectoriality among public policies demanded by the concept of 'integral health', a notion closer to broader concepts such as 'reproductive justice' and 'reproductive freedom', present in the political arena since the 1970s and 1980s. The article also discusses the revival of certain demands in the women's health agenda, as well as the recent recovery of those previous concepts with great power to produce confrontations and resistance to the neoliberal policies that have affected the fields of health, work, education, and social assistance.

Finally, we discuss the impacts of the COVID-19 pandemic on the health and reproductive rights of Brazilian women. The greatest humanitarian catastrophe of the last century deepens inequalities on several social levels. The ability to respond to the first pandemic of the twenty-first century depends on the institutional arrangements of each country (which includes the multilateral agreements that nations are able to produce), while revealing the political determinants for its confrontation.

In this paper we bring some elements for the analysis of the situation of reproductive health and rights in Brazil in 2020s, a quarter of a century after the Cairo International Conference for Population and Development (ICPD, 1994), facing three threats: the right-wing fundamentalistic context, the dismantling of the State (and the erosion of social policies), and the COVID-19 pandemic. Using official documents, media reports and academic researches, we discuss the progresses in recent decades and the critical situations related to reproductive health and rights, in the unfortunate encounter between a public health disaster and a fascist ruler.

## From 'materno-infantilism' to women's integral health

In Brazil a vocal women's health movement emerged in the early 1980s, building from other social movements for the democratisation during the military dictatorship (1964–1984), including in some regions a popular health movement where women had a large participation (Diniz et al., 1998). By that time, the debate about population and development in Brazil ignored women's agency and rights to choose on reproductive issues. On one hand, there were pro-natalist forces: religious groups against contraception and abortion, and the military that ruled the country in those years, aiming to increase fertility to occupy the national territory. On the other hand, eugenic anti-natalist national and international groups advocated for population control to solve economic and social problems, focusing on reducing fertility among poor women (Ávila, 1993; Osis, 1998).

This was the context where the Women's Integral Health Program (PAISM) was created in the Health Ministry in 1983, even before the end of the dictatorship (1964–1985) and of the creation of the Unified Health System (1988). It was a result of the feminist presence in the so-called Partido Sanitário ('Health Party', a coalition of progressive forces for health reform and universal health care), rooted in the Brazilian Social Medicine culture (rebranded Collective Health, or 'Saúde Coletiva'), where the concept of 'integral health' flourished (d'Oliveira, 1999; Osis, 1998).

Brazilian feminist critical perspectives to medical establishment and to mainstream epidemiology was rooted in the movement's deep links with the Latin America Social Medicine (LASM) movement, which had, comparing with their international counterparts a 'new and distinctive methodological tradition in the field: the critical and ideological analysis of what is usually presented as purely technical knowledge' (Vasquez et al., 2020). This 'critical and ideological' perspective will contrast with the mere vindication of health service, as it identified health care for women as both necessary, and a source of patriarchal oppression (Ehrenreich & English, 1973).

The concept of *integralidade* (comprehensiveness), developed by feminists and others, was complex, inspired in the Alma Ata definition of health as including biological, psychological and social dimensions. It was a rupture with 'materno-infantilism', the sole focus on women's reproductive

roles, often overtly aiming not women themselves, but the 'product of conception', a healthy baby. It opened a broad agenda to include health issues from childhood to ageing, mental health, occupational health, and articulated networks from primary care to specialist treatment. Sexuality, fertility regulation aiming to increase the range of contraceptive choice, abortion and maternity services were included in this feminist-inspired public health programing (d'Oliveira, 1999; Diniz et al., 2012).

Encompassing both fertility regulation and childbearing, biological as social determinants of health, and questioning gender norms, the overall set of ideas was closer to the current notion of reproductive justice, although such words were not used at that time. A strategic part of PAISM was its educative component, aimed at increasing women's autonomy and ability to make decisions, as part of an effort to decrease the high medicalisation and 'surgification' of reproductive events in the early 1980s (Diniz et al., 1998). Surgical sterilisation, in the 1980s and 1990s, was the main contraceptive method, provided with little to no regulation, with peaks in electoral campaigns, and often justified by elective cesareans (Berquó, 1999).

Brazil was also heading to have elective, pre-labour cesarean as routine care for the wealthy. Routine episiotomy (an obsolete surgery to open the vulva and vagina during childbirth) in the 1980s and 1990s was performed in over 90% of all vaginal births, affecting poorer, public health service users (Diniz et al., 2012). Many of these critical educative materials about health care were produced by feminist NGOs, that were often partners in governmental initiatives. Not rarely feminist activists were integrating local or federal governments (Osis, 1998).

Along with legal equality for women and other rights, feminist movements defended women's right to self-determination, and family planning as a formal right, which were successfully included in the 1988 Federal Constitution. That was an extraordinary victory of women's movements organisations, as religious forces nationally and internationally were fiercely advocating for the 'right to life since conception' (Correa, 1993). Women's movements were part of the successful efforts to include in the 1988 Federal Constitution the right to universal health care and the creation of the Unified Health System (SUS), which reinforced the principles of integral health present in PAISM since the early 1980s.

## From *integralidade* to reproductive health and rights: women's bodies as the political battleground

Although the ideas of 'integrality' had already introduced the social and political dimensions of women's health and rights in the public debate one decade before the Cairo Conference, the advent of the concepts of reproductive health and rights (RHR) in the 1990s was much welcome by Brazilian feminists (Osis, 1998). These notions came with a strong theoretical and political approach to support the right for self-determination, affirming women's human right to regulate one's fertility, including not only contraception, but also abortion, which was by that time as it is now, a taboo subject and allowed in only a few cases (Ávila, 1993; Osis, 1998). The focus on fertility regulation – in a conservative catholic country where these rights are constantly under attack – was an important step, and although more related to individual right to self-determination, it clearly demanded public provision, understood as social rights. In this way, RHR further authorised and facilitated the needed rupture with the materno-infantilist tradition.

The enthusiasm with the RHR approach was reflected in the influential Brazilian participation on the way to the international conferences of the 1990s (and pre- and post-conferences processes) that organised the consensus on women's rights, against neo-Malthusian forces in Rio (1992), for the human rights of women in Vienna (1993), establishing the notions of reproductive health and rights in Cairo (1994) and adding sexual health and rights to the agenda in Beijing (1995). These movements were catalysed by the creation of the Feminist Health and Reproductive Rights Network in 1991 (later Feminist Network of Health, Sexual Rights and Reproductive Rights), that was highly influential in public policies and had as its priority agenda to implement the PAISM (Correa, 1993).

Several other health issues were added to this agenda, such as the AIDS epidemics and violence against women, and innovative policies were developed and implemented. Productive coalitions were created in different local and federal governments, as can be seen in the considerable history of implementation of rights and policies in dialogue with the State, in search of social, civil demands translated into political rights and public policies (Machado, 2016).

The concepts of reproductive health and rights, the years of preparation for the Cairo Conference and the post-Cairo momentum, all contributed to promote this inter-sectorial dialogue materialised in the creation of the National Council for Population and Development in 1996. Many other public policies were gestated in less or more active Women's Rights Councils in the federal and local levels, helping to invent and to put forward an agenda of gender-oriented public policies in RHR and other areas.

Although joining the international movement for reproductive rights was quite affirmative in the Brazilian context, there were contradictions on how this language was translated into political issues. First, the absence of issues related to having children and mothering tended to reduce reproductive decision to an individual problem of access to contraception or abortion, unrelated to the concrete life conditions that constraint choice, including poverty and racism. This was an area of tension, especially with black feminists and in relation to coercive sterilisation (Diniz et al., 1998; Oliveira et al., 2003). A second problem was the easiness in accepting the partnership with the medical establishment, an arrangement in which risks were minimised as a strategic alliance to increase contraception and medical care access for all women. In the 1980s, an evident fracture of the movement was the fierce criticism of some groups of international NGOs devoted to distributing drugs and devices with little supervision, and of certain methods such as implanted hormonal contraceptive. In the 1980s, 'contemporary conceptions of ethics in research with human beings were still rudimentary and the idea of scientific autonomy was framed in traditional frameworks' (Pimentel et al., 2017). Feminist movements helped to bring into light these contradictions, which are even more evident today.

Although extremely progressive in many aspects such as the institutionalisation of reproductive rights, the Cairo Conference reflected the trends in the neoliberal consensus of the 1990s. According to Petchesky (1995), a key problem was the contradiction with 'the main principles and goals related to reproductive health and rights, and sustainable human development ("the social dimension")'. The agreements explicitly 'promote the "increased involvement of the private sector" in producing and marketing contraceptives and providing reproductive health services, as well as "the selective use of user fees" and "social marketing" techniques'. In the 1990s, the decade of de-regulation of markets, the Cairo agreement 'encourages governments to lift regulations on the private sector and its "efficient production of commodities for reproductive health, family planning and service delivery"'. In a health system perspective, it was a sharp contrast with the political perspective of PAISM or the SUS universal right to health. According to this author, 'the Cairo document promotes the very privatization, commodification and de-regulation of reproductive health services' (Petchesky, 1995). These contradictions will be present in several political fronts of women's health, not only RHR.

The very idea of integrality is counter-hegemonic and difficult to operationalise by medical establishment, and even after formally adopted by SUS as one of its principles, it remains a conceptual nuisance. If every radical idea loses radicality when it becomes institutionalised, it was not different with PAISM, often kidnapped by conservative and market forces. As expected, PAISM critique of medicalisation of women's body were in shock with the financial conveniences of the medical establishment, characterised by a misogynistic, passive perspective of women's body and rights, leading to strong resistance to incorporate innovative, participatory, woman-centred approach (d'Oliveira, 1999; Diniz, 2012).

Incorporating the notions of reproductive health and rights formally in its documents, the PAISM and its new names (rebranded as 'policy' instead of 'program' in 2004) survived in less or more stable alliances with public policies, usually with the presence of clear feminist leadership

in the Health Ministry. This alliance was cracked in 2010 with the election of Dilma Rousseff in her first term, when any mentions to reproductive rights were traded off in a negotiation with conservative parties to guarantee her election, against a ferocious ex-social democrat turned into religious fanatic during the campaign. Elected, she created a Stork Network, aiming to reduce women's health back to materno-infantilism, trying in vain to calm down conservative forces (Diniz, 2012).

The proximity of women's movement with the State was further fractured since Rousseff's impeachment in 2016, when right-wing extremism has taken charge of Brazilian politics, with the support of market-oriented fundamentalistic neoliberalism, leading to the presidential election of Jair Bolsonaro in November 2018. Since then, Brazilian population is witnessing a catastrophic backlash in the social rights.

Affiliated with the extreme right principles, Jair Bolsonaro policies arises with racist, misogynistic, homophobic, anti-environmental and eugenic characteristics, and violates systematically any respect for human rights. Its actions have destroyed important public policies that had been structured in the last decades to reduce social exclusion. The government dissolved the Ministry for Women's Policies and the Ministry of Human Rights, and created the Ministry of Women, Family and Human Rights, headed by a right-wing fundamentalistic evangelical pastor, famous for her anti-feminist preaching.

## Reproductive health and rights and public policies in Brazil

### *Contraception: the late institutionalisation of a right*

Reproductive rights affirm the right to decide, free of coercion and responsibly, on the quantity, spacing and timing of having (or not having) children, as well access to information and to the means to fertility control. In Brazil, almost two decades elapsed between the repeal of a law (in 1979) that prohibited the dissemination or advertising of contraceptive methods (Vianna & Lacerda, 2004) and the institutionalisation of a reproductive planning policy (Family Planning Law – Brasil, 1996) that regulates several actions in the fertility and contraception field.

The late obligation of the State to provide resources for fertility control did not prevent the rapid and sharp fall in the fertility rate in the country. In four decades, it has gone from the average level of 6 children per woman (1960s) to 1.8 children per woman (below the level of population replacement) currently. This fall was not the result of a population policy, but of a complex composition between devices available in the national health system and in the market, as well as the indirect effect of other policies designed for other purposes (Cavenaghi & Alves, 2019; Martine, 1996). The increasing and unacceptably high emotional, social, existential and material cost of motherhood, especially for the poor, are also pointed as important reasons for this decline (Muniz & Veneroso, 2019).

In 1996, the country already had a high level of prevalence of the use of modern methods of contraception (that is, hormonal or medical-dependent methods), based, however, on two main devices: oral contraception and tubal ligation. To a certain extent, this profile remains in the last survey on demography and health (DHS), in 2006, despite the expansion of the contraceptive mix (Brasil, 2009). The lack of updated population data in the area of reproductive health is, in itself, a major health and political problem (the last DHS was in 2006, and the 2016 round was cancelled). Conducted every decade, this type of population survey shows advances and gaps in current public policies and allows for debate, review and constitution of new actions aimed at meeting contraceptive needs and guaranteeing the rights to implement reproductive preferences for women and men (Cavenaghi & Alves, 2019). The realisation of 'public policies without data' can once again place women at the mercy of the logic of the market.

Despite the efforts to expand the range of contraceptive options by the government, in which the strategy of unified purchase of inputs by the federal government and distribution to states and municipalities was successful, we are still faced with a scenario of unmet needs for contraception

(Cavenaghi & Alves, 2019; Olsen et al., 2018), in which unexpected pregnancy and fulfilled fertility are examples. Brazil still faces a high rate of unplanned pregnancies (it varies around 46–55% – Lago, 2015; Theme-Filha et al., 2016), as well as high percentages of declaration regarding the inappropriate moment of having a child (Theme-Filha et al., 2016). These phenomena are not homogeneous in society (Brasil, 2009): the differences between women according to regions of the country, race, years of schooling, show an unfavourable scenario for those in situations of greater social precariousness, whether in terms of occurrence (and outcomes) of an unforeseen pregnancy, either in relation to the achieved fertility.

More than two decades have passed since the enactment of the Family Planning Law. However, we still need studies that allow us to analyse not only its positive aspects, but also its unexpected effects, such as new/unforeseen barriers of access to it.[1] In recent years, we have seen a strong increase in the market for long-term reversible contraceptives (LARC), especially the hormonal ones. The Brazilian context remains marked by an unequal access to the range of contraceptive options, and the LARC seem to be occupying a space left by the retraction of female sterilisation and seen as the 'ideal method' for postponing (and spacing) reproduction. It is not by chance that LARC has being also called as 'soft sterilization'. However, the selective supply of the LARC as a public policy, aimed at certain female segments, especially the poorest, youngest, and vulnerable groups such as drug users and homeless (Brandão & Cabral, 2021), violates the principles underlying the notions of reproductive rights, namely universality, indivisibility, diversity and the democratic principle (Correa & Petchesky, 1994).

Female body remains tutored in Brazilian society: in addition to the aforementioned conditionalities for performing sterilisation, the Family Planning Law still requires the spouse's explicit consent to perform the sterilisation.[2] Thus, the illegality of abortion, the conditionalities for sterilisation, and the more or less subtle contexts of 'contraceptive coercion' (Senderowicz, 2019) put in place by government initiatives, all of them reveal political and ideological disputes over events that are not only biological, but materialised in female bodies (Correa & Petchesky, 1994).

## *Abortion: the never-ending tug of war*

The regulation of fertility with contraceptive devices was highlighted in the negotiations between women, doctors and the state, while the debate on abortion continued as peripheral and/or taboo. In Brazil, termination of pregnancy is permitted only in three cases: when pregnancy is the result of rape, when there is risk of life for the mother (these two situations permitted by Article 128 of the 1940 Penal Code) and in case of fetal anencephaly (permission obtained only in 2012). The other countless situations of voluntary termination of pregnancy are still illegal.

Although we have had two legal permits for almost 80 years, the institutionalisation of legal abortion assistance is quite recent in the country, with the first by local governments in the late 1980s. Few documents from the federal executive branch address the issue of legal abortion. The first one was published in 1999 by the Ministry of Health in response to the demands of feminist organisations, together with representatives of Febrasgo (Brazilian Federation of Gynecology and Obstetrics), who asked for the implementation of abortion services for victims of sexual violence (Camargo, 2020). Only in 2005, the Ministry of Health published a specific document on Humanized abortion care (document revised and expanded in 2011). There is also in 2014 the publication of 'Attention to women with anencephalic pregnancies'. These initiatives seek to provide qualified information and support material to health professionals and services (Brasil, 1999, 2005, 2014).

These are timid advances in the executive branch compared to the numerous barriers faced for access to legal abortion. In a country of continental dimensions such as Brazil, in 2015 there were only 37 active services to provide this type of assistance, all located in capitals and in large urban centres.[3] Besides the small network of assistance, there is also the mistaken requirement for documents such as expert report or police report (in case of pregnancy resulting from rape) by some services. Moreover, even in services registered as qualified to carry out the termination of

pregnancy, women sometimes encounter health professionals who claim conscientious objection and refuse to perform the procedure, even in cases provided by law (Fonseca et al., 2020).

Despite the victory achieved in 1988, in which the guarantee of life since conception was not incorporated in the Federal Constitution, the conservative moral crusade has intensified its efforts. Nowadays, there is an increasing number of bills, within the scope of the federal legislative branch, which seeks to criminalise abortion in any situation, excluding the few existing legal permits (Brandão & Cabral, 2019). One of the most notorious bills in this political-moral clash is known as the Statute of the Unborn (PL 478/2007). It proposes the recognition of the fetus as a subject with rights and with the right to life, and prohibits abortion under any circumstances. This project has the unrestricted support of the current Minister of Women, Family and Human Rights, Damares Alves.[4] The most recent initiative, in parallel with the preparation of this article, is the proposed bill, led by the Presidency of the Republic, to institute a commemorative date for the "National Day of the Unborn and Awareness of the Risks of Abortion". The context is quite imprudent, as threats to women's reproductive rights are more and more frequent and come from the organs that should be responsible for their maintenance and or expansion.

Despite being criminalised, women continue to interrupt unintended pregnancies, in less or more safe conditions, depending on their social and economic capital. It is well known that the illegality of abortion in the country does not prevent its occurrence, but pushes women that are more vulnerable into unhealthy and life-threatening situations. Young, black women, with low schooling, and without a partner are those who have a higher risk of death from abortion (Cardoso et al., 2020). Women with financial resources are able to terminate safely their pregnancies, albeit in a clandestine situation.

### *Pregnancy and childbirth: the demedicalisation struggle*

It was not uncontroversial if or not 'maternity care' was included in 'reproductive health'. For many, reproductive health was the fertility regulation added to the traditional and conservative 'maternal and child health' component that was already there. Except when it came for maternal mortality, which was a key issue for feminist activism. Womeńs groups had the main role in creating the present system of maternal mortality information and surveillance, practically inexistant in Brazil until the late 1980s when both the Global Network for Reproductive Rights, and the World Health Organization developed campaigns on the issue. Feminist included the visibility of maternal deaths related to unsafe abortion, creating public health visibility for this taboo issue.

The very progressive Chapter VII of Cairo ICPD 'Reproductive health and reproductive rights' include 5 subheadings: (a) 'Reproductive health and reproductive rights'; (b) Family planning; (c) Sexually transmitted diseases and prevention of human immunodeficiency virus (HIV); (d) Human sexuality and gender relations and (e) Adolescence. Although maternity services are the main cause of women's health service visit around the world, there is no mention in chapter VII to antenatal, childbirth or postpartum care, reflecting a separation of the agenda of 'reproductive rights' as the rights related to fertility regulation. Maternity services will appear in Chapter VIII, about 'Health morbidity and mortality', in the form of safe motherhood, together with HIV again, and child survival.

To facilitate more feminist attention to maternity care, in 1993 feminists from the Feminist Health Network of Reproductive Rights organised with diverse partners, another network, the Humanisation of Childbirth – Rehuna (Diniz, 2012; Sena & Tesser, 2016). Its foundation letter (Rehuna) stated the aim of promoting reproductive health and rights and the implementation of PAISM, against violence in childbirth, and the fight for the so-called 'humanized' birth, affirming the human rights of both women and babies in childbirth, and the need for evidence-based care.

This vindication was and is up to now a political innovation: the role of social movements to promote transparency and scientific evidence in policy-making, in an unprecedent inversion – women were defending the best science and promoting evidence literacy, against irrational, obsolete

and potentially harmful routine care in practice by the medical establishment. Virtually without any funding, Rehuna has influenced public policies and civil society initiatives, and many changes were implemented such as the right to companionship, reducing rates of interventions, better ambience and privacy, and the availability of midwives in some settings. Rehuna was also a promoter of other forms of organisation and incubated many other networks, from evidence-based care to doulas and midwives and against obstetric violence, anticipating debates that are currently mainstreamed (Diniz et al., 2018).

In maternity care as in fertility regulation, part of the radicality of the feminist health agenda was lost to the need for alliances with a conservative and self-serving medical establishment, and the debate about the right to autonomy, and to safe and appropriate medical resources was diluted in the search for expanding access. Reproductive health resources depending on 'soft technology' such as educative sessions (ex. for the use of vaginal barrier methods), or high-value, low technology (such as nursing or midwivery-led care), were often replaced by the almost exclusive offer of rapidly hormonal contraception prescription, or rapid surgery like surgical sterilisations and pre-labour cesarean sections, frequently offered together. Reproductive 'surgification' is much more profitable and convenient for providers, institutions, and the medical industry (Diniz et al., 2012).

Although maternal health status and access to care improved markedly in these decades (women are more educated, there is universal health antenatal care, immunisations and institutionalised childbirth), maternal health indicators in Brazil are not encouraging. Maternal mortality rate is stagnant in the last two decades, in part by the improvement in the investigation of the causes of death. Thanks to intense activism, the cesarean section rate was partially regulated in recent few years, but these trends are being reversed by the market-oriented deregulation, even in the public sector. Complaints of abuse and disrespect in childbirth are widespread, but at least some of the most outrageous routines, such as episiotomy and Kristeller (fundal pressure), have become visible and have largely decreased (Leal et al., 2019). One of the most successful descendent of Rehuna is the Parto do Princípio Network, a consumer association that in 2006 proposed a legal action based on the human rights and reproductive rights framework, against the private sector for violating women's human rights to autonomy and bodily integrity, by lying to women on the safety of interventions, and not offering evidence-based care. The Public Ministry in several states took action, and the private sector was sentenced in 2014 to provide a list of alternatives in terms of information and models of care. For the first time in the century, the cesarean section rate, that used to increase 1.5–2.0% a year, having reached 57%, decreased in 2015 and in some cities decreased over 10%, although the change was higher in the already astronomic rates in the private sector (over 80%) (Leal et al., 2019).

Unfortunately, with the erosion of democracy, these changes are threatened, and since 2019, local laws have being approved to facilitate the access to cesarean in the public sector, ironically sometimes arguing the right to autonomy and the prevention of abuses in childbirth.

## Reproductive health and rights in the covid-19 pandemics: intensification of disruptions in the political, administrative and assistance levels

The covid-19 pandemic is a social phenomenon: it highlights the abysmal social, class and gender inequalities, as well as racism, misogyny, the endemic domestic violence and the contempt for the elderly. Thus, the ongoing double battle in Brazil, sanitary and political, brings immense challenges to the maintenance of some of the achievements in terms of health and reproductive rights; some have been daily eroded in this never-ending nightmare.

Right at the beginning of the pandemic, several documents from international organisations, such as WHO (2020), UNFPA (2020a), international societies of gynecology and obstetrics (such as FIGO – Townsend et al., 2020) drew attention to the threats to sexual and reproductive rights due to the actions and measures adopted by countries in the attempt to contain and mitigate the COVID-19 pandemic (Hussein, 2020). In Brazil, threats quickly became concrete actions. Military

occupation of Ministry of Health (MH) jobs and dismantling of the technical area of women's health are prime examples of this. MH career professionals were dismissed after the elaboration of a technical note that only summarised indications made globally by international organisations and associations (such as FIGO, UNFPA, WHO),[5] but the note was taken as a 'document that advocated abortion'. Its content defended the maintenance of the limited actions, already present in previous official documents, in the field of health and reproductive rights. The note was withdrawn from circulation and the technicians were fired.

UNFPA Reports (2020b, 2020c) draw attention to the possible epidemic of unintended pregnancies due to the interruption of reproductive health services when they are considered 'non-essential'. International organisations have insisted that the provision of modern, short- and long-term contraceptives, information, counselling and services (including emergency contraception) are vital inputs and must be available and accessible during the response to the COVID-19 pandemic. This is a consequence whether due to the interruption of the supply chain that generates a shortage of inputs in public health services, or by the reduction in family income that ends up compromising the acquisition of contraceptives in private pharmacies. Since Brazil has a contraceptive mix that is more dependent on short-term methods (pill, EC, condom) than other countries in Latin America, UNFPA estimates that almost two million women would be discontinuing the use of contraceptive methods in the country. This represents not only a high impact on the indicator of unmet needs for contraception ('return to levels recorded 20 years ago') but also an increase in demand for reproductive health care services in the coming year.[6]

Antenatal, childbirth and postpartum care were also disrupted by the adjustment of the health system to provide beds for covid-19 cases. In many cities, elective consultations including antenatal care were suspended even for high-risk pregnancies. Maternity beds in general hospitals that became dedicated to covid-19 patients were transferred to other services, sometimes much further than the original ones, sometimes in very overbooked hospitals. The rights for companionship were suspended in many places, for the lack of personal protective equipment, or for no other reason, and women were not allowed to stay with the newborns, even if asymptomatic, if they did not have a recent COVID-19 negative test.

In the first publications about the impact of COVID-19 in pregnancy, it was believed that the infection posed no additional risk for pregnant women. That was not what we found in Brazil: by July 2020, according to the Respiratory Infections Surveillance System (SIVEP), at least 202 women had died in pregnancy or postpartum, and (as the rest of the pandemic) they were disproportionally black women, dependent from the public sector.[7] They also had inadequate access to intensive care and to mechanical ventilation when compared to the general population. This analysis was published by the COVID-19 and Pregnancy Brazilian Group, an independent research group with ObGyn, nurses and midwives, using public datasets and working in a voluntary base (Takemoto et al., 2020), reflecting the new forms of feminist articulation and technical activism in recent years.[8] Data released in April 2021 shows that weekly maternal mortality in 2021 is more than double the one in 2020 (Colucci, 2021).

The peak we are seeing in maternal mortality is not accidental; it is related to the increased biological vulnerability to the infection in pregnancy and postpartum (potentially complicated by social and programmatic vulnerabilities and co-morbidities that are already important causes of maternal mortality), and is a consequence of the COVID-19 disastrous management, leading to disruption of care that could be prevented with appropriate management of the new challenges during the pandemic.

## Reproductive rights and health: updating the challenges for the 2020s

In Brazil, the reproductive health and rights agenda, translated into cultural changes and reflected in public policies such as PAISM, was part of a broader agenda of changes promoted by the feminist movement, acting on several fronts such as academia, policy-making and social movements. With

the erosion of democracy and of public commitments to promote equity and social justice in recent years, many of these policies have been discontinued, indirectly by under-financing or by the total withdrawal of funds, or even by the stigmatisation of certain policies such as the few legal abortion services. In the present federal government, the growing participation of religious and military sectors and the most reactionary sectors of medical organisations contributes to this desolate situation.

Despite this adverse context, in recent years, the resistance from existing social actors is refreshed by new movements that have joined the struggle of reproductive rights as human rights, attracted by some of their original demands. For instance, younger generations of feminist are resuming the enthusiasm in the PAISM ideas. Although much unfulfilled in its radicality and implementation, this luminous moment reflects a confluence of feminism innovation, as part of 'Collective Health' movement and the LASM tradition. In facing the immense present political challenges, these insights can be 'in an excellent position to offer theoretical and practical elements' to those interested in health as a right and a public good (Tájer, 2003).

### *Overmedicalisation and violence in healthcare are back to the agenda*

The resurgence of the criticism of medical practice has returned in less or more organised movements, in diverse health and rights issues. One of them is the international activism against the violations of human rights of women in childbirth and abortion care (also called 'abuse and disrespect'), not only in relational issues, but nominating 'routine' practice of unconsented, obsolete, brutal and unsafe procedures such as episiotomy, Kristeller in childbirth, and uterine curettage in abortion, as forms of violations of human rights. Empirical research shows the maintenance of high prevalence of such abuses in childbirth (25%), that are even higher in abortion care (52%), mainly in black and poor women (Hotimsky et al., 2013). The movement was able to mobilise a whole new generation of activists in social movements, academia and the judiciary system, leading to the creation of new networks, research agendas, and legal resources to prevent and remedy abuse, using the human rights framework. A national slogan of the movement 'enough of a violent delivery to sell cesarean section', express a synthesis of the reasons for the high acceptability of cesarean section in Brazil and Latin America, as forms of coercion of women, since the only alternatives are a surgical birth or an abusive childbirth experience (Diniz et al., 2018).

We emphasise the role of Latin America and Brazil in the conceptualisation of this form of gender-based reproductive violence, which is now recognised worldwide and is a reason for great tension in the dialogue between these movements and the medical establishment (Sen et al., 2018). In 2019, the Ministry of Health under Bolsonaro government even proposed that the term 'obstetric violence' should be officially censored. This term is an 'epistemic leap' in the authority of women to express their experience and escape the bonds of medical gendered subjection of women, and an example of successful resistance to the attempts to censor female narratives about reproductive injustice. Alternatively, the term officially considered acceptable in international documents, 'abuse and disrespect' (Miller & Lalonde, 2015) in childbirth and abortion care, has the advantage of being highly self-explanatory.

Conflicts of interest and the appropriation of the reproductive health and rights agenda are also visible in terms of the absolute hegemony of market forces in contraceptive provision, with a virtual disappearance of women-controlled barrier methods in the method mix, in both private and public sectors (Cavenaghi & Alves, 2019). This is an example of some unwanted outcome of the Cairo Conference, 'the very privatization, commodification and de-regulation of reproductive health services' (Petchesky, 1995).

A front of resistance to this situation is the spontaneous organisations of women confronting the abuse of prescriptions for hormonal contraceptives and the doctors' indifference or overt denial regarding serious or even fatal adverse effects of pills and other hormonal contraceptives. Communities of women who consider themselves to have adverse effects of hormonal contraception such as strokes and other injuries, organise themselves spontaneously, through social networks like

Facebook (Pissolito, 2019). Another recent example is the organisation of women who have sequalae of the contraceptive Essure (Bayer), who recently organised through social networks demonstrations to denounce their situation in several Brazilian cities, even during the pandemic, to demand the withdrawal of the device, and reparation of the sequalae (Brandão & Pimentel, 2020).

These frequently spontaneous movements act as informal post-marketing epidemiological surveillance of adverse effects of drugs, in the absence of responses from governmental or non-governmental organisations, even worse in the context of the overall dismantling of health surveillance resources in Brazil.

## *Social rights and reproductive justice: rediscovering powerful concepts*

The idea of the indivisibility of reproductive rights as social and economic rights was present in the early moments of the feminist movements for reproductive justice, not only in Brazil. Before the notions of reproductive rights, or even of reproductive justice, the early days of the movement was for the so-called reproductive freedom, clearly including social rights on the equation of reproductive choice. The Coalition for Abortion Rights and Against Sterilization Abuse (CARASA) in 1979, stated that 'along with adequate abortion services and an end to involuntary sterilizations', reproductive freedom meant:

> … the availability to all people of good public childcare centers and schools; decent housing, adequate welfare, and wages high enough to support a family; and of quality medical, pre- and post-natal and maternal care. It must also mean freedom of sexual choice, which implies an end to the cultural norms that defines a woman in terms of having children and living with a man; an affirmation of peoples' right to raise a child outside of conventional families; and … a transformation of childcare arrangements so that they can be shared among women and men. (Petchesky, 2006)

These concepts, according to Petchesky, although primitive, 'had a breath of vision that insisted on the linkages between class, race, gender, reproduction and sexuality', and were broader and more inclusive than it came to be in the institutionalised version of sexual and reproductive rights that were able to put in place. The debate about intersectionality and reproductive rights, with the strong protagonism of black feminists, had since the late 1990s reintroduced race and class in the debate, with less or more impact (Oliveira et al., 2003). The idea of reproductive justice is understood not as a substitute for reproductive rights, but as an integration of the complementary reproductive needs, including reproductive health (dealing with health care service delivery), reproductive rights (the legal regimes, and also their expansion to encompass all reproductive needs), and reproductive justice, that focus on organising resistance and movement building using human rights standards (Ross et al., 2017).

In the context of the COVID-19 pandemic, the notion of reproductive justice is strongly back to agenda, given the extreme evidence of the social determinants of health it exposes (GEA, 2020). It can be defined as 'the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities', including the obligation of governments and society to ensure that the conditions are suitable for implementing one's decisions. Although refined by black or multiracial women's organisations, reproductive justice 'is not an exclusive, essentialist race-based movement, but a movement for the human rights of all people' (Ross et al., 2017, pp. 20–21).

The traditional relation between global public policy processes and countries' policymaking, including health, suffers at this moment a strong rupture due to the political context in Brazil. It is not by chance that the response to the COVID-19 pandemic is frequently called a genocide and expressions like 'pandemic-pandemonium' are repeatedly present on social media alluding to Bolsonaro's government (Lancet, 2020). Thus, we are facing a new historical challenge, not only in the health dimension, but also a strong backlash in the field of rights, in the secular state and democracy. And we do need to continue the struggle for social justice in as many areas as possible.

The re-appropriation of these notions of social rights and justice in reproductive life are especially important in the COVID-19 pandemic, when the precariousness of labour and income, with an even higher impact on women, black and poor people, will demand strong commitments to social policies in support for reproductive health and rights. Active social movements are needed to imagine new forms of hope and activism able to promote these changes.

## Notes

1. For example, access to the method is extended to the male population; tubal ligation ceases to be a marketing agreement between doctors and patients and becomes a guaranteed right, since certain conditions are met: to be at least 25 years old or to have two live children at the time of sterilisation, and to have a minimum period of 60 days between the manifestation of the will and the surgery (Brasil, 1996).
2. A bill (PLS 107/2018) has been in progress in the Federal Senate since 2018, which seeks to facilitate the access of women and men to sterilisation procedures, allowing sterilisation in the postpartum or immediate post-abortion period, and ending the spouse's need for sterilisation consent for both women and men. https://www25.senado.leg.br/web/atividade/materias/-/materia/132552.
3. The first legal abortion service in the country was created in 1989, in the municipality of São Paulo, when the city was governed by a female mayor (Luiza Erundina of the Workers' Party – PT) and with strong support from a feminist staff and member of her government.
4. The PL 478/2007 continues to await an opinion from the Chamber of Deputies' Committee on Women's Rights. The current rapporteur, Emanuel Pinheiro Neto, is a young deputy who until recently considered becoming a priest.
5. Technical Note 16/2020: 'Access to sexual health and reproductive health in the context of the COVID pandemic', published on June 1, 2020 by the Ministry of Health.
6. Tobar, Frederic. Webnario # 15 The impact of COVID-19 on access to contraceptive methods. On: August 5, 2020. https://www.youtube.com/watch?v=jBaKGJHyqL8&t=1683s.
7. https://www1.folha.uol.com.br/equilibrioesaude/2020/07/caso-unico-brasil-passa-de-200-mortes-de-gravidas-e-puerperas-por-covid-19.shtml.
8. Another example is the Feminist Network of Feminist ObGyn, whose members are part of several of the initiatives, helping to disseminate women's rights among their peers in this grim scenario.

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