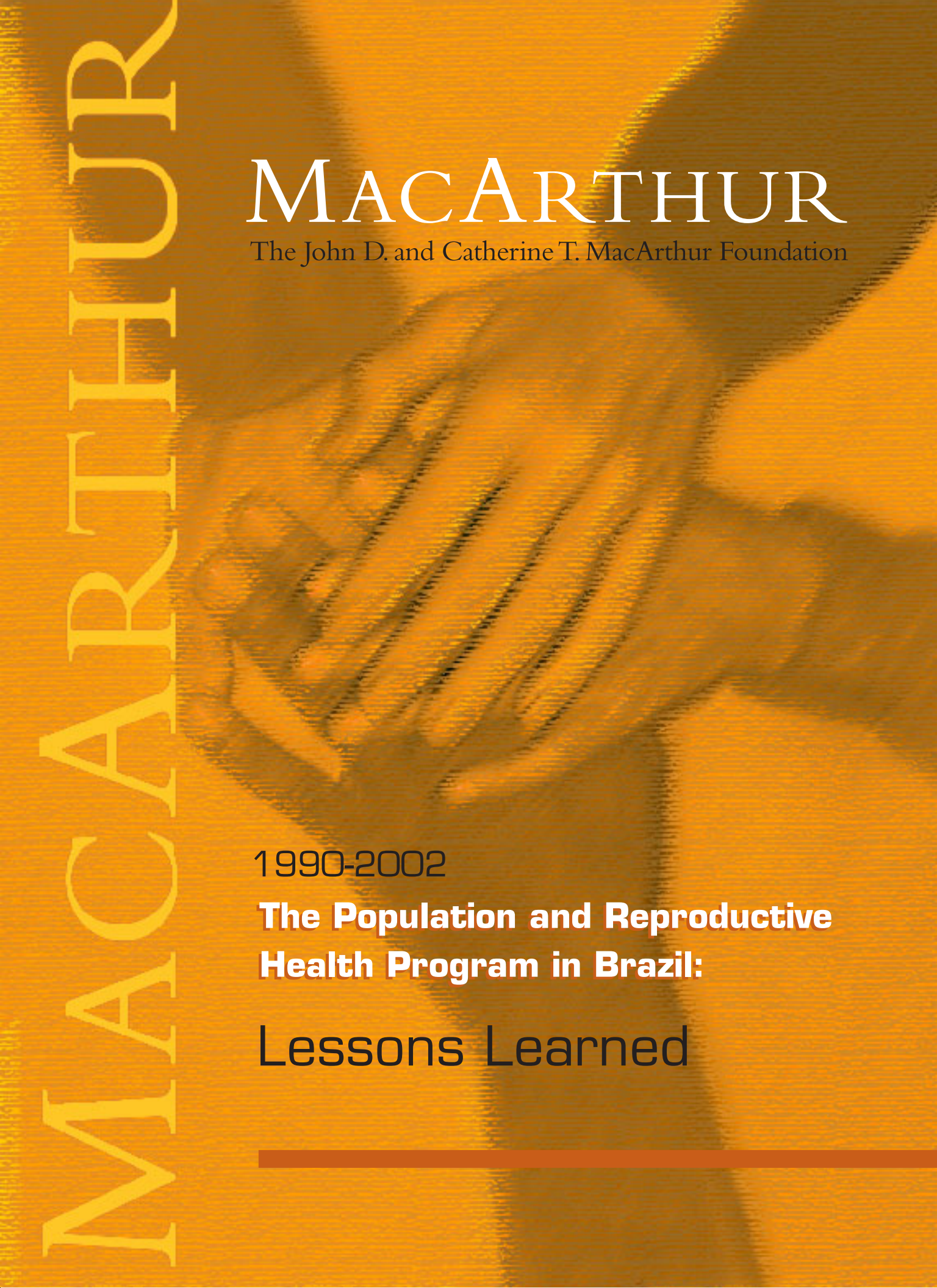

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The John D. and Catherine T. MacArthur Foundation

1990-2002

The Population and Reproductive Health Program in Brazil:

Lessons Learned

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Foreword

The story of Brazil's evolution in sexual and reproductive health and rights during the 1990s is an exemplary tale. It documents not only a decade of change in the population field, but the powerful role of social movements in a democracy. Brazil is a case study of key national players both shaping and being shaped by international discourse and agreements, including the 1993 World Conference on Human Rights in Vienna, the 1994 International Conference on Population and Development in Cairo, and the 1995 Fourth World Conference on Women in Beijing. During the next decade, as the international development community works toward the United Nations Millennium Development Goals, we can expect to see continued progress in areas such as gender equity, maternal health, and HIV/AIDS prevention around the world. We hope the lessons from Brazil will help inform national and local efforts to promote these goals.

This publication, summarizing the lessons learned from the MacArthur Foundation's grants in Brazil, was originally written and published in Portuguese for a Brazilian audience. Because we believe the work is worthy of note for scholars and advocates worldwide, we have translated it into English and are offering it to a wider range of colleagues. The Foundation is pleased to share this experience, in the hope and expectation that the thoughtful overview and examples from specific organizations in Brazil will spark discussion and action elsewhere.

Although MacArthur has closed its Brazil office and concluded its direct grantmaking there, the Foundation has left a substantial endowment to provide ongoing support for Brazilian programs in population and reproductive health. The country-specific efforts of the Foundation's Population and Reproductive Health program are now focused on two priorities: reducing maternal mortality and morbidity, and improving young people's sexual and reproductive health and rights. We continue to fund this work in India, Mexico, and Nigeria—countries where MacArthur has long had a presence, and where progress toward these goals will affect the lives of millions of people.

I would like to thank Carmen Barroso, Director of MacArthur's program in Population and Reproductive Health from 1990 to 2003. During her tenure, Carmen spearheaded the Foundation's work in this area with energy and vision; the success of the Brazilian grants owes a great deal to her efforts.

Judith F. Helzner
Director, Population and Reproductive Health Area
December, 2003

I had the privilege of seeing the birth of the MacArthur Foundation's program in Brazil. In May of 1990, the Foundation convened a group of Brazilian specialists to define strategies for action in the area of population. The participants included people from varied backgrounds, all extremely accomplished. Elsa Berquo, Ruth Cardoso, Sonia Correa, Anibal Faundes, Felicia Madeira, Marta Suplicy and others engaged in thoughtful debate about the national situation and presented recommendations for action in three principal areas: women's health and sexual education, communications, and the interaction between population and natural resources. George Martine, in a report that inspired the Foundation's work, recommended that the Foundation maintain a flexible style and focus, allowing the readjustment of priorities as conditions dictated.

This recommendation was embraced with enthusiasm, and flexibility became a hallmark of the MacArthur work. Of the three initial areas, reproductive health became a priority, thanks to a constant process of formal and informal consultations with experts such as members of our International Advisory Group, members of the selection committee of the Fund for Leadership Development, mentors to the individual grantees or evaluators. The Foundation program officers—initially Cheywa Spindel and Stuart Burden, and later Magaly Marques—always benefited from rich dialogue not only with the advisors, but also with grantees.

This publication continues the spirit of listening to those directly involved in the development of actions and policies that helped define the field of reproductive health in Brazil. We asked Sonia Correa and Peter McIntyre to coordinate a consultation process and analyze the visions and perceptions of some of the principal actors in the field. Carla Rodrigues and Anabela Paiva conducted the interviews, in which people generously contributed their ideas and perceptions. This process of transatlantic collaboration worked smoothly. Unfortunately, it was not possible to interview all of the people whose work is important in this area, nor to describe all the organizations that received funding from the Foundation. The objective of this report is to offer a sampling of the varied and complex visions of the field of reproductive health in Brazil.

We're very grateful to Sonia and Peter for the dedication and good humor with which they undertook such a complex assignment, and for the quality of report that they have produced. We extend our appreciation to all who participated, in one form or another, in the report's creation. Our biggest thanks go to the people and organizations that the Foundation had the privilege to fund during its years of working in Brazil.

Carmen Barroso
Director, Population and Reproductive Health Area
1990-2003

Introduction

Brazil: Inequalities evident in sexual and reproductive health

Brazil is a land of contradictions. While it is one of the world's top ten economies, it rates only an average score on the human development index. Though it is an influential giant in its region, Brazil's maternal mortality ratios are worse than those of some of its poorer neighbors.

Inequality is at the heart of this contradiction. While the average income in Brazil in 1999 was US$3,000 a month, 40% of the population lives on a tiny fraction of that—just US$65 a month.

There is inequality in Brazil between north and south, between rich and poor, between black and white, and between men and women. Those most affected by poverty are children under the age of four, young people aged 5-17, and single mothers, who head more than a third of poor urban households.

These inequalities express themselves in sexual and reproductive health as in many other aspects of life. The country's fertility rate has fallen sharply since 1970, from 5.8 births per woman to 2.34. Although rates are still high in the North (3.2) and in the Northeast (2.7), historical analysis indicates a clear convergence of fertility patterns across regions and social groups. This means that Brazil cannot be portrayed as a country experiencing a 'population growth problem'. Rather, one of its major policy problems is that many people, especially women, cannot yet fully exercise their sexual and reproductive rights.

The pace, features, and implications of Brazilian demographic changes achieved broad public visibility in the 1990s. The decline in fertility was first identified in the 1970s, and by the mid-1980s its core characteristics were already clear. The immediate causes were the increased use of contraception by women, especially the pill and the "preference" for female sterilization—often associated with unnecessary Caesarian sections—along with recourse to (illegal) abortion. Despite this general decline in fertility, reproductive health indicators, such as maternal mortality and cervical cancer rates, remained unacceptably high.

Thanks to advocacy work by non-governmental organizations (NGOs) since the late 1980s—including significant contributions from organizations supported by MacArthur—maternal mortality became a priority policy issue in the 1990s. In Brazil, despite the fact that about 95 percent of deliveries take place in hospitals, maternal mortality ratios are still high. Recent research sponsored by the Minister of Health concluded that the maternal mortality ratio was 84 deaths per 100,000 live births in 2001. These deaths result from lack of antenatal care, poor assistance in delivery, and unsafe abortions. About 90 percent of these deaths would be preventable with timely, good quality care.

Nationally, abortion is the fourth most common cause of maternal mortality. In a country where abortions are only legal after rape or to save the life of the mother, and where even legal abortions are hard to obtain, there are many unwanted pregnancies, leading to somewhere between 700,000 and one million unsafe and illegal abortions annually, according to the public health system database. Some poor women go to unskilled abortionists, putting themselves at high risk of hemorrhage and infection; others use the drug Cytotec. Most of them go to a public hospital looking for help after a clandestine procedure.

In Brazil, as in most other countries, the age of first sexual experience is falling; in 1996 it was 16 years 4 months for girls and 15 years 3 months for boys. More than 60% of adolescents aged 16-19 are sexually active. One survey showed that one in seven girls under the age of 15 had already had a baby. Again, the statistics show stark inequalities: Girls who have less than four years of education are six times more likely to become young mothers than girls who complete nine years of education. Girls in the poorest region of Brazil, the Northeast, are much more likely to have a baby during adolescence than are girls in the more prosperous Southeast.

These inequalities are also related to ethnicity. The population of Brazil is divided evenly between those who describe themselves as white and those who describe themselves as black. In 1999, Brazil occupied the 74th position in the UNDP ranking for Human Development. However, when the Human Development Index for that year was calculated specifically for the white and black populations, the results indicated that 'white Brazil' would rank 49, while 'black Brazil' would occupy the 108th position. On average, white people in the country live six years longer than black people. The educational gap between black and white people is roughly 2.3 years, about where it has been since 1920. Even in the case of higher income groups, there is a gap between the educational level of black and white children and young people.

While most Brazilian women say their ideal family size is two children, almost half of their pregnancies are not planned. Young women today know far more about contraception than did previous generations, yet many who are sexually active do not use it regularly. Furthermore, policies to promote sexual and reproductive health and rights have traditionally omitted men and young people. The result is that, in 1996, more than half of men interviewed in a national survey still believed they were at no risk of contracting HIV-AIDS. Meanwhile three quarters of young women aged 15-24 say they have not changed their sexual behavior after learning about HIV-AIDS transmission.

In 2000, for the first time heterosexual HIV transmission rates in Brazil were higher than bisexual or homosexual transmission rates. In March 2002, the National AIDS epidemiological surveillance body registered 597,443 people with HIV infection, of which 232,588 were cases of AIDS. Of those infected with HIV, 217,641 (36 percent) were women, including more than 17,000 women who were already pregnant when their infection was discovered. Women make up about a quarter of the people with AIDS, and their proportion is steadily growing. During the 1980s, the rate of infection was 6.5 men for each woman. In the late 1990s it fell to 2.4 men for each woman.

These inequalities express themselves in sexual and reproductive health as in many other aspects of life.

Ministry of Health statistics show that more than half of all AIDS cases occur among 20-34 year olds, suggesting that infection often takes place during adolescence. The December 2002 bulletin from the national HIV-AIDS program shows that among young people aged 13-24, the rate of infection is already the same for males and females.

Why MacArthur chose Brazil

The MacArthur Foundation decided in 1988 to work on reproductive health and population issues in Brazil, India, Nigeria and Mexico. These four countries contained among them a significant proportion of the population of developing countries, and each represented a different set of challenges. Brazil was chosen because it has authority and influence in its region, and because its cultural and political environment gave NGOs opportunities to influence policy and practice.

The strategic approach of the MacArthur Foundation is to work with civil society organizations and individuals who are, or who can become, agents of change within a country. MacArthur identified key NGOs that could use external support to increase their leverage and to develop their capacity to effect change. (The Foundation has supported individuals through the Fund for Leadership Development [FLD] program, and NGOs through selective grantmaking to institutions.)

Civil society organizations work through networking and by leveraging their influence on more powerful bodies. They select and use compelling information to highlight the consequences of failure and success in sexual and reproductive health. They also develop and advocate for polices and strategies that will meet their aims. In Brazil, these aims focused on three aspects of women's sexual and reproductive health:

- Access to high quality services, especially to a full range of family planning services, including abortion;
- Ability to prevent sexually transmitted infections (STIs), including HIV-AIDS, and to negotiate safer sexual practices;
- Ability of individuals to enjoy sexuality free from coercion and violence.

In 1994 MacArthur added a fourth aim:

- Sharing of responsibilities between men and women for birth control, sexual health and child care.

Advocacy in Brazil focused on two main activities:

- Providing women with health care services that addressed some of the inequalities and met their needs;
- Creating a legislative framework that allows women to obtain abortions and other needed services, and that allows adolescents to meet their sexual health needs.

Policy changes and the role of civil society

By the time MacArthur had set up a country presence in Brazil, the women's movement and health campaigners had already begun to develop an approach to reproductive health that moved away from population control and towards the rights and needs of women. They argued, for example, that because illegal abortions put women's lives at risk, the provision of safe and legal abortions was a simple health necessity.

Since the 1980s a strong women's movement in Brazil was already campaigning for reproductive rights. The struggle over abortion in Brazil resulted in a legal stalemate. In theory, abortion was legal in cases where a woman had been raped or her life was in danger; in practice, however, abortion was almost non-existent. On the other hand, attempts to outlaw abortion by writing into the constitution "the right to life from the moment of conception" also failed.

In 1984 the Minister of Health designed a Comprehensive Program for Woman's Health (PAISM), integrating antenatal, delivery and post-natal care, cancer prevention, STI care, adolescent and menopausal care, and contraception. It acknowledged abortion as a public health problem, and included, for the first time, a public mandate for contraceptive methods. The program was threatened by institutional instability, but after 1997 it would gradually regain its strength. Despite many ups and downs, PAISM has remained the main inspiration for policy-making and advocacy in women's health.

The full implementation of the new legislation is currently one major challenge faced by reproductive health and rights activists in the country.

The new Constitution adopted in 1988 was one of the critical breakthroughs of the decade, establishing the principle of gender equality. In particular, it represented a victory for the health reform movement, which had been active since the 1970s. It guaranteed reproductive freedom of choice and access to family planning. It defined health as a right and set forth the Integrated Health System (SUS) as a universal, integral, and decentralized policy with built-in public accountability through health councils at national, state and local levels.

The HIV-AIDS pandemic appeared against this backdrop. It first appeared in Brazil in 1982 and quickly expanded, through both blood contamination and sexual transmission. The absence of scientific knowledge and treatment caused fear, panic and discrimination. But in Brazil, the social response was energetic and was led by civil society. Well-known people who had been infected—including Betinho, a progressive NGO leader, and Cazuza, a popular singer—talked publicly about their experiences and spoke out against discrimination. They called for a public health policy response to the crisis not simply as an epidemiological problem, but as a political and social issue. The first State policy initiative was in São Paulo in 1984; and a national program was formalized in 1988, although at times its structure was undermined and its effectiveness impeded by institutional turmoil.

Since the early 1980´s, female sterilization has been widely used as a method of contraception in Brazil: today more than half of married women who are using contraception have had tubal ligation. In 1997 a law was approved to set criteria for access to family planning through the public health system. The full implementation of the new legislation is currently one major challenge faced by reproductive health and rights activists in the country.

In 1998, the Ministry of Health (despite strong opposition) approved regulations outlining how SUS should respond to women who had suffered gender violence—including women seeking legal abortions after rape or where the woman's life was at risk. Although the law on abortion has remained unchanged, practice has evolved. There are now 245 government-sponsored gender violence public health services (82 hospitals and 163 clinics) that offer counseling and treatment, including emergency contraception and HIV prophylactic treatment. Of these, 73 services provide abortion procedures in the two cases permitted by law, and the number of sites is growing rapidly.

The MacArthur Years

During the decade that MacArthur worked in Brazil, it assisted NGOs which offered the most innovative and consistent approaches to achieving the aims of the program. It also supported two- and three-year fellowships to 86 outstanding women and men who have worked to improve reproductive health, combat HIV-AIDS, and reduce inequalities in the country. In total, MacArthur awarded grants worth US$36,085,086 in Brazil, focusing on those organizations that could most effectively advocate for and support policy changes that would make the greatest difference. The results of this work were published regularly in *Perspectiva*, a publication concerned with issues ranging from young people's rights to the ethnic inequalities in Brazil.

It was clear by the end of the 1990s that the NGO movement in Brazil had matured, even if individual NGOs still suffered from institutional weakness. Two decades of work by the women's movement was beginning to be reflected in the election of mayors and other officials with a record of support for reproductive health and rights. After an outside evaluation, MacArthur decided in 2000 that the Brazil program was ready to graduate from Foundation support. Under the phase-out plan, the Fund for Leadership Development (grants to individuals) was discontinued in January 2001 and the country office was closed in December 2002.

Before the closing, the Foundation made several significant exit grants to key NGOs, to build their organizational capacity and ensure that they would be able to continue their work. These grants were carefully designed not only to increase institutional stability, but also to encourage them to collaborate and to become more reflective about their own long-term aims and objectives. MacArthur also made a final grant of US$2 million, plus US$300,000 for administrative costs, to seed a continuing source of grants. These grants will be administered by the Brazilian Social Planning and Analysis Center (CEBRAP) through the Commission for Citizenship and Reproduction. The fund will continue for at least five years and is committed to raising at least US$500,000 from within Brazil.

This exit strategy reflects the Foundation's desire to support innovation and creativity—one of the core values of its grantmaking—and to stimulate the indigenous philanthropic movement in Brazil.

The Voices of Experts in the Population and Reproductive Health Field

The sharing of knowledge and experience among social actors and policy sectors has been a distinctive feature of the John D. and Catherine T. MacArthur Foundation Program in Brazil. In 2002, as the process of closing down its operation at the country level was coming to an end, our advisors were brought into the process. They were asked to express their views on the changes in population and in sexual and reproductive health and rights in Brazil over the last twelve years, the period in which the Foundation provided significant support to advance policy in these areas.

Between October and December 2002, Foundation representatives interviewed twenty-three people who had worked closely with the Foundation as individual or institutional grantees or advisors. They identified where they believe progress has been made and where there are still needs in relation to population trends, sexual and reproductive rights, and health policies. They also shared their insights about the challenges ahead. This document draws on their perceptions, assessments and ideas.

For a variety of reasons, it was not possible to include all Brazilian experts in this exercise. Despite this limitation, the experience and ideas shared with the Foundation by those who were involved provides an insightful assessment of what has—and what has not—been achieved. These perceptions provide a road map to guide individuals, organizations, and policy-makers who are committed to keeping alive and expanding the sexual and reproductive health and rights agenda in Brazil and are relevant elsewhere as well.

Persons Interviewed

Alexandre Grangeiro, Deputy Coordinator of the national STI-HIV-AIDS
Policy in December 2002, Brasília

Caio Rosenthal, MD, HIV-AIDS specialist, São Paulo

Cristina Pimenta, General Coordinator of ABIA- AIDS, Rio de Janeiro

Edna Roland, Psychologist, Founder and President of "Fala Preta!"

Eduardo Luiz Rios Neto, Demographer, UFMG, former President of ABEP (Brazilian Association for the Study of Population), Belo Horizonte

Elza Berquó, Demographer, Professor at NEPO/UNICAMP, researcher at CEBRAP, President of the National Commission on Population and Development between 1995 and 2002

Estela Aquino, MD, Public Health Specialist, Professor at the Instituto de Saúde Coletiva—ISC/UFBA, Coordinator of MUSA, ISC Women's Health Research Program, Salvador

Fátima Oliveira, MD, Bioethicist, Executive Secretary of the RedeSaude – Rede Nacional Feminista de Saúde e Direitos Reprodutivos e Sexuais, Belo Horizonte

Fátima Pelaes, Federal Congresswoman (PSDB-Amapá), Brasília

Gilda Cabral, Economist, Founder of CFEMEA, Brasília

Jacira Mello, Journalist, Founder of Instituto Patrícia Galvão de Comunicação e Midia , São Paulo

Jacqueline Pitanguy, Sociologist, Founder and Director of Cepia, Rio de Janeiro

Margareth Arilha, Psychologist, former member of the National Council on Health and Coordinator of CISMU, presently Officer at UNFPA regional technical assistance unit for Latin America, Mexico City

Maria Betânia Ávila, Sociologist, Founder and Coordinator of SOS Corpo, Gênero e Cidadania, Recife

Maria Coleta Ferreira Albino de Oliveira, Demographer, Professor at the Núcleo de Estudos da População/ Unicamp, elected President of ABEP (Brazilian Association for the Study of Population), Campinas

Maria José de Araújo, MD, National Coordinator of Women's Health Policy of São Paulo

Maria José Rosado Nunes, Sociologist, Founder and Coordinator of Catholics for a Free Choice/Brazil, São Paulo

Maria Luiza Heilborn, Anthropologist, Professor and Researcher at Instituto de Medicina Social, Rio de Janeiro

Marta Suplicy, Sexologist, Founder of GTPOS and Honorary President of GTPOS, current Mayor of São Paulo

Miriam Ventura, Lawyer, Founder and Coordinator of Advocaci (Human Rights NGO), Rio de Janeiro

Sueli Carneiro, Sociologist, Founder and Executive Coordinator of Gedelés—Instituto da Mulher Negra, São Paulo

Tânia Lago, MD, Coordinator of the national women's health policy in December 2002, Brasília

Vera Paiva, Psychologist, Founder of and Researcher at Nepaids, USP, São Paulo

The Policy Scenario of the Last Twelve Years

When the MacArthur Foundation started its Brazilian Population Program, in 1990, the country was experiencing political troubles that would lead, two years later, to the impeachment of President Fernando Collor. The political institutional crisis of the late 1980s and early 1990s negatively affected the relationship between civil society and the state, especially in the area of sexual and reproductive health. One example was the downgrading of the status of the government's National Council on Women´s Rights in 1989. In addition, the implementation of the 1988 Constitution's sections on the public health system were delayed. Finally, Brazil's recent demographic dynamics are also a critical element to fully understanding the evolution of sexual and reproductive policies in the 1990s.

Old and New Demographic Issues

The Brazilian demographic picture of the early 2000s combines old and new trends. In Dr. Elza Berquó's analysis:

> *The bulk of fertility decline happened in the eighties, but continued in the 1990s. The 2000 survey tells us that national fertility rates are 2.3 children per woman. But in São Paulo, Rio and the South, fertility is already below replacement level. This is not surprising as women have expanded their participation in the labor market, they are investing in their own education and professional lives and they have decided to provide good care to just one or two children. This trend is here to stay.*

New issues, debates and research questions are emerging. Some voices call attention to the reduction of the population under age fifteen, which facilitated the expansion of primary education in the 1990s and offers an opportunity for stronger social investments in health and education in the years to come. But the 15-24 age group is large, as a result of previous higher fertility rates, and this will put pressure on the labor market in the short term. The Brazilian demographic community is concerned about the implications of sub-replacement fertility rates and an aging population, particularly with respect to the dependency of older people, the impact on health care, and the effect on social security systems.

Data collected in the mid-1990s and HIV-related research indicate that male use of contraception is increasing, which is positive. On the other hand, as noted by Coleta de Oliveira, patterns of female contraceptive observed in the 1980s—in particular the high rate of (irreversible) sterilization—have not entirely disappeared. Since many women over 25 are already sterilized, the relative contribution of young and adolescent women to overall fertility has increased. This has encouraged a "crisis discourse" on teenage pregnancy. Although teenage pregnancy may have a negative impact on young women's education, Maria Luiza Heilborn reminds us that young people themselves do not always experience early pregnancy as a crisis. She considers that the high visibility given to teenage pregnancy may lead to conservative policy approaches, such as promoting sexual abstinence. Demographers have also noted that if the average age of female sterilization continues to fall, it may accelerate the pace at which Brazil moves towards fertility radically below replacement level. This is a strong argument in favor of improving and expanding young people's access to reversible contraception.

Dr. Berquó and Eduardo Rios Neto have also mentioned new trends. One is the rise of international immigration and emigration as both a demographic concern and a human rights issue. An estimated two million Brazilians have emigrated since the 1980s because of labor market constraints; many of them are living as non-legal migrants, prone to risks and abuse. The conditions under which non-legal migrants are living in Brazil are also a matter of concern. At the same time, the pattern of internal migration is also changing: observers have noted the continued growth in metropolitan regions, return flows from larger urban areas to the region of origin, and a new trend of urban-urban migration between regional poles of attraction. Finally, since the mid-1990s Brazil has seen an increase in urban violence. The impact of violence on mortality ratios and sex ratios has not yet been demonstrated at a national level. However, there has been a substantial increase in mortality ratios among young urban males, who are mostly poor and black.

After the political institutional crisis of the late 1980s and early 1990s, civil society regained its strength and re-directed its energies on reproductive health issues: instead of pressuring the executive, organizations began

educating policymakers in parliament. They also worked through the courts to overcome discrimination and to gain access to treatment. Many institutions supported by the Foundation were established in this period, including Casa de Cultura da Mulher Negra, CDD-BR, CEPIA, CFEMEA, the Commission on Citizenship and Reproduction, Cunhã, ECOS, and the National Feminist Network for Sexual and Reproductive Health and Rights. Some strategies proposed by these and other NGOs would later be incorporated into law and policy. For example, their evidence to the Federal Parliamentary Commission on Sterilization helped in the formulation and approval of Law 9263- 1996 regulating the Constitutional Provision of Family Planning. And a series of lawsuits paved the policy ground for the 1996 legislation ensuring free and universal treatment for people living with HIV or AIDS.

From 1989, the Brazilian AIDS movement opted for a judicial strategy because we did not have the time to wait for specific legislation to be approved. As we kept winning different lawsuits the Executive and Parliament were under pressure and this resulted in the National AIDS policy and later on (1996) in free access to treatment. (Miriam Ventura, Advocaci)

In 1994, a new Economic Stabilization Plan (Plano Real) was adopted and Fernando Henrique Cardoso was elected President; he would be re-elected in 1998. Cardoso's long administration completely changed the Brazilian policy environment, creating paradoxical patterns in Brazilian policy. On one hand, the country experienced unusual economic, political, and institutional stability, which favored the establishment of a wide range of mechanisms for social accountability and the legitimization of a national policy agenda on human rights.

Brazil, in the 1990s, had some advantages compared to other Latin American countries. There has been policy continuity and civil society did not experience major backlashes as in the case of other settings where democracy is still very unstable. This stability allowed for a leap forward in terms of population and sexual and reproductive health policies. Brazil is one of the few countries in the region that has retained the principle of universal access to health care. (Margareth Arilha, United Nations Population Fund (UNFPA) technical advisor)

On the other hand, these were also years of erratic economic growth, with bouts of financial instability and fiscal stringency. There were major negative trends in society, including high levels of unemployment, stagnation of income, and an increase in everyday violence. Fiscal stringency put the brakes on public investment in many strategic areas, particularly in social policy. However, these constraints were not as detrimental to health policy as they were in other areas, for two reasons. First, the 1988 constitutional changes provided a safeguard to the public health system. Second, beginning in 1993, the Integrated Health System (SUS) was decentralized and its managerial structure, operations, and accountability were tightened. After 1996, the health sector was kept relatively financially stable with additional resources from a bank and financial transaction tax (CPMF). In 1999, a new constitutional provision was adopted, dividing financial responsibility for SUS among federal, state and municipal levels and setting an annual increase in the health budget directly related to the increase in GDP.

An estimated two million Brazilians have emigrated since the 1980s because of labor market constraints; many of them are living as non-legal migrants, prone to risks and abuse.

Since 1994, the institutional environment has favored the expansion of primary health care and the use of sophisticated systems for epidemiological surveillance, health information collection, and policy monitoring. These structural elements made possible the robust policy response to HIV-AIDS in 1992-1993, and the revival in 1997-98 of strategic components of A Program for the Comprehensive Care of Women's Health (PAISM).

Intersection of National and International Agendas

A number of advisors identify the 1994 United Nations International Conference on Population and Development (ICPD) in Cairo, along with other important conferences of the 1990s and later, as important influences on Brazilian policy. Many advisors spoke of the consequences of national mobilizations surrounding the ICPD in Cairo and its five-year follow-up. (Jacqueline Pitanguy, for instance, underlines the resulting internationalization

of the Brazilian women's movement.) The role of the Brazilian government in these two conferences is also widely recognized. Some advisors note that there has not always been effective compliance at the national level with commitments made at the international level. But they agree that the national dissemination of conference outcomes reactivated debates on issues such as abortion. For black feminist activists, the most important point of reference is the World Conference Against Racism, Racial Discrimination, Xenophobia and related forms of Intolerance (Durban, 2001), which made a breakthrough in the national debate on 'denied racism' and affirmative policy measures. It is important to note that many consider that the major impact of Durban occurred in Brazil. During the 1990s, Brazilian HIV-AIDS activists also participated intensively in International AIDS Conferences and brought the impact of those conferences back into their work at the national level.

These conferences also helped bring about formal mechanisms and other initiatives aimed at monitoring the implementation of policy.

These conferences also helped bring about formal mechanisms and other initiatives aimed at monitoring the implementation of policy. The most frequently cited example is the creation of the National Commission on Population and Development in 1995. The Commission's mandate is to follow up the implementation of ICPD and related international debates at national level, and to raise awareness of the demographic implications of public policies. At the civil society level, a variety of projects are following up on ICPD, 1995 Fourth World Conference on Women (Beijing), and the 2001 HIV-AIDS General Assembly Special Session.

The 1993 Vienna Conference on Human Rights must also be highlighted as a turning point. It is the origin of the National Human Rights Program established in 1995, which was later (2002) reviewed and re-defined as a state priority policy. Its guidelines cover a wide range of issues addressed by Foundation advisors, including gender violence, racial issues, sexual orientation, HIV-AIDS-related discrimination, and access to abortion. The preparations for and aftermath of Beijing+5 also influenced the human rights policy process, on several fronts: the creation of a National Secretary for Women's Rights (May 2002); the ratification of the Optional Protocol of the Convention on the Elimination of Discrimination against Women (CEDAW) (June 2002); and governmental compliance under the Convention through national reports for years 1988, 1994, 1998 and 2002. Currently, Brazilian NGOs are making increasing use of international instruments to call for government accountability and to promote new thinking about gender relations and access to health care.

Sexual and Reproductive Policies: What Has Changed?

In the 1990s sexual and reproductive polices would gradually become a priority in Brazil, starting with the HIV-AIDS program that gained legitimacy and financial strength through a World Bank loan in 1993. The program had four components: epidemiological surveillance, prevention, institution-building, and research. The prevention component included allocations for civil society organizations and for community outreach. Strategies were also devised within a broader human rights framework. Over the course of three loan cycles (AIDS I, AIDS II, AIDS III) the program emphasis changed in response to the changing pattern of the epidemic. In the first phase, the focus was on the groups that were then most vulnerable, including homosexuals, sex workers, transvestites, and drug users. In the next cycle, the focus shifted to the poor and women, where AIDS was then taking hold. More recently, emphasis is again being given to men who have sex with men (MSM) and, in partnership with the women's health program, to vertical (mother to child) transmission.

In 1993—a period when HIV-AIDS was expanding rapidly and the public health system was struggling to respond—the World Bank loan gave the national program the financial stability, managerial flexibility, and opportunity to reach out into civil society. As Cristina Pimenta recalled in a recent debate on AIDS and Development:

> *We certainly need to evaluate the long-term financial implications of the World Bank loan. But at the same time it is important to recognize that in 1993—given the Ministry of Health's (MoH) institutional problems—it would have been impossible to design and implement a national policy that would effectively respond to social groups more vulnerable to the disease.*

Clearly, the financial investment and policy prioritization of HIV was a crucial step in the political strategy that led, in 1996, to legislation mandating free treatment for people with HIV-AIDS. The strategy sustained Brazil's commitment to universal access to drugs against all odds—including the strong reluctance of the World Bank—and underpinned Brazil's open challenge to pharmaceutical companies regarding the patenting and prices of HIV drugs (2000 and 2001). Most analysts today recognize that free access to treatment provided a favorable environment to expand preventive health care, not least because people—particularly in disenfranchised groups—gained confidence in the health system.

These conferences also helped bring about formal mechanisms and other initiatives aimed at monitoring the implementation of policy.

HIV-AIDS Policy Progress in the 1990s

- In 1991 the Public Health System started distributing AZT to HIV-AIDS patients.
- In 1992 a unit was created at the National HIV-AIDS Program to promote connection with civil society organizations and develop a human rights approach to the epidemic.
- In 1993 a new legal provision (Law No. 8742/93) ensured a basic income (one minimum wage) to people affected by illnesses that hamper their ability to remain in the labor market, including HIV-AIDS.
- In 1994 the Brazil-World Bank agreement was finalized and the so-called AIDS I Program started.
- In 1996 a legal provision (Law No. 9313) ensured the free distribution of HIV-AIDS drugs.
- In 1998 the new Brazil-World Bank agreement was approved (AIDS II), including women as a priority group and emphasizing vertical (mother to child) transmission.
- In 2001 Brazil threatened pharmaceutical companies with compulsory licensing in order to reduce the cost of HIV-AIDS drugs. This strategy effectively led to price reduction.
- In 2002 a new program was started to detect and treat HIV-AIDS in delivery wards.
- In 2002 a US$1 million development cooperation program was signed between Brazil and four countries—El Salvador, Colombia, Paraguay and Mozambique—to provide drugs and to transfer HIV prevention and treatment technology.

- In 2002, two new federal laws were approved. The first (Law No. 11.199/02) prohibits discrimination against people living with HIV-AIDS. The second (Complementary Law No. 10.409-02) regulates harm-reduction procedures as a public health strategy.
- The Ministry of Health currently distributes 4 million condoms annually, via 520 distribution posts across the country. By 2002, MoH had procured two million female condoms to be provided to HIV-positive women and those living with AIDS, sex workers, women who have experienced gender violence, and those whose partners are drug users. Brazil purchases 75 percent of the global female condom production.
- There are currently 381 out-patient clinics providing HIV-AIDS-related services, including the testing and provision of drugs. In addition, 1,126 primary health care units provide STI diagnosis and treatment.
- Hospital-based care is offered in 365 units across the country. There are also 79 centers providing hospital day care, and home-based care is offered in 53 localities.
- In 2001, roughly 120,000 people had access to free HIV-AIDS drugs. The cost of HIV-AIDS treatment has been reduced 54 percent since 1997.

The reactivation of the National Women's Health Policy, however, was much slower than the positive evolution of the HIV-AIDS policy. Before 1997, the program structure at the MoH level remained fragile and disconnected from the rapid changes taking place in SUS. In 1995 and 1996, the positive title PAISM (A Program for the Comprehensive Care of Women's Health) was dropped and the official title returned to the old Maternal and Child Care paradigm. Much effort and political pressure was required before the policy once again received a high priority. This rebuilding started slowly in mid-1997 and took off decisively a year later.

There was also a new emphasis on achieving consensus on women's health policy and priorities among health managers in federal, state, and municipal government bodies.

Four important features characterized this new phase of the Brazilian women's health policy. The first was a semantic and conceptual revival: women's health again became the official name of the strategy, and its guidelines drew on PAISM, as well as Cairo and Beijing.

Second was an expansion of the human resources devoted to women's health.

Third, the new women's health team identified areas where, after fourteen years of PAISM, there were critical gaps in coverage and quality of services, and where epidemiological outcomes remained unacceptable. While keeping the comprehensive PAISM framework as a motivating idea, the team concluded that clear priorities were needed to achieve tangible results in the short term. They adopted a three-pronged strategy:

- Supporting women in reproductive decision-making by giving them access to information and to high-quality services for antenatal and delivery care and contraception;
- Reducing female mortality from preventable diseases, with an emphasis on cervical cancer and HIV-AIDS;
- Strengthening the involvement of the health sector in policy efforts to prevent and reduce gender violence, including expanding legal abortion services.

Within this framework, investment was focused on specific programs:

a) pregnancy, childbirth and postpartum care;
b) abortion and contraception (implementation of the family planning law);
c) maternal mortality;
d) gender and sexual violence;
e) breast and cervical cancer prevention and treatment;
f) STI, HIV-AIDS prevention and treatment among women.

The fourth major feature of the new women's health policy was its integrated approach. PAISM had been a vertical, top-down policy from the MoH, isolated from related policies and programs at the local level. Now,

clear efforts were being made to overcome this isolation. Dialogues began and partnerships were forged between women's health and other policies and programs within and outside the MoH. These included primary health priority strategies as national primary health policy guidelines, the Family Health Program (PSF), and the Community Health Agents Program (PACS). These dialogues have also involved the STI-HIV-AIDS National Coordination, the Adolescent Health program, the Ministry of Justice and National Human Rights Program on gender violence, and the new regulatory agencies dealing with private provision of health care (Agência Nacional de Saúde Suplementar) and Health Surveillance (ANVISA). The new sense of connection was reinforced by incorporating women's health priorities into the regulatory standards and financial rules of SUS. This included an increase in payments for childbirth procedures, financial investment in infrastructure (REFORSUS), incentives at the municipal level to expand prenatal coverage, and better quality control of drugs. There was also a new emphasis on achieving consensus on women's health policy and priorities among health managers in federal, state, and municipal government bodies.

Recent Progress in Women's Health

The national coordination body of the Women's Health Program has concluded an assessment of policies implemented during the period from 1998-2002. The assessment identified a number of areas where clear progress had been made:

- In obstetric care, there was investment in hospital equipment and training of health professionals, especially nurses. An award was created to give higher visibility to services that provide good quality care in childbirth. A major achievement was the reduction in Caesarian sections from 34 percent to 25 percent of all births in SUS hospitals.
- The focus on obstetric care contributed to a reduction in hospital-based maternal mortality from 34 to 24 deaths for every 100,000 women attended in a hospital. The number of states that set up committees to investigate maternal deaths increased from seven to twelve. There are also 387 municipal maternal mortality committees. Epidemiological investigation was carried out on all deaths (199) of women of fertile age that occurred in 26 state capital cities in the first six months of 2002. Of these 199 deaths, only 58 had originally been classified as maternal deaths. The investigation raised that number to 93. This study allowed epidemiologists to adjust maternal mortality ratios in different parts of Brazil, compensating for problems in the collection of data. The research results indicate that for the whole country, the actual maternal death rate is 1.62 times higher than in collected data. (When broken down geographically, different regions of the country have different multipliers: 2.0 for the Southeast, 1.29 for the North, 1.85 for the Northeast, 1.67 for the South, and 1.25 for the Center-West region.)

Decentralization has helped to reduce the gaps between managers, providers, and users, and has improved transparency and accountability.

- Antenatal care has expanded from 5.4 million women in 1997 to 10.1 million in 2001. The average number of consultations per woman increased from 2.0 to 4.2 over the same period.
- An agreement between the MoH and municipal health managers included incentives for good care, and established a national information system for monitoring services.
- Longstanding problems of procurement, quality control, and distribution of reversible contraceptive methods started to be overcome at the central (MoH) level. Assessments have been made of delivery at local levels.
- Screening for cervical cancer has expanded, reaching out to women who have never had a Pap test.
- Advances have also been made in services for women victimized by sexual and other forms of gender-based violence. An important first step was the approval, in 1998, of an SUS Protocol (Norma Técnica de Atenção às Mulheres Vítimas de Violência) that provides guidelines for these services, including those related to emer-

gency contraception and abortion procedures in the case of rape, risk to the woman's life, and HIV prevention. Another protocol adopted in 2002 requires that all gender-based violence cases seen by the public health system be reported. A large number of health professionals have been trained. There are now 245 gender violence services (82 hospitals and 163 clinics) that offer counseling and treatment, including emergency contraception and HIV prophylactic treatment. Of these, 73 services provide abortion procedures in the two cases permitted by law.

- A national program was established to provide early detection and treatment of sickle-cell disease, which primarily affects the black population.

It must be said, however, that the priority given to sexual and reproductive health at the federal level does not always translate into efficiency and quality of care across the system. SUS is a gigantic machinery delivering services to 100 million people in an extremely diverse country. Decentralization has helped to reduce the gaps between managers, providers, and users, and has improved transparency and accountability. But tensions also remain with respect to power relations among the various levels of the system, particularly regarding allocation rules and their effects on the flexibility allowed to municipal managers. And with the extreme variation in technical capabilities, human resources, and ideologies across the system, federal rules and incentives do not always ensure access or quality of services. Consequently, assessments of progress and gaps may vary widely, depending on where the measurement is made.

Appraising Policy Progress

In some policy areas there is a strong consensus on recent progress. The most frequently cited example is the success of the HIV-AIDS program, which is praised for its comprehensive approach, it human rights dimension, the partnership with NGOs and, in particular, for the free access to treatment and the pressure on pharmaceutical companies to lower prices for HIV drugs. Some point to the way that HIV-AIDS information effectively reaches the public school system as a key indicator of a productive and effective collaboration across sectors. Such effective collaboration is not found in other areas, such as sexuality education or adolescent reproductive health needs.

In women's health, most experts consider one of the great achievements to be the expansion of services for victims of gender-based violence. They point in particular to the two SUS Protocols adopted during the 1998-2002 period and, especially, the provision of abortion procedures in the case of rape and risk to life. They also mention the family planning law (1997), SUS regulations and payment rules for childbirth and sterilization procedures, the expansion and improvement of antenatal care, and the first steps towards providing the public with reversible methods of contraception.

Despite this progress, gaps remain. Even in the case of the successful HIV-AIDS program, some experts point out that its performance is sometimes compromised by the scale, heterogeneity, and social inequality of the country, as well as by operational bottlenecks in SUS at the local level. In the poorest regions, access to testing and treatment remains difficult. Although testing and drugs are available, they are not always offered to those who need them. Not every local health manager gives the necessary priority to HIV-AIDS needs. One aspect of the program that both civil society activists and MoH personnel identify as a policy failure is HIV-AIDS prevention and treatment among women. As Alexandre Grangeiro, deputy coordinator of the national HIV-AIDS program, says:

Today the epidemic is expanding more rapidly among women. In 1985, there were 24 men infected for each woman. Today the ratio is two men to one woman. We estimate that 60 percent of infections occur in heterosexual relationships... Health services are not yet fully prepared to identify women potentially at risk. The picture is improving but what is being done is not yet enough. Although the test is free and available, just 35 percent of women attending a public service for antenatal care are being tested. Although this is better than what is registered for other basic tests, as in the case of syphilis, it is still a scandal.

This failure in an otherwise extremely successful policy directly relates to the poor quality of maternal and child health services—a sign that intractable obstacles still hamper the implementation of an effective reproductive health agenda.

In other areas, the experts' appraisals of policy results diverge. In regard to the cervical cancer screening program, for example, Betânia Ávila's critique echoes the views expressed by many sectors of the Brazilian women's health movement since the program's start, in 1998:

Implemented as a campaign, the national cervical program can never become a routine service. Many women who had the examination never got the results. Others who tested positive for cancer had no access to treatment. This should not be a matter of campaigning, but should be part of the routine daily operations of the health system.

In contrast, Dr. Tania Lago and Margareth Arilha point out that the campaign adopted in 1999 and 2002 reached many women who otherwise would never have had a Pap smear. Still, Dr. Lago recognizes that the campaign model is not well accepted inside and outside the health system. In her view this is because it often discloses service flaws—for example, in the accuracy of laboratory test results or in access to treatment—that would otherwise remain invisible. When these faults are highlighted, strong criticism of health services emerges from civil society, and health managers and professionals feel threatened.

The assessment of strategies to reduce maternal mortality also receives mixed reviews. Most experts recognize that, from 1998 on, significant investments have been made in efforts to address the problem. But they also observe that the governmental response was slow, and that Brazilian mortality ratios remain unacceptably high when compared to other countries in Latin America. They note as well that maternal mortality is one critical area in which the gap between decisions taken at the federal level and implementation at municipal level is particularly difficult to resolve. Dr. Fátima de Oliveira reminds us that federal funds earmarked for antenatal care at the municipal level are not always invested appropriately, and may be channeled into other programs. Dr. Maria José Araújo expands on this theme:

The Minister of Health has made an effort in the last decade. This is undeniable. But women's health only becomes a priority if the local health managers are committed, or if women's organizations exert pressure for change... If maternal mortality has not decreased it was not because the Ministry of Health was not concerned. At the local level the health system is still problematic: antenatal, childbirth and post-natal care are not of the required quality. This is why maternal mortality is considered a good indicator of how governments treat women.

The São Paulo Municipal Experience

Marta Suplicy, the Mayor of São Paulo, in her interview emphasized the investments made by the municipality in women's health since 2000, under the program then coordinated by Dr. Maria José Araújo:

- The Municipal Health Department prioritized primary (basic) health care through the Family Health Program that presently includes 4,000 doctors, nurses and community health workers organized in 670 teams. All primary care units were restructured.
- Within this broad framework, women's comprehensive health care was also prioritized. Financial resources were made available to buy equipment, produce educational materials, and recruit health professionals.
- Over 460,000 Pap smears have been performed, and the provision of pregnancy tests and contraceptive methods has been expanded.
- Additional screening equipment was acquired for breast cancer prevention, and over 10,000 examinations have been performed.
- A new antenatal and childbirth program—To Be Born Well—offers quality care to women and their babies. Additional beds for delivery and neonatal care have been guaranteed in the municipal health network, and the Maternity Ward School of Vila Nova Cachoeirinha was restored. All these measures were aimed at reducing maternal death rates.

Dr. Fátima de Oliveira highlighted research findings that indicate black women have less access to care, and receive lower quality care, in reproductive health.

- Twenty-one basic health care units offer specialized care after gender violence. Highly qualified, multiprofessional teams now provide legal abortion procedures in five hospitals (an increase from two hospitals in 2000).
- Reversible contraceptive methods are being offered in the primary health care units and female sterilization and vasectomies are available in eight hospitals. Ultrasound equipment has been provided for services that offer antenatal care and tubal ligation.
- Specialized services provide screening for congenital diseases that especially affect the black population, with particular attention to sickle cell disease.

Some experts have also called attention to persistent problems in addressing race-based health inequalities and discrimination. Dr. Fátima de Oliveira listed a number of chronic health conditions that prevail among the Brazilian black population: sickle-cell disease, high blood pressure, adult diabetes, and uterine myomas (fibrous tumors). She also highlighted research findings that indicate black women have less access to care, and receive lower quality care, in reproductive health.

Dr. Oliveira pointed to a study by Alaerte Martins in the state of Paraná that reviewed 986 maternal deaths of women aged 10 to 49. Martins found that the ratio for black women was almost seven times higher than that for white women. Dr. Oliveira also called attention to demographer Ignez Perpétuo's analysis of 1996 DHS data, which revealed that while 77 percent of white women attended six antenatal consultations, as recommended by World Health Organization (WHO), the percentage decreased to 61 among black women. Finally, Oliveira referred to recent research by Fundação Oswaldo Cruz, which concluded, after interviews with 10,000 women, that the public health service discriminates against black women. For example, Cruz found that 95 percent of white women were given anesthesia during natural childbirth, compared to 89 percent of black women.

Two new policy initiatives adopted between 1998 and 2002 do address racial disparities in health: the establishment of a national sickle-cell disease program, and the inclusion of race information in the HIV-AIDS epidemiological surveillance form. But in light of the striking disparities in reproductive health described above, and the continuing national debate on racial inequality and discrimination, these steps are clearly insufficient.

Dr. Tânia Lago, Margareth Arilha, and Cristina Pimenta identify another major weakness in the system: the sexual and reproductive health and rights of adolescents. In contrast to the major strides made in HIV-AIDS and women's health, the national policy framework for adolescent sexual and reproductive health has not been reshaped. Local programs do exist, but they remain underfunded, fragmented, and isolated. Maria Luiza Heilborn calls attention to the fact that while HIV-AIDS information is widely provided in the public education system, the same is not true of reproductive health education, particularly in regard to contraception. In her opinion, the best approach to teenage pregnancy is not to view it as a "social crisis," but rather to ensure that adolescents have accurate information and access to good quality services.

Finally, most people interviewed do agree that the "problem-solving" approach adopted by the women's health national program in the 1998-2002 period has achieved positive results. It enabled Brazilians to tackle long-standing problems, such as antenatal care and reversible contraception, and led to the opening of new frontiers in reducing unsafe abortion and gender violence. However, some experts also say that this prioritization has pushed aside a number of other important health problems that affect the well-being of Brazilian women, such as menopause-related ailments, breast cancer, chronic diseases like high blood pressure, mental health, and occupational diseases.

The Role of Civil Society

Despite the gaps and weaknesses in the Brazilian sexual and reproductive policies of the 1990s and early 2000's, real progress *has* taken place—in part because the agenda was sustained and expanded by civil society and academia. The many HIV-AIDS-oriented NGOs that began forming in the 1990s now account for more than 500 initiatives across the country. Local and state-level AIDS forums are established in many settings and can be extremely vocal when policies do not work properly. While the development of new drugs has been a critical breakthrough for all countries, for Brazil an equally important factor was the sustained mobilization of civil society for prevention and access to treatment. As described by Caio Rosenthal:

> *In relation to AIDS, civil society was critical. It has been able to review old values, enhance tolerance with respect to diversity, and criticize unequal gender relations. In sum, it struggled to overcome prejudice and inadequate moral stands. This created the ground for a successful policy response and the expansion of prevention.*

Women's sexual and reproductive rights initiatives were also consolidated in the period. The best illustration is the RedeSaude, which, as Maria José Araújo reminds us, expanded its affiliations from forty-five members in 1991 to more than 150 organizations and individuals in 2002. Another important breakthrough of the

last decade was the increasing ability of women's organizations to lead public debate on these issues. This—as underlined by Jacira Mello—has directly influenced policy-making and legal reforms, and most notably, has opened a space for a positive engagement with the media. Betânia Ávila says that this fresh wave of feminist public discourse signals a new comprehensive approach:

Margareth Arilha notes that not all Latin American countries have women's organizations like those in Brazil—with the expertise to engage in the public education of parliamentarians.

> *The approach to these issues has moved beyond a demand agenda... In previous years we have made fragmented requests to policy makers for antenatal care, childbirth services, contraception and the legalization of abortion. The full adoption of a reproductive rights framework allows for a comprehensive approach to these diverse problems and relates them back to broader trends and the human rights agenda.*

Within that comprehensive framework, as many voices emphasized, major progress has been made in the abortion debate. The first major breakthrough occurred in 1989, with the establishment in São Paulo of the first public service providing abortion in the two cases permitted by law. From the mid 1990s, as some voices on the international scene legitimized the expansion of abortion services and the call for legalization, conservative forces in the country worked to restrict access. In 1995, these forces proposed a constitutional amendment guaranteeing 'the right to life from the moment of conception.' In 1997, when a Congressional Commission expanded abortion services, there was another political debate. A year later, when the MoH adopted the technical protocol to regulate SUS abortion assistance, the standard was systematically attacked in Congress. Despite these attacks, legal abortion services expanded from four sites in 1994 to 73 by the end of 2002. In fact, these critical moments have been used by the feminist movement as an opportunity to enhance the public debate and to clarify arguments in favor of decriminalization. As Maria José Rosado says:

> *In the last few years the press has published articles and favorable editorials. Public opinion polls demonstrate the progressive acceptance of more liberal legislation that would include other circumstances when abortion will be allowed. Specific research also indicates that the Catholic population increasingly expresses a surprisingly open attitude to the legalization of abortion or, at least, to the partial reform of existing legislation.*

Margareth Arilha notes that not all Latin American countries have women's organizations like those in Brazil—with the expertise to engage in the public education of parliamentarians. And these efforts are not limited to the abortion issue. At the urging of women's organizations, at least two other actions were taken at parliamentary level. The first, recalled by Fátima Pelaes, was the parliamentary investigation commission (CPI) on sterilization (1992) that resulted in the Family Planning Law (approved in 1997). In 1996, Ms. Pelaes, who was rap-

porteur to the parliamentary investigation, called for another commission to investigate maternal mortality. It was established in 2000 and completed its work in 2001 with major success, as Ms. Pelaes recalls:

> *This has been another important occasion, as we have been able to deconstruct the complacency of society, which tends to view a woman who dies of maternal mortality as if she were a heroine. We have demonstrated that many women do not have access to antenatal care simply because they cannot pay for transportation.*

Another important aspect of civil society dynamics was the emergence and consolidation of black women's organizations and the incorporation into their agendas of sexual and reproductive health and rights. In Sueli Carneiro's view, this is especially notable because it evolved within the larger human rights framework, in close connection with the struggle against racism. Although, as we have seen, policy advances on race-related issues have been meager, race is part of the structure of sexual and reproductive health and rights, and can no longer be ignored in the national debate.

The Contributions of Research

> *"We must avoid the 'amateur debate.' It is not enough for social movements and NGOs to have political legitimacy. Political and policy-oriented work must be grounded in correct information, knowledge, research. One of the high points of the last decade was the new light shed on the participation of the black population in Brazilian society, through a combination of research and advocacy efforts"* (Elza Berquó).

Dr. Berquó's comments are grounded in her own experience as the mentor of the CEBRAP research and training program on demography for black researchers. Many experts have cited this program as a model, as its research has helped address the complex issue of racial inequality in health, in a society that has long denied the existence of racial discrimination. For example, the program has identified diseases to which the black population is more vulnerable and has revealed racial disparities in access to and quality of services. Edna Roland observes that:

> *This is a particular aspect of the Brazilian context. In the US more attention is given to the improvement of self-esteem of the black population than to academic analyses of racial inequality. In Brazil, it is possible to operate in this field because of the linkages that exist between the black women's movement and researchers in demography.*

Policy-relevant research in several other areas has also been addressed by the MacArthur Foundation Program in Brazil. For example, the Training in Reproductive Health and Sexuality Research Methodology conducted by the consortium NEPO/UNICAMP, IMS/UERJ and MUSA/ISC-UFBA has been highly praised. Advances in gender studies, particularly in gender-related health issues, have also been mentioned. In 2000, Estela Aquino identified 49 groups conducting research on gender and sexuality, or gender and reproductive health, in the portfolio of the major national agency responsible for instigating and funding academic research (CNPQ). She also calls attention to the proliferation of gender studies units and research networks. Miriam Ventura points to the recent, very positive trend of law researchers increasingly adopting a social sciences framework. Maria Luiza Heilborn observes that groups working within a "sociology of health" framework are beginning to incorporate sexuality and reproductive health issues into their work.

Cristina Pimenta underlines how new conceptual approaches to sexuality have helped to advance knowledge about the HIV-AIDS pandemic in the country:

> *In the 1990s, the study of the social and cultural construction of sexuality, with research performed on the patterns of transmission of HIV-AIDS, has greatly advanced the better understanding of the epidemic. Academic institutions and the health sector started using the concept of vulnerability in order to assess behavior and other factors—structural, social and cultural—that can make people more or less at risk and more or less able to protect themselves.*

Another critical contribution of research in the 1990s was the development of effective approaches to social interventions in sexuality education and HIV-prevention. In this area, as we are reminded by Vera Paiva, Brazilian researchers and activists developed a unique model, inspired by Paulo Freire's popular education methodologies, that made possible a consistent critique of the dominant behaviorist approach, which views individuals as "rational beings" who make sexual and reproductive decisions in a vacuum. The Brazilian model of intervention emphasizes the need to understand how people themselves perceive sexuality. It also gives great attention to inter-subjective relations and context, and most principally recognizes the complexity and fluidity of sexual practices (and identities). It addresses HIV awareness, prevention, and treatment within a comprehensive framework that draws on both the personal and collective ability of people to deal with the individual aspects of their sexual experience and of the disease, with the medical discourse, and the power of health institutions. This model has also shown very positive results in sexuality education, as it integrates other dimensions of life that are as relevant as sex in young people's experience.

The Brazilian model addresses HIV awareness, prevention, and treatment within a comprehensive framework.

The experts mentioned several additional areas of demographic research that have offered critical input to policy-making, including studies of the incidence of Caesarian sections, female sterilization, childbirth practices, and, most significantly, maternal mortality. They also noted the maturation of academic centers, the expansion of courses in a variety of themes and degrees, and the diversification of conceptual and methodological approaches, including a wider use of gender analyses. The Brazilian demographic community has also widened its international connections. Following the General Population Conference sponsored by International Union for the Scientific Study of Population (IUSSP) in Bahia in 2001, the Brazilian Association for the Study of Population (ABEP) strengthened its role as a national and regional scientific network.

Finally, Brazilian capacity and ability in biochemistry has permitted the production of HIV drugs and facilitated both basic research (such as the global multi-center HIV vaccine research) and trials of new products, including the female condom. Foundation advisors have also been involved in this area, particularly by raising ethical concerns in regard to research standards and abuses and by keeping up the pressure to make drugs accessible.

Cross-Sectoral, Policy-Oriented Action

Just how do the connections between researchers and NGOs work to change policies? Vera Paiva offers a compelling recollection of how this has worked in the case of HIV-AIDS:

> *Caio Rosenthal, or another doctor, informed us that a new drug was available and that he wanted to provide it for an HIV patient. Jorge Belochi, who is a teacher in the University of São Paulo, a leftist gay activist and a founder of two or three AIDS NGOs, would go to the press and make a fuss: 'I am an academic professor, HIV-positive, and I want to have access to the drug!' He did what ordinary people living with HIV-AIDS do not have the courage to do, because of stigma. Then a group was set up to sue the government for not providing free and universal health treatment. Academic researchers provided the clinical and scientific argument to ground the judicial action. The judge made his decision backed by the constitutional provision regarding the public health system, and the government had to comply and supply the medication. We can say that almost everything we have managed to achieve has been gained through this type of cross-sectoral strategy: the right to free condoms, the removal of tax applied to condoms, the inclusion of condoms in the basic food basket and lastly, free access to anti-retroviral drugs.*

The Role of Policy Accountability Mechanisms

In Brazil, a web of mechanisms for policy accountability greatly favors the engagement of civil society in monitoring policy. The 1988 Constitution provisions that set forth the Integrated Health System (SUS) included health councils operating at all levels—national, state, and local—and comprising an equal mix of providers and users, government and civil society representatives. As SUS gradually consolidated, the number of these councils grew and they gained political and management legitimacy.

The National Council of Health meets monthly to monitor MoH policy-making and it may propose resolutions and recommendations that can eventually become policy guidelines. Commissions advise the Council on specific policy areas. In 1996, a Cross-sectoral Commission on Women's Health was reactivated, and began to play a critical role. Also in the second half of the 1990s, a National Commission for Ethical Review of Research on Human Beings was established, the National Commission on Maternal Mortality was re-structured, and a National Commission on Trauma and Violence was created to advise the National Health Council. In addition, since 1992 the National HIV-AIDS Program has put in place a series of bodies to facilitate consultations and provide accountability in specific policy areas. These include the National AIDS Commission and specific committees on prevention, treatment, women, epidemiological surveillance, and research. Women's health and HIV-AIDS activists, along with other members of civil society, have a seat on all these bodies.

Specifically regarding the health councils, it is worth noting that at the local level, in order to receive full financial transfers from the federal government (which make up 65 percent of public health expenditures), municipalities must comply with some rules, which include the existence of a functioning health council. One council mandate is to review and approve the municipal health budgets. Presently, more than 100,000 people participate in the councils nationwide. In addition to this per-

manent monitoring of health policies and budgets, periodically (roughly every four years) a National Health Conference is organized, which is preceded by similar events at state and municipal levels. The conferences involve health managers, providers and councilors and its main goal is to appraise policy progresses in health (in the long run) and devise its new strategic guidelines.

In the mid-1980s, a National Council on Women's Rights was established; its mandate includes reviewing policies that address gender equality. Similar bodies have mushroomed at the state and municipal levels, creating a network that, while less structured than what is seen in the health policy domain, has been critical in keeping gender equality and gender violence issues on the agenda. In May 2002, the government created a new National Secretary for Women's Affairs, an office with ministerial status under the Ministry of Justice. In January 2003, the Secretary was placed in the Presidency of the Republic, a step that gives it higher status.

In 1995, the National Commission on Population and Development (CNPD) was created as a concrete expression of the government's commitment to the Cairo consensus. Its composition encompasses relevant ministries (Health, Education, Foreign Affairs, Labor, Social Security, Justice and Environment, Budget and Planning, and the Presidential Cabinet), specialized agencies dealing with data and policy analysis, and eight members from the academic sector and civil society organizations. The core CNPD mandate is to:

- enhance and support research on emerging issues in population and development;
- expand understanding of the demographic implications of public policies;
- establish a permanent dialogue with national and international organizations involved in population and development analysis and advocacy, particularly those directly involved in ICPD implementation.

Various HIV-AIDS commissions and committees, as well as health councils at all levels, have been and remain a crucial point of entry to ensure free access to drugs, quality of care and respect for human rights of people living with HIV-AIDS. In early 2002, in Rio de Janeiro, NGOs mobilized to denounce and pressure the state-level health department because it was not properly providing testing and anti-retroviral drugs. Again in 2002, the HIV-AIDS community representative at the National Council of Health proposed a formal resolution, which the Council approved, protesting the position of a high-level member of the Catholic hierarchy condemning the use of condoms.

The Cross Sectoral Commission on Women's Health (CISMU) has promoted conversation among various programs within MoH to reactivate the PAISM agenda, and has systematically assessed policy initiatives in women's health, including those concerning: obstetric assistance, maternal mortality, cervical cancer, family planning, and HIV-AIDS among women. In 1997, under pressure from CISMU, a resolution was approved by the National Council of Health—and later adopted by the MoH—to make maternal mortality cases subject to compulsory reporting. The major breakthrough achieved by CISMU was the adoption of the SUS Protocol regarding gender violence services and access to abortion procedures in the case of rape and risk to a woman's life (Norma Técnica de Atenção às Mulheres Vítimas de Violência).

In August 1997, the Congress Commission on Constitution and Justice approved a legal provision aimed at ensuring abortion assistance in SUS services for these two kinds of cases. The Minister of Health declared he would call on the President to veto the law, and the Catholic representatives in the House requested that the bill be voted again. CISMU immediately called on the National Health Council to support the provision and to approve a resolution requesting the MoH technical team to prepare a protocol to regulate abortion services in the SUS network. Six months later the Health Minister resigned—but not before signing the resolution. A new Minister finally approved the protocol in October 1998. As we have seen, this policy tool is considered by many to be one of the major reproductive health and rights advances of the last decade. WHO and Pan-American Health Organization (PAHO) have translated the Protocol into English and Spanish to disseminate it in other countries where the law may allow for the same model of government-sponsored safe abortion in cases where the provisions of the law allow it to be carried out.

Challenges Ahead

MacArthur Foundation advisors in Brazil have considered the policy and related challenges that lie ahead and have outlined the thinking and actions that need to be developed in civil society and academic domains.

Policy Sustainability and Remaining Gaps

The year 2002 marked a political transition in Brazil: Lula da Silva from the Workers' Party was elected President, and new administrations came to office at the state levels as well. Experience has shown that political transitions affect the performance of health policies at all levels. Although the interviews were conducted before the final results of the election were known, there was a strong consensus that the major challenge ahead is to sustain sexual and reproductive health policies. We are encouraged that the newly appointed Minister of Health has already expressed strong commitment to the HIV-AIDS policy guidelines and to the primary health strategies. These have progressed significantly since 1993, and include important strategic links with the women's health agenda. The Minister recently nominated Dr. Maria José Araújo as the new coordinator for the national women's health policy.

However, MacArthur Foundation advisors believe that more than political will is required to ensure that the policies are sustained.

One critical objective for AIDS III—the third Brazil-World Bank Agreement—is to integrate the policy guidelines for the National HIV-AIDS program into the management and financial structure of SUS. This will require important changes in the national coordination and financing rules. Cristina Pimenta raised a concern that the transition may weaken the national coordination team, at least in the first stage, and consequently delay local implementation. She also notes that new financing logic could directly affect the sustainability of prevention activities conducted by NGOs:

> *In the new modality, the funding of NGOs will be defined by SUS managers at local level and will rely on domestic public health resources. It is not so easy to sustain sexual and reproductive health priorities and the funding to NGOs in the new policy cycle, because new priorities may be defined.*

Dr. Caio Rosenthal emphasized that Brazil should sustain a tough stance on the pharmaceutical industry, since the industry's market requirements have been an obstacle to effective implementation of the Brazilian government's policy of universal and free provision of HIV-AIDS drugs to those infected with the virus. The threat made by Brazil's government in 2001 to break the patent on AIDS drugs led not only to negotiated price reductions, but also to a key declaration adopted by the World Trade Organization (WTO) at its Fourth Inter-Ministerial meeting in Doha, Qatar in November of that year. The declaration states that intellectual property rights cannot have primacy over public health needs. In August 2003, the WTO Council finally reached an agreement regarding the criteria and technical implications of the Doha statement. This agreement allows Brazil, under strictly regulated circumstances, to export Brazilian-made drugs to poor countries with no capacity of production. Brazilian HIV-AIDS activists, however, consider the WTO agreement very limited and are currently proposing the reform of the national patent law, in order to provide more justification for the development of Brazil-based pharmaceutical technologies.

Regarding women's health, Jacira Mello strongly advocates transforming current guidelines into a stable and long-term policy. In her view:

What has been achieved can be interpreted as a result of a governmental policy. It was done under one specific administration. Nothing guarantees that it will be sustained. The women's health policy does not have the status of a long-term government policy commitment. This is urgently required to give it the necessary political legitimacy, financial stability and continuity.

Margareth Arilha calls for strategies to avoid backlashes. She believes that a new approach may be needed to ensure that women's health policies are sustained in this new policy cycle.

A new government has just been elected that clearly defined the elimination of poverty and hunger as its priority. Therefore the greatest challenge ahead is to deepen the understanding of linkages between poverty, inequality, sexual and reproductive health and human rights. The development of consistent analyses of the relation between macro-social trends and sexual and reproductive indicators has become urgent.

Most experts call for the closing of policy gaps: racially based health inequalities, shortcomings in youth and adolescent health, and in particular the need for prevention and treatment of HIV-AIDS among women. For this to happen, any remaining problems in collaboration among women's health and HIV-AIDS technical teams must be overcome at all levels. In Alexandre Grangeiro's view, this requires that the HIV-AIDS agenda be given a higher priority among women's health organizations; that prevention programs developed by other NGOs systematically involve women; and that the attitude of health professionals providing health care to women be transformed.

In addition, says Margareth Arilha, additional conceptualization is needed to incorporate gender as a critical and structural health differential. This will require, among other things, the creation of an effective public policy agenda aimed at empowering women and transforming male roles and ways of thinking:

HIV-AIDS infection rates have increased mostly among poor women who have less power of negotiation with their partners and less access to good quality services. (Maria José Araújo)

"Women are married to men who still have other unprotected sexual relations. The public campaigns designed for women—particularly in the case of those channeled through TV that have enormous impact—are concentrated on condom use. But condom use is almost entirely dependent on persuading men to use them. The campaigns do not emphasize male education." (Maria Luiza Heilborn)

Finally, Dr. Caio Rosenthal says that public health policies must go beyond HIV-AIDS and tackle other infectious and endemic diseases. He reminds us that the prevalence of malaria, other tropical diseases, and tuberculosis is unacceptable in a country as urbanized and industrially developed as Brazil. This vision converges with the call by many women's health activists to move the national women's health agenda beyond sexual and reproductive health to include chronic diseases, mental health, occupational health hazards, and other health concerns.

Dr. Caio Rosenthal says that public health policies must go beyond HIV-AIDS and tackle other infectious and endemic diseases.

Legal Framework and the Judiciary

The view of those taking part in the consultation is that, by and large, legal reform is not the most important challenge ahead. As Miriam Ventura has said, it is important first to strongly defend what has already been gained. The major task is to translate existing paper rights into real rights in everyone's daily life, particularly the lives of women, young people, sexual minorities and people living with HIV-AIDS. Conservative forces constantly attack existing legal and normative definitions—for example, the SUS Protocol for providing abortion in the case of rape—while the principle of health services as a right is periodically threatened by privatization proposals.

At the same time, most experts emphasize that there is one major legal reform that must be tackled: the full legalization of abortion. The Brazilian experience in the 1990s of ensuring access to abortion within the limitations of existing laws is widely and positively noted. The dominant perception now is that the illegality of abortion in most cases is inconsistent with the Brazilian political and cultural environment of related issues, such as

sexuality, family patterns, citizenship, and human rights. This view is strongly expressed by Gilda Cabral:

> *Sexual and reproductive rights mean that men are responsible for their sexuality and its effects on reproduction and that women can decide when to have children. The legalization of abortion is implicit in this agenda. The translation of this understanding to daily life is a great challenge for all of us.*

Some experts identified other critical areas and offered ideas for closing the gap between the law and people's real-life experiences. Alexandre Grangeiro and Vera Paiva see a need for better strategies and mechanisms to monitor and eliminate rights violations by public health institutions and others. Miriam Ventura suggests that the women's health and rights movement should go beyond seeking legal reform, following the path opened by the HIV-AIDS community. The movement must be more active on the judicial front, she says, using litigation to ensure that policy failures and abuses—like those in the areas of maternal death and racial discrimination—are brought to light and eliminated.

In the Realm of Civil Society

The trajectory of reform over the period 1990-2002 demonstrates that policy frameworks have been transformed because civil society has been able to craft positive agendas, promote public debates, and mobilize and engage with government bodies. By extension, policy continuity and improvements over the next few years depend on the sustainability of a creative web of civil society organizations. The MacArthur Foundation's exit grants are therefore of great strategic importance, as they seek to sustain and expand the work of partner institutions in Brazil in those areas requiring more close attention in the current scenario.

By extension, policy continuity and improvements over the next few years depend on the sustainability of a creative web of civil society organizations.

Jacira Mello, for instance, emphasized challenges relating to communication and media. She thinks that women's organizations, and social movements in general, must devise clearer messages to inform the public debate on controversial issues such as abortion. She calls for the construction of more persuasive arguments and the use of more seductive language in public campaigns and educational materials. Similarly, other experts believe that while public conversation on sexual and reproductive rights has gained leverage in recent years, much remains to be done. As Betânia Ávila says:

> *It is not so difficult to simply contrast sexual freedom with conservative repressive positions. It is something entirely different to address sexuality as a right in a society where "sex" has been fully publicized—even vulgarized—by the media. The argument that sexuality is a domain of citizenship in which the dimensions of equality and freedom must be addressed does not get an immediate and positive response from the media (or the public). This is because what prevails in the media and the public debate is a sort of commercialization of sex. A discourse that aims at social and cultural transformation is always much more complex and not so easily captured.*

Experts also spoke about the role of civil society vis-à-vis existing accountability mechanisms. Dr. Fátima de Oliveira, speaking as the new coordinator of the National Feminist Network for Sexual and Reproductive Health and Rights, says that one of the great challenges ahead is increasing the ability of women's organizations to engage with and influence the agenda of thousands of health councils across the country. RedeSaude, with UNFPA support, is already implementing a nationwide training program to improve the capacity of women's health activists to monitor health policy at all levels.

Cristina Pimenta believes that, from now on, municipal health departments will increasingly define HIV-AIDS policy. The sustainability and quality of such policies will therefore rely on the capacity of civil society groups to closely monitor activity at the local level. Miriam Ventura also considers this to be a critical arena for renewed intervention. In her view, investments should be made to ensure connections among the various agencies that deal with sexual and reproductive health and rights—including health, education, and children and adolescent councils—which currently have contradictory guidelines.

Finally, in assessing the performance of the National Commission on Population and Development, Eduardo Rios Neto thinks that a strategy must be formed to evaluate the demographic implications of public policies:

> *One obstacle is still the lack of understanding on the part of policy-makers regarding the relevance of the so-called demographic component in their decision-making process. CNPD has made some effort in that direction and we have already noticed a gradual change of attitude. But much remains to be done. Brazilian policy-makers must be sharply aware of the impact of demographic dynamics, mainly with respect to age structure and fertility decline, which have critical importance for health, education, employment, and social security policies. The fact that fertility is reaching levels below replacement should not be seen as a minor consideration for present and future policy formulation. In addition, gender, generation, and race differentials must be incorporated into the planning process to achieve the reduction of the inequalities.*

Research Agendas

Another consensus emerging from the interviews deals with future research challenges: for example, the urgent need to improve data on racial disparities in health. Most experts blame the lack of policy addressing racial inequalities on the absence of reliable aggregated data on racial differentials in access to services, and in mortality and morbidity ratios. Since 2000, under the influence of Durban, progress has been made in measuring racial disparities in education, labor, and income. But the available information does not allow the full examination of differentials in health. The SUS administrative database (DATASUS) and other relevant sources do not include information on race or color as they do sex, income, and residence. (The one recent exception is the HIV-AIDS national surveillance system.) Consequently, MoH personnel, academics, and activists have called emphatically for the systematic inclusion of race in DATASUS.

Experts also called for demographic research aimed at better understanding the impacts of violence and international migration trends. Dr. Berquó says that international migration must be analyzed in relation to fertility differentials between countries, particularly in light of sub-replacement fertility levels in Europe and Japan. She reminds us that this phenomenon has a gender dimension—women are not willing to have more children—and that demographic deficits in these countries must be compensated by migration. With Brazilian fertility rates now reaching replacement levels, the experiences of Europe and Japan should be studied closely.

With respect to biomedical research, Dr. Caio Rosenthal expressed the view that, in the years to come, Brazil should invest more in research and development of drugs and medical technology. The country already has the initial capacity to move in that direction, she notes, and clinical research in HIV-AIDS treatment—which is now conducted predominantly by foreign pharmaceutical companies—has not always taken into account the social and cultural environments of developing countries, which can affect individuals' biological response to drugs. Brazil has the potential to contribute enormously to the progress of global biomedical research on HIV-AIDS.

In the years to come, Brazil should invest more in research and development of drugs and medical technology.

Obstacles Identified

Overall, the MacArthur Foundation advisors recognize progress made since 1990 and the possibilities for future improvement. Nevertheless, they have identified several obstacles that may hinder future progress.

One set of concerns centers on Brazil's high levels of social, gender, and racial inequalities. Such inequalities have historically impeded the implementation of health policy in Brazil, hindering both access to information and people's ability to exercise their health rights. Health inequalities create their own demands and put constant pressure on the resources available to the public health system. Problems that are not directly health-related, but are caused by poverty, are drawn into and overburden health services. Therefore the completion of a positive sexual and reproductive health and rights agenda in the country depends upon economic growth and redistribution.

Another obstacle is the training and attitude of health providers, which interferes with the quality of services. Programs aimed at gender-sensitizing health professionals, such as the one developed by CEPIA in Rio de Janeiro, are critical in addressing this issue. But some advisors believe that to solve the problem in the long term, they must directly influence the formal curricula of medical and nursing schools.

Health inequalities create their own demands and put constant pressure on the resources available to the public health system.

The slow pace of policy change was noted by many advisors. Some people believe that the increased participation of women in politics and in the executive branches of government will enhance the institutional environment for sexual and reproductive health and rights at all levels. They believe that a greater number of voices—from both the feminist and the HIV-AIDS communities—can overcome what they see as the major obstacle to progress: the expansion and growing influence of conservative forces.

Already in the 1980s the Catholic hierarchy had limited the scope of sexual and reproductive health policies. Over the past twelve years the influence of evangelic and conservative Catholic groups on the populace and in the media has grown, particularly through the acquisition of radio and TV broadcast systems. Even as legal frameworks become more liberal, regressive positions tighten their hold on society. Catholic and Protestant conservative forces have increased their presence in legislative houses, both nationally and locally. In recent years—in addition to the Congressional battles on abortion—conservative forces have started to threaten state and municipal legal frameworks and health programs. A few advisors note that these trends within Brazil correspond to international trends regarding abortion and sexuality, and will need to be addressed with a combination of local, national and global action.

Conclusion

The status of sexual and reproductive rights in Brazil is considerably stronger today than it was when MacArthur began its work in the country. This is partly a result of international changes and agreements, which have had a significant impact on Brazilian society. They were able to have this impact, however, because of changes already taking place within Brazil: the ground was fertile and people were ready to express higher expectations. Notably, the progress reflects the level of activity and self-confidence found in the Brazilian women's and HIV-AIDS movements, and their ability to represent both the general population and especially disadvantaged groups, such as black women in Brazil. It has already been noted that Brazil itself played a positive role in the development of the international movement towards sexual and reproductive health rights.

There is a still a gap between what has been accomplished and what it is possible to achieve in reducing maternal mortality, unwanted and too-early pregnancies, and sexually transmitted infections including HIV-AIDS. This is due in part to unresolved ideological and ethical

debates that have hindered the development of services. In some respects Brazil has taken a very practical approach to these ideological differences. The law on abortion has changed little, but the services available to women who have been raped or whose life is at risk have expanded rapidly in the recent past.

However, further change depends on the extent to which sexual and reproductive health issues become the concern of both men and women. The degree of violence against women, including rape and sexual violence, is a reflection of a society in which boys and young men have not come to terms with their responsibilities. Yet there are relatively few services targeted at boys and men, and they have not expanded at the same rate as services for women. Until men take an equal share in responsibility for contraception, and until sexual relations are freely entered into (and freely rejected), the ability of women to choose whether or not to have sex, to become pregnant, or to put themselves at risk of sexually transmitted infections will be severely compromised.

The way that HIV-AIDS prevention programs have been introduced into schools has been widely praised. But this has not been integrated into a broader sexual and reproductive health program for schools—a program dealing with issues of equality, respect, and rights. Boys and girls alike are bewildered at this age by the mixed messages and conflicting expectations they pick up from parents, school, and the mass media. They are both in need of sensitive programs that allow them to make choices and resist unwanted pressures.

Conservative values in sexual matters do not appear to have any positive impact on behavior. The age of first sexual initiation continues to fall, whether adults disapprove or not. A program that does not face this reality leaves young people unprotected and at risk. The rights agenda appears to offer greater hope of making a real difference in the lives of girls and boys as they grow into women and men.

The rights agenda also offers new opportunities for black women in Brazil to improve their circumstances. The development of a cohort of black women academics who are taking a special interest in sexual and reproductive health will ensure that the spotlight remains on this area of work. The trend towards recording data on ethnic group as well as gender will surely increase, as it becomes obvious that there are real and fundamental differences in outcomes for black and for white women.

It has already been noted that Brazil itself played a positive role in the development of the international movement towards sexual and reproductive health rights.

This specialization of knowledge and attention does not mean, however, that the broad movement for sexual and reproductive health rights should become fragmented. On one hand, attention must be paid to particular groups within society, by age, by gender, and by ethnic origin. On the other hand, their rights can only be guaranteed if there is a broad consensus in society that both sexes and all sections of society are equally entitled to these rights. Reducing maternal mortality, for example, means ensuring that high quality antenatal, delivery, and postnatal services are available to women in all parts of the country. Delivering the rights to sections of society, especially those who have enjoyed them least in the past, is a step on the road to making them universal and indivisible.

As women become more able to exercise their choices, the future pattern of population change will emerge; mostly likely it will be at or below replacement level. The creative forces in Brazilian society, which have done so much to develop policy over the past 20 years, will rise to these new challenges because they have strong organizations, a sense of civil society solidarity, and networks that can pull diverse forces together. In addition, they will be able to rely on the permanent mechanisms for monitoring health policy and implementation at all levels.

Fund for Leadership Development

Promoting leadership, developing expertise

One notable aspect of the MacArthur Foundation's support in Brazil has been the Fund for Leadership Development (FLD), which each year has offered support to about eight men and women—86 over the past decade—at a critical moment in their work. The two- or three-year grants have allowed these individuals to develop their expertise, establish critical NGOs, and bring projects to fruition.

FLD grants have been awarded to academics, researchers, physicians, and people working with NGOs in a variety of ways, including through the arts. The grants allow these professionals to develop their careers and to have a significant influence in their areas of work. In many cases the grant has led to groundbreaking projects or research. Several recipients have also helped other grantees to develop and continue their work with NGOs.

A few examples illustrate the power of the FLD grant:

Adele Schuartz Benzaken, a doctor, created a public health service at the Fundação Alfredo da Matta to help people with sexually transmitted diseases. She also founded the Amavida Movement, an NGO that sets up projects to help commercial sex workers and their clients prevent AIDS and other STDs.

José Ricardo de Carvalho Mesquita Ayres, a physician at Samuel Pessoa Health Center and Federal São Paulo University Medical Center, used his three-year research and training grant to develop strategies for preventing the spread of HIV-AIDS among the adolescent population in a local slum area. He also works with the Enhancing Care Initiative, investigating the vulnerability of women and adolescents living with HIV-AIDS and the health care they receive.

Marta Oliveira was a technical advisor to the Rio de Janeiro Health Department. She used a two-year research grant to identify specific examples of the denial of health care to Afro-Brazilians. She says, "The support provided by the MacArthur Foundation has been extremely important for my growth as a professional and as an activist. Particularly because, during the years I was a grantee, issues related to racism and racial discrimination became more frequently debated nationally and internationally."

Ana Vasconcelos, a lawyer, was President of the NGO Casa de Passagem (the Brazilian Center for Children and Adolescents) when she received a three-year FLD training and education grant in 1992. She introduced a program to integrate sexual and reproductive health care into outreach efforts aimed at street girls and poor women in Recife.

Antonio Fernandes Lages received a three-year grant to establish a public health service for women victims of sexual violence at the Odete Valadares Maternity Hospital in Belo Horizonte, which includes abortion procedures in the cases allowed by law (rape and women's life risk). The unit provides medical and psychological care as well as legal support. Fernandes developed courses for health professionals and helped create similar services in other localities. As President of the Obstetrician and Gynecological Society of Minas Gerais, he sits on the state commission looking into legal abortion services.

Débora Diniz Rodrigues is director of the Feminist Approaches to Bioethics Network and the winner of the WHO/PAHO Manuel Velasco-Suarez International Bioethics Award. She has helped lead a nationwide feminist debate on the ethics of reproductive technology and abortion—at considerable personal cost. Supported by the FLD program from 2000 to 2002, she initiated a number of research and media advocacy projects. But after she spoke on the issue of abortion and morality at a debate organized by the prosecutor's office, she lost her job as a professor in the Catholic University of Brasilia.

Diniz is unbowed by this experience. She says, "Academic freedom is a constitutional right and must be protected and promoted by the Brazilian universities, even when the discussion is about themes as sensitive and hard to speak about as abortion."

Samantha Buglione, a lawyer who advises the NGO Themis, used her grant to help health centers identify and address reproductive rights violations in marginal communities of Porto Alegre. In doing so she came to understand how rights are inhibited by the different perceptions of people living in poor communities and the health workers who serve them. "In the beginning," she says, "the project dealt with the juridical paradigm of sexual rights and reproductive rights. It took some time to understand the limitation of these concepts and to include diversity as a constitutive element of rights."

A number of grants have helped individuals develop programs in the media or through the arts:

Radio producer **Mara Régia Di Perna** accepted a three-year grant to train people in Amazon communities to use the radio to promote women's and health issues. She hosts a radio program directed at Amazon women, Live Nature/Women Nature, and has also trained health workers, including midwives, to use the radio to reach isolated women with health promotion messages.

Joelzito Almeida de Araújo used a three-year grant to help African-Brazilian organizations use video to examine racial identity, health, and self-respect. He received a prestigious award for his film *A Negação do Brasil — História do Negro na Telenovela Brasileira (Denying Brazil — History of the Black Person in Brazilian TV Soap Operas)*.

Highly acclaimed dancer **Dora Isabel de Araújo Andrade** developed the EDISCA School of Dance and Social Integration for Children and Adolescents. Working with children from poor neighborhoods, EDISCA uses dance to develop self-discipline, self-esteem, and a sense of citizenship with both individual and social responsibilities.

A successful actress and theater director, **Maria Eugênia Viveiros Milet** used her grant to give stability and continuity to her work in the public schools with the NGO Integral Reference Center for Adolescents (CRIA). She is now the director of CRIA, which uses theatre and adolescent creativity to raise issues about citizenship, self-image, and development.

Some grantees have used their expertise to assist international organizations.

Some grantees, after the completion of their projects, have been engaged by international organizations. One example is **Denise Dourado Dora**, who was coordinator of the NGO Themis, later served as a MacArthur Foundation consultant to strengthen the FLD program in Nigeria and is currently a program officer with the Ford Foundation's Human Rights Program in Brazil.

Projects Supported in Brazil: Some Examples

Associação Brasileira Interdisciplinar de AIDS (ABIA) Brazilian Interdisciplinary AIDS Association

Challenging the silence and stigma of AIDS

The history of the AIDS pandemic teaches us that open societies deal with it best, while closed societies, or societies in denial, unwittingly help HIV infection to spread.

Brazil in the 1980s was beginning to move from military rule toward democracy. But in 1986, when the Brazilian Interdisciplinary AIDS Association (ABIA) was formed, there was little openness about the disease or about treatment for those who had been infected. HIV infection was still being spread through tainted blood products from paid donors, and almost half the country's 5,500 hemophiliacs were infected this way.

In 1986, when the Brazilian Interdisciplinary AIDS Association (ABIA) was formed, there was little openness about the disease or about treatment for those who had been infected.

The professionals who founded ABIA aimed to mobilize Brazilian society and to highlight the government's failure to deal with HIV-AIDS—including, as the founders said, "the criminal situation prevailing in the country's blood bank system, the lack of quality information on HIV-AIDS, and civil rights violations towards people living with HIV-AIDS." The Association was established with funding from inside and outside Brazil. It sought to break through the confusion caused by sensational reporting in the media and the lack of frank discussion about the risks of unprotected sex and needle-sharing. In countering these trends, ABIA built a reputation for providing accurate and accessible information.

This work expanded so quickly it outstripped the organization's capacity to manage it; by 1991 ABIA had to put some projects on hold while it reorganized. It was at this critical point that MacArthur offered its first three-year grant, allowing ABIA to invest in managerial and administrative capacity and improve its organization.

ABIA had been born out of a need to confront pointedly the key issues of AIDS in Brazilian society. Now the organization moved toward a new professionalism, focusing on projects and production, analysis, and the dissemination of information. Its new approach allowed ABIA to take advantage of a range of funding from overseas agencies.

ABIA brought together many of the top researchers in the social and medical aspects of AIDS in Brazil, publishing two landmark books on the subject. Over ten years, studies have looked at the behavioral changes among homosexual and bisexual men; sexual attitudes among students; knowledge, attitude, and behavior toward HIV of low income people; and the use and impact of combination therapies.

Since 1996, Brazil has had a policy of developing drugs and providing them at little or no cost to those infected with HIV, a policy that has helped reduce the number of AIDS deaths by two-thirds. However, falling death rates bring with them the danger of public complacency about HIV and infection risks. Notably, the rate of infection among women has not decreased. And sexual minorities and people living with HIV-AIDS still face considerable stigma.

ABIA helps to combat complacency by coordinating national and international forums to update knowledge, share information, monitor health policies, and develop programs. These forums bring together a range of partners from government agencies, NGOs, the academic community, and civil society.

ABIA runs projects geared toward young homosexuals, male sex workers, and HIV-positive people being treated with anti-AIDS drugs. It runs courses to educate health professionals about issues that may affect the willingness of a patient to adhere to a treatment regimen, including the quality of patient-doctor relationships, drug reactions, and other side effects from treatments. ABIA uses a variety of approaches, from condom distribution, to workshops for professionals, to targeted support for communities and organized groups. Through its Documentation and Reference Center (CEDOC), ABIA distributes information to 1,800 organizations inside Brazil and 200 international organizations. It has a website at www.abiaids.org.br

ABIA now sees its priority as updating its management model and ensuring financial stability so it can step up its efforts to address the still-growing AIDS epidemic.

Casa de Cultura da Mulher Negra
House of Black Women's Culture

Raising the profile of sexual and domestic violence as a public health issue

In Brazil domestic violence has traditionally been a hidden, shameful, issue. Only 2 percent of battered women seek police help. Now this issue has moved up the political agenda, thanks in part to the work of Casa de Cultura da Mulher Negra, established in 1990 to support black women's rights, fight racial discrimination and violence, and strengthen cultural traditions.

Casa de Cultura da Mulher Negra (CCMN) has become a symbol of resistance against domestic, sexual, and racial violence. The organization uses the mass media to highlight these issues, while providing individual counseling and legal support for 400 women a year from all ethnic groups.

With funding support from MacArthur, one main focus of CCMN's work has been to address violence against women as a public health issue. The organization realized that health services were a critical entry point to reach battered women who were not seeking help, and that the staff could do more for these women than patch them up and send them home for more abuse.

CCMN has developed domestic violence protocols to encourage health staff to put an abused woman in touch with counseling services and to allow her to make an informed choice about prosecution. In 2001, CCMN published *Violence Against Women—A New Approach* as a manual for health professionals.

Casa de Cultura da Mulher Negra (CCMN) has become a symbol of resistance against domestic, sexual, and racial violence.

CCMN has been able to build on its individual support work for women. In its home base of Santos, about one hour from the city of São Paulo, CCMN created a "zero tolerance" campaign in the community and with local authorities and the media. The organization played a leading role in the creation of a women's shelter in Santos and has campaigned for similar shelters in other cities of the region. CCMN has established seminars, workshops, and media campaigns to reduce community tolerance of racism and violence against women, extending its influence to other regions and influencing nationwide federal legislation.

Results have been spectacular. Municipal legislation to support women who are attacked has been passed in the cities of Belo Horizonte and São Paulo, and a state law was passed in Rio de Janeiro. In March 2002 the Minister of Health approved a protocol requiring state health departments to notify and report on cases of violence against women, effectively establishing this as a nationwide public health issue.

The Center is now turning these legal advances into real change on the ground, encouraging women's organizations to monitor their local state health departments. It is also working with the local Chief of Police to educate police officers to provide a better response to victims of racial or domestic violence.

CCMN publishes an electronic bulletin, *Eparrei*, to create closer links with women's and black groups. For three years it served as the executive office of the National Feminist Network against Domestic, Sexual and Racial Violence. CCMN is a member of the Post-Durban Monitoring Commission, and in 2001 it became the first Brazilian NGO to be accredited by the Organization of American States to monitor the rights of women and afrodescendants across the Americas.

Casa de Cultura da Mulher Negra says: "MacArthur Foundation's support and confidence in the area of health and domestic violence allowed us to dare to extend our work to the other Brazilian regions, and to improve the publications, informative materials, and national seminars which place us as one of the main Brazilian references on this issue. With better resources we have been able to influence the actions of governmental and women's groups in several states."

Católicas pelo Direito de Decidir—Brasil
Catholics for a Free Choice—Brazil

Catholics seek to broaden church view of sexuality

Catholics for a Free Choice Brazil (CDD-BR) came into being in 1993. A decade later CDD-BR is a persistent public voice supporting women's rights and promoting debate within the Catholic population on ethics, sexuality, and religion. Its main aim is to challenge the ideological basis for policy-making that condemns millions of women to unwanted pregnancies or illegal abortions. It seeks a tolerant approach to family planning, abortion, and homosexuality.

Although it is a small organization, CDD-BR says it represents the views of millions of ordinary Catholics in Brazil. It organizes conferences and has a regular presence in the media.

There are many illegal abortions in Brazil, with abortion being the fourth highest cause of maternal mortality in the country. Yet as long ago as 1994, polls showed a majority in Brazil is in favor of decriminalizing and regulating abortion. In another poll, four in ten Brazilians said that people should decide for themselves, informed by their own conscience, whether to have an abortion.

The coordinator of CDD-BR is Maria José Nunes, a professor at the Catholic University of São Paulo and a former nun, who in 1994 received a MacArthur Fund for Leadership Development grant.

CDD-BR contends that the same forces that do not want to liberalize Brazil's strict laws on abortion, also oppose the use of condoms, family planning, emergency contraception, and sex education in schools. Maria José Nunes argues that although the church believes it is taking a 'pro-life' position, its policies can put women's lives at risk. In an interview in *O Jornal do Brasil* she said: "To the extent that sectors of the church oppose a law that would reduce the extremely high maternal mortality rate, they are taking a position against life."

One successful initiative of CDD-BR was the production of five CD-ROM radio programs in which women and men discuss sexuality and religion, and how to rid sexuality of guilt and the risk of disease or unwanted pregnancy. This series, *Sexuality—People Reach Understanding through Dialogue*, has been widely broadcast by community radio stations across the country as part of education programs on sexuality and AIDS prevention. CDD-BR maintains a lively web site that has become an important resource for the media. It also produces easy-to-read material on violence, abortion, sexuality, and motherhood.

CDD-BR formed a theological reflection group and through links with other organizations has broadened its work to encompass homosexuality, AIDS prevention, and gender violence. It has taken part in actions to improve legal abortion services and to ensure that hospitals and health professionals deal properly and sensitively with the consequences of illegal abortions.

CDD-BR has presented testimony in Congress and has worked with the Mayor's Office in São Paulo and the Federal University of Public Health to encourage health workers to take more decisive and effective action on behalf of victims of sexual and domestic violence.

The Brazil organization coordinates the Latin America Network of Catholics for a Free Choice and has links with Catholics for a Free Choice in the US and European Union (EU) countries. It also belongs to networks for health and women's rights in Latin America. In July 2002 it joined a protest at the International AIDS Conference in Barcelona, Spain, using the slogan Condoms=Life. CDD-BR intends to strengthen its partnerships with government agencies and to conduct research on the subject of violence against women in the Catholic Church.

Centro Brasileiro de Análise e Planejamento (CEBRAP) Brazilian Social Planning and Analysis Center

Training black scholars to focus on health needs

It has been difficult to identify and understand the special health needs of the black population in Brazil, or to spotlight areas where health services do not meet those needs, because the crucial information has not been routinely collected.

Under a long-standing policy of 'racial democracy,' Brazilians considered it divisive to collect data according to ethnicity; consequently, most official statistics cannot be broken down by race. It is only relatively recently that, spurred by the Durban World Conference against Racism, NGOs and government sources have acknowledged the need to collect ethnic data and have sought the means of doing so.

One group, however, has been pursuing this agenda for a decade: the Centro Brasileiro de Análise e Planejamento (CEBRAP), a leading social science research organization with a record of standing up for uncomfortable truths. CEBRAP was formed by a group of professors and researchers who left the University of São Paulo in 1969, when the military seized control of the country and cut off the freedom to think beyond official policies.

Over the years CEBRAP has developed a reputation for high-quality research, particularly in demography and population studies. In 1992, with the support of the MacArthur Foundation, the organization began a training program in these fields for young black scholars.

A second training course is now under way—this one to improve understanding of race-specific reproductive health problems, and to train a small group of black scholars who are interested in the demographics of these issues. The intention is that, by pursuing their interest in these topics, the scholars will become influential in the field of health policy and help design reproductive health programs that will meet the needs of—and be welcomed by—black families in Brazil.

The scholars will spend three years with CEBRAP learning how to conduct high-quality studies, both quantitative and qualitative, on under-researched problems relevant to the health of black women in Brazil. The project will study cervical cancer at the Hospital of Vila Morais, the only health center in São Paulo to include the race of the patient in its routine statistics. Because researchers will be able to analyze the findings by race, the study should improve the understanding of how cervical cancer differentially affects people of different ethnic groups. The research will help to target policy and inform the public.

Over the years CEBRAP has developed a reputation for high-quality research.

Centro Feminista de Estudos e Assessoria (CFEMEA) Feminist Center for Studies and Consulting

Center presses for women's rights in Congress

In little more than a decade, the Feminist Center for Study and Consulting—CFEMEA—has established itself as an important partner in the fight for social justice, equality, and democratic human development in Brazil.

CFEMEA promotes public education in the Senate and Chamber of Deputies, closely following debates related to women's rights across a broad range of issues, including labor, social security, health, and violence. Its monthly newspaper, *Jornal Fêmea*, informs parliamentarians and women's organizations across the country about new and proposed legislation that may threaten existing entitlements. One role of the news-

paper is to describe in ordinary language legislation that affects women's lives—the first step in a process to transform paper rights into real change.

CFEMEA was founded in 1989 to help women achieve full citizenship and equal rights. At the time, Brazil had just approved its new Constitution, part of a movement to consolidate democracy in Brazilian society. CFEMEA now has 13 associates and 18 professional staff, overseen by a governing council and advisory bodies. It holds general meetings to ensure dialogue and democracy.

The Center helped mobilize a Women's Parliamentary Group in the National Congress, with representatives from a broad range of political parties. The Group's objective is to offer the Chamber of Deputies and the Senate a gender perspective on legislative and government programs.

The MacArthur Foundation has supported CFEMEA financially since 1992, enabling the organization to attract and retain high-quality staff. MacArthur support helped CFEMEA establish the Women's Rights in Law and in Life Program (PDMLV), which promotes the social rights of women among legislators.

CFEMEA has made a significant contribution to improved social rights for women, and helped win public support for the Cairo Conference 1994 Program of Action on family, sexuality, and reproductive rights. Some political parties, labor unions, student organizations, and others have implemented quotas for women on ruling bodies to strengthen women's empowerment and ensure greater gender equity.

The Center helped mobilize a Women's Parliamentary Group in the National Congress, with representatives from a broad range of political parties.

The women's movement in Brazil has been able to expand support programs for women who are victims of violence. Women can now have legal abortions in public hospitals when the mother's life is at risk or if the pregnancy resulted from rape. CFEMEA played an important role in this evolution, according to Gilda Cabral, one of the founders of the organization.

In February 1992, CFEMEA launched Jornal Fêmea, which now has a 13,000 monthly circulation. The Center has run radio campaigns about political participation, AIDS, and women rights; produced a weekly television program for working women, and used its web site to inform a wide audience about women's rights and struggles.

CFEMEA has developed important national and international political links since the 1994 Cairo Conference; it is considered an important partner in the fight for social justice and for sustainable and democratic human development. CFEMEA is a part of the World Social Forum, and is affiliated with the Brazilian Association of NGOs, the Concerted Action of Brazilian Women (AMB), and the National Feminist Health and Reproductive Rights Network.

The Center is now seeking a broader range of funding from companies and governmental bodies, to lessen its dependency on international agencies.

Cidadania, Estudo, Pesquisa, Informação e Ação (CEPIA) Citizenship, Study, Research, Information and Action

The case for reproductive health services—the training to deliver it

Cidadania, Estudos, Pesquisa, Informação e Ação (CEPIA) has played an important role in developing a movement in Brazil demanding better health services for women and adolescents.

CEPIA—the name means Citizenship, Studies, Research, Information and Action—used its first grant from the MacArthur Foundation in 1992 to monitor national health policies related to women's reproductive rights. CEPIA then used a variety of media to take health messages to mainstream audiences, increasing the pressure for greater reproductive rights and better access to high-quality women's health services.

In 1993 CEPIA hosted a significant international conference for scholars, program coordinators, physicians, and grassroots community leaders. In 1994 it used public service announcements on TV to examine such sensitive topics as abortion rights and the spread of HIV among married couples.

Later, CEPIA turned its attention to training programs to increase awareness of women's health issues among medical students, nurses, physicians, and police officers. With the University of Rio de Janeiro, the City Health Department, and the Ministry of Health, it provided innovative training to help professionals work sensitively and effectively with women who have been abused.

Cidadania, Estudos, Pesquisa, Informação e Ação (CEPIA) has played an important role in developing a movement in Brazil demanding better health services for women and adolescents.

Nurses and doctors learned about national abortion policies at the same time as they were learning about safe abortion procedures. Medical officers learned about the association between domestic violence and health issues, including HIV-AIDS, and about care options, including emergency contraception and abortion. Hospital staff debated issues of informed consent, reproductive choice, and quality of care.

Police officers were sensitized on issues of rape and other forms of violence against women. The training of police officers is especially important because police have not always been seen as allies of women who have been abused. Police wages are low, recruits may not have finished high school, and there are few opportunities for new police officers to learn about these issues. Training in responding to rape and violence against women sets out the legal framework and the medical and health implications within a human rights context.

After supporting these early successes, MacArthur provided a grant that continued this training through to June 2003, extending it to students at the Medical and Nursing Schools of the Federal and State University of Rio de Janeiro. Training continued for city police officers in Rio, and is also under way in two major hospitals in the capital.

CEPIA has also been broadcasting messages on commercial television and radio to open up public debate on abortion, sexual violence, HIV-AIDS, and equality in gender relations.

Communição e Cultura—Instituto de Saúde e Desenvolvimento Social—ISDS
Communication and Culture—Institute of Health and Social Development

Young people learn and teach, on the street and in the news

Ceará in the Northeast of Brazil is one of the poorest states in the country's poorest region. More than a third of the population is between 10 and 24 years of age, and almost half live in poverty.

Young people's health, education, and rights are often neglected. The local government estimates that 43% of women are pregnant or have had a baby by the time they turn 24. In the state of Ceará, as many as 28% of all births are to young people aged 10-19, and, partly as a result, the school dropout rate is high.

The MacArthur Foundation has supported two organizations that have found innovative and exciting ways to tackle a broad range of issues affecting young people in this state. Projects sponsored by these organizations give thousands of young people the opportunity to express themselves creatively, to learn about their own health and development, to become more assertive about seeking services, and to learn skills that will make them more employable. Young people directly involved with the projects do not just learn these things on their own behalf but teach others in their peer group, improving their skills and self-esteem as they learn.

The initiative brings together two highly effective NGOs working in the arts and in media, and encourages them to collaborate in a way that may continue long after the funding has ended.

The first organization, Communição e Cultura, provides young people with the skills and equipment to produce a school-based newspaper that serves as a forum for expressing and learning about sexuality. Communição e Cultura says that young people feel a sense of responsibility for their community and schoolmates, and they enjoy preparing material that will help others learn about

their sexual health. While these student journalists work on sexual health issues, they are also learning technical and communication skills that make them more employable.

Communição e Cultura had been running this course for six years, working each year with 120 students aged 12-19 from 23 schools. With the help of the MacArthur grant they are expanding the project to reach 2,680 students from 184 schools over three years, reaching out to small cities along the coast and to the capital city, Fortaleza. They hope eventually to cover the whole state, reaching 700 schools.

Communição e Cultura has divided participating students into two groups, The first, De Igual para Igual (Equal to Equal), has formed the Clube do Jornal (Newspaper Club), where students write up the topics for the papers. The other group, Mobilização Social (Social Mobilization), uses a variety of other ways to communicate its messages.

Developing skills and disseminating information in innovative ways is also a central aim of the second organization, Instituto de Saúde e Desenvolvimento Social (ISDS). ISDS is running a theatre training project, Arts against AIDS, involving 250 students and a number of out-of-school teenagers in Fortaleza. The project uses drama to address issues related to the body, sexuality, and gender roles and organizes debates for out-of-school youth. Two former MacArthur Fund for Leadership Development grantees lead this work. Theater training is coordinated by Ranulfo Cardoso, former FLD grantee and an advisor to the Ministry of Health on AIDS prevention; gender workshops are led by Gloria Diógenes, an FLD grantee who has a Ph.D. in social psychology. Both are experienced in reaching street youth with a structured agenda.

Young people directly involved with the projects do not just learn these things on their own behalf but teach others in their peer group, improving their skills and self-esteem as they learn.

While the projects are run independently of the schools, both the newspapers and the dramas are taken back into the schools to reach other young people with topics such as reproductive health, sexually transmitted infections, AIDS, gender violence, and safe sexual practices.

The evidence is that when sexual and reproductive health information is offered to adolescents in this way, they are more likely to adopt less risky lifestyles. The two organizations expect that their projects will improve young people's knowledge and understanding of the links between gender inequities and reproductive and sexual health, increase awareness about gender-based violence, and encourage the state to respond to young people's health and education needs.

This grant advances three important Foundation goals: improving young people's sexual and reproductive health and rights, strengthening the capacity of grassroots organizations to address sexual and reproductive health rights, and increasing the involvement of young people in program design, implementation, evaluation, and advocacy.

Cunhã—Coletivo Feminista
Cunhã—Feminist Collective

Strengthening demand for services in Northeastern Brazil

The Northeast of Brazil is the poorest region of the country and has the highest birthrate: 3.1 children per woman. Contraceptive use is much lower than in the industrialized South, while infant mortality, at 74 deaths per 1000 live births, is three time the rate in the South and almost twice as high as the next worst region.

Since 1990, Cunhã has been training community leaders in the northeastern state of Paraiba, and producing and distributing information about reproductive health and rights that will improve the ability of young women and men to exercise their sexuality responsibly. Cunhã helps develop community leadership, train teachers and health professionals, carry out community-based education, and initiate media campaigns. Cunhã has grown from a group of committed friends to a position as a respected leader in the Northeast, and a partner of women's organizations nationwide.

Cunhã, which means 'woman' in the local indigenous language, has demonstrated a tenacious determination and has grown as an advocate for reproductive health. It has the potential to become a strong resource in the impov-

erished Northeast, with an ability to influence public opinion, increase human rights awareness, and generate demand for public services. Its activities are directed at changing the attitudes of the public, which feels relatively powerless, and the authorities, which have neglected reproductive health rights locally.

MacArthur's approach has been to support this organization in its efforts to play a leadership role. This has proven to be more effective and more sensitive than the approach taken by some international organizations, which directly funded programs to reduce fertility and increase family planning. These programs aroused controversy, with accusations that international donors sought to control the fertility choices of local people. After three decades of multi-million dollar investment in this area, fertility has fallen, but without improvements in sexual and reproductive health indicators or a narrowing of the economic gap between the Northeast and other regions of Brazil.

In contrast, MacArthur has seen Cunhã build the self-esteem and ability of women to take greater control of their own fertility, while building bridges to health professionals who had shut themselves off from the public. Cunhã has increased public awareness of how to prevent unwanted pregnancies and sexually transmitted diseases, and has forged close links with the local Health Secretariat.

Cunhã sees one of its main challenges as overcoming prejudice and countering sensationalist and biased media treatment of issues such as abortion.

Cunhã tackled abortion as a 'right to choose' issue, which allowed the group to focus on contraception and unwanted pregnancies as well as abortion. Cunhã produced advertising campaigns addressing abortion, emergency contraception, and use of contraceptives; responsible fatherhood; and sex during adolescence. Among the most successful is *Nobody Gets Pregnant Alone*, a campaign to prevent unwanted pregnancies, which had impact both with the media and with local communities. Cunhã's efforts helped move the abortion issue away from the crime pages of newspapers onto social issue pages, and led to the creation of a unit in the local public health system to support women who are victims of sexual abuse.

Cunhã has also developed a constructive critique of the public health system's family planning program, and has encouraged the government to broaden its approach. The goal is to make the family planning program a service to women, rather than an instrument of population control. Cunhã has called for the creation of a resource center to provide education and information on all aspects of contraception. Cunhã already works to disseminate accurate information through its *Health Hints* magazine, which deals with aspects of women's health that are rarely addressed in the mainstream media.

Cunhã helps develop community leadership, train teachers and health professionals, carry out community-based education, and initiate media campaigns.

Cunhã strongly believes that future success lies in strengthening participation and collaboration among civil society, government, and municipal agencies, and in making the case for policies that support women.

This region of Brazil, above all others, needs strong institutions that can lead a public debate and influence policy and public services. In selecting Cunhã for one of its exit grants, MacArthur recognizes that the organization must secure its future in order to improve its capacity to influence public opinion, increase human rights awareness, and generate demand for public services.

ECOS—Comunicação em Sexualidade
ECOS—Communication on Sexuality

Pioneering group advances reproductive rights of young people

The mission of ECOS—Centro de Estudos e Comunicação em Sexualidade e Reprodução Humana—is to promote and advance the sexual and reproductive rights of young people. Since its founding in São Paulo in 1989, ECOS has become one of Brazil's best known and most effective organizations in the field, earning a reputation as a pioneer in communication, training, and surveys. While the general public may not yet recognize the right of young people to high quality sex education, ECOS materials have gained increasing acceptance among educators, health professionals, managers, government agencies, community organizations, and a variety of advocacy project leaders.

The mission of ECOS—Centro de Estudos e Comunicação em Sexualidade e Reprodução Humana—is to promote and advance the sexual and reproductive rights of young people.

ECOS has become well known for its videos, supported by written materials, which reach large audiences and have won awards inside and outside Brazil. Overall, ECOS has produced 20 educational videos, 12 discussion guides for videos, 18 manuals for educators, 40 bulletins, and two books. The materials address a broad range of themes, including reproductive health, unwanted teenage pregnancy and abortion, emergency contraception, prevention of AIDS and other STDs, drug abuse, men and sexuality, gender relations and stereotypes, and sexual violence.

ECOS was one of the first organizations to understand the importance of including boys and young men in sex education. In 1990 the group produced a pioneering video called *Boys, the First Time*.

In 1994 ECOS signed an agreement with the Ministry of Health to work with public school teachers and students on sex education and STD/AIDS prevention. The contract has been renewed every year since then. Recently ECOS was chosen by the Ministry of Education to implement national sexuality education. ECOS will develop tools and materials for elementary school, high school, special education, indigenous education, and adult education.

ECOS is a member of the commission formed by the National Health Council, the National Commission on Citizenship and Reproduction, and the Ministry of Health to reduce adolescent pregnancy. The group also sits on the Intersectorial Commission on Women's Health.

ECOS has formed effective partnerships with private corporations as well. For example, it recently produced a series of books and videos, called *Sexuality: Pleased to Meet You*, with support from the largest Brazilian commercial television and media corporation.

Topics such as teenage pregnancy, AIDS, and sexual abuse of adolescents have gained increased attention through the technical and communications work of ECOS. The organization has trained more than 40,000 health and education professionals and reached more than 600,000 adolescents and adults with its educational activities. More than 30,000 videos and 777,000 copies of its bulletins have been distributed. ECOS materials are being used in Portuguese-speaking countries in Africa and are being translated into Spanish for use elsewhere in Latin America.

ECOS has received support from MacArthur since 1989. During that time, professional NGOs such as ECOS have helped bridge the gap between government agencies that may not be skilled at sensitive social interventions, and voluntary groups that do not have a broad reach or the resources to sustain their work over time. Among the important activities funded by MacArthur was a collaboration among ECOS and two other high-quality NGOs in Brazil, CRIA and GTPOS, to promote sexual and reproductive rights education.

The MacArthur Foundation selected ECOS for one of its exit grants, awarding the organization $300,000 over three years to ensure that it can develop other sources of funding and strengthen the marketing of its videos, educational material, and training. ECOS will use some of this money to strengthen its ability to respond to local and national requests by equipping its staff with computers and information systems.

Fala Preta—Organização de Mulheres Negras
Black Talk—Black Women's Organization

Group sets health needs of young Afro-Brazilians in wider context

Afro-Brazilian women are affected by race-specific conditions, and by illnesses resulting from race discrimination and negligence, in ways that are overlooked by both the public and the health system.

Fala Preta — Organização de Mulheres Negras is a relatively new organization, but it is led by a group of people with many years of experience in working for the rights of Afro-Brazilian women. Its focus is on health issues, particularly reproductive health.

Fala Preta has pioneered work on the health of the Quilombola population, African descendent communities who maintain African traditions and live in remote rural areas. The organization has also developed an innovative approach to reaching young Afro-Brazilians, a project in which reproductive health is integrated into a broader educational approach. The project begins with the concept that all human beings are entitled to universal rights, and that each person is responsible both for himself/herself and for the well-being of his or her community. It highlights the way that biological, social, emotional, and historical factors come together to create a sense of self and a sense of community. Sexuality and reproductive rights are presented as an important element within this broader human rights framework. The project focuses on the need to make informed decisions and to counteract the racial discrimination that limits choices and opportunities for young people.

Fala Preta works with schools, community organizations, city councils, and other NGOs.

Fala Preta works with schools, community organizations, city councils, and other NGOs. A MacArthur three-year grant is helping Fala Preta increase its work with young Afro-Brazilian women and men. The organization has agreed to cooperate with other grantees working with young people to develop common benchmarks and indicators of success.

Grupo de Trabalho e Pesquisa em Orientação Sexual (GTPOS)
Research and Work Group on Sexual Education

Bringing sex education into line with young people's perspectives

Grupo de Trabalho e Pesquisa em Orientação Sexual, one of the first organizations MacArthur worked with when it opened its office in Brazil, was tackling the difficult question of sexuality education in schools.

The group of young educators, psychologists, and psychoanalysts who launched GTPOS believed that sexuality education must be grounded in young people's own reality, and that understanding what young people think, believe, and do is an essential starting point in this process.

This was an exciting time for educators. The ideas of Paul Freire had revolutionized the relationship between those who teach and those they are teaching. Freire understood that the teaching/learning process cannot be seen as pouring information into a bucket. It is more a process of sharing, in which a skilled teacher enables people to use what they already know, and helps them find out more. Intimate and deeply held beliefs that govern people's daily lives are not easily changed, Freire said. If the world brought new dangers or suggested new ways of living, that was a journey people had to make themselves, by applying their own life experiences.

Freire's ideas had had an impact across the world, and in 1998, just after the creation of GTPOS, he became Municipal Secretary of Education in São Paulo. GTPOS began to work with teachers in the school system on a method of teaching about sexuality that emphasized responsibility and autonomy, from a perspective of gender equality.

Beginning in 1994, with support from the Ministry of Health, this work was extended to six Brazilian state capitals. Eventually, GTPOS trained more than 2,000 teachers and reached more than 100,000 children.

In the early 1990s GTPOS joined with two other MacArthur grantees, ECOS from São Paulo and ABIA from Rio de Janeiro, and with the New York-based Sexuality Information and Education Council of the U.S. (SIECUS),

to produce Brazilian material on how to conduct this teaching. The resulting publication, *Sexuality Education Guidelines and Methodology—from Preschool to High School*, has sold 20,000 copies and is now in its 10th edition.

From 1994, GTPOS included STD/AIDS prevention in its work, training health care professionals, community leaders, and adolescent peer leaders. With funding from the Brazilian private sector, the Ministry of Health, MacArthur, and other foundations, GTPOS trained more than 5,600 adults and 150 adolescent peer leaders on AIDS and STD issues.

With the dramatic impact of AIDS, the Ministry of Education urgently needed to adapt its national curriculum. They asked two members of GTPOS to draft a program of sexuality education. GTPOS did so, including support materials not only for students but for teachers, in response to questions they had raised about teaching these topics.

GTPOS began to work with teachers in the school system on a method of teaching about sexuality that emphasized responsibility and autonomy, from a perspective of gender equality.

In 1979 the Ministry of Health widely circulated *Adolescence and Vulnerability*, a picture album produced by GTPOS to illustrate the vulnerability of young people to AIDS and other sexually transmitted infections. In 2002 the organization added to its set of innovative resources a game about pregnancy during adolescence, called *Antes-Durante-Depois* (Before-During-After). GTPOS is now working with other organizations to promote emergency contraception, and has become a regional reference center on this issue.

GTPOS has had a huge impact on Brazilian efforts to provide young people with skills and knowledge to avoid unwanted pregnancies and sexually transmitted diseases. Its ideas have become part of the accepted approach in some areas. Indeed, Marta Suplicy, elected Mayor of São Paulo in 2000, is honorary president of GTPOS.

One of the final grants given by MacArthur has been to encourage GTPOS, ECOS, and the Centro de Referência Integral de Adolescentes (CRIA) to work more closely. They will set common long-term goals to advocate sexual and reproductive rights for adolescents and young people and to evaluate their collective impact.

Ipas

Providing better care for women after unsafe abortions

In Brazil many women die each year from complications following unsafe abortions. Women suffering from incomplete abortion who seek help in public sector hospitals generally receive poor treatment. Adolescent girls, poor women, and those who live in rural areas are at a special disadvantage.

Abortions are legal in Brazil only when pregnancy is the result of rape or where the mother's life is at risk. Legal abortions are available in just 73 hospitals in a country of 160 million people, and there are somewhere between 700,000 and one million illegal abortions each year. It's not surprising, then, that illegal abortion is one of the leading causes of maternal mortality and of devastating complications such as sterility, chronic pain, and disability.

Ipas, an NGO with headquarters in North Carolina, works globally to prevent unsafe abortions and to improve the treatment of complications. With support from MacArthur, Ipas initiated a program of post-abortion care training in Brazil, establishing training centers in ten priority states and expanding training within municipal, state, and university facilities. The programs include training in counseling, post-abortion family planning, quality evaluation, and meeting the special needs of adolescents.

A second MacArthur grant increased by 60 percent the number of places where abortions and post-abortion treatment could be offered, and helped providers gain access to manual vacuum aspiration instruments to simplify and improve post-abortion treatment. Ipas trained staff to use these techniques, which do not require anesthesia and allow women to leave the hospital after a few hours. Ipas demonstrated the need for, and the feasibility of, a nationwide network of high quality post-abortion services.

With increased public education, Ipas expects demand for services to continue to increase. Many women in the country are unaware of the circumstances in which abortions are legal, and don't know that hospitals can be required to provide these services where they are legal.

Many health care providers are frightened of the opposition to abortion from conservatives and some religious groups. By training doctors and nurses in safe abortion procedures, Ipas provides a critical service and removes the ignorance that can sometimes become an excuse for inaction.

Ipas has also helped create an advisory committee with representatives from health institutions, women's organizations, and relevant NGOs. Ipas is forging links among groups working in this area to ensure that resources are well used, that maximum effort is brought to bear on the problem of unsafe abortions, and that the women who most need services receive them.

Programa de Apoio ao Pai (PAPAI) Program in Support of the Father

Helping young men assume their rights and responsibilities

There are few organizations in Brazil that deal exclusively with the needs of young men for sexual and health education. Programa de Apoio ao Pai (PAPAI) tackles this in northeastern Brazil, where the spirit of *machismo* strongly affects young men's self-image.

PAPAI works with adolescents and young adults in the working-class areas of Recife and in the neighboring city of Camaragibe. The organization addresses the needs of young men who have already become fathers, those who have been involved in sexual violence, and those who have experienced a problem affecting their sexuality or sexual health. It provides workshops for recruits and officers at the Army's northeast headquarters. And it is a sponsor of the Brazilian White Ribbon Campaign to end violence against women.

Programa de Apoio ao Pai means Program in Support of the Father, and the acronym PAPAI spells Dad in Portuguese. This is a young organization that has gained prominence quickly. Its founder, Jorge Lyra da Fonseca, carried out postgraduate research on men and masculinity and, after designing a project in support of teenage fathers, received a three-year award from the MacArthur Fund for Leadership Development in 1997. Lyra used the grant to help psychologists and other professionals working with adolescents become more aware of the importance of the adolescent father in the young family group.

Jorge Lyra says, "We try to promote gender equality among young people, helping them to become citizens with duties and rights in our society, particularly when sexuality and reproductive rights are concerned."

PAPAI recognizes the role that machismo plays in Brazilian society. It carries out research on men and masculinity, develops programs to support young men living in poverty, and promotes public policies to improve access to basic health care for young people.

Over three decades, contraception efforts in Brazil have been aimed almost exclusively at women. PAPAI turns the responsibility around and promotes it as a male duty. By providing practical support to young men who are attending antenatal clinics, it also promotes a positive role for young fathers. One result has been a higher acceptance among health and education professionals of the need to involve young men in caring for their own and their partners' sexual and reproductive health.

In Várzea, Recife, PAPAI works with adolescent boys and girls in school, holds separate weekly meetings with boys, and also conducts workshops for teachers.

In the neighboring city of Camaragibe PAPAI conducts workshops designed to sensitize young men to sexual health issues and to increase protection against sexually transmitted infections and AIDS. It conducts activities in places where young men gather, such as bars and sports halls, holds health fairs, and gives out condoms. PAPAI also conducts workshops at the 7th Military Command headquarters, encouraging recruits and officers to reflect on the roles of men in society and the place of health in their lives.

One result has been a higher acceptance among health and education professionals of the need to involve young men in caring for their own and their partners' sexual and reproductive health.

PAPAI works in partnership with a number of state bodies and other NGOs. It was awarded one of the nine exit grants given before MacArthur's withdrawal from Brazil in 2002. This grant will be used for institutional capacity building, particularly regarding its ability to attract alternative funding. One special project supported by the grant focuses on a single school, where PAPAI is holding workshops with a total of 1,600 students and 54 teachers. PAPAI will use this project to strengthen its curriculum and develop a model that can be replicated in other schools.

Rede Nacional Feminista de Saúde e Direitos Reprodutivos
National Feminist Network on Health and Reproductive Rights

Forging links across Brazil in the struggle for women's health and reproductive rights

It is now 12 years since 40 Brazilian organizations came together to form a National Feminist Reproductive Health and Rights Network. Rede Nacional Feminista de Saúde e Direitos Reprodutivos is dedicated to keeping alive throughout Brazil a permanent network of NGOs, research groups linked to universities, women's rights protection councils, feminist labor union committees, healthcare professionals, and female researchers working on women's health issues.

The Network was founded at Itapecerica da Serra in 1991, during a landmark National Feminist Seminar on Health and Reproductive Rights; the seminar was sponsored by SOS-Corpo with Coletivo Feminista Sexualidade e Saúde. The Network has grown rapidly since those early days. Though its presence is primarily in Brazil's larger cities, it now has 205 affiliates in 22 Brazilian states and 9 regional offices. The Executive Secretariat recently moved from São Paulo to Belo Horizonte.

For more than a decade the Network has scrutinized public policy-making and the work of legislative bodies, sponsored research on reproductive and contraceptive technologies.

The principle aims of Rede Feminista de Saúde are to:

- strengthen the work of the women's movement on women's health and sexual and reproductive rights, at the local, regional, national, and international levels;
- gain recognition that sexual and reproductive rights are human rights;
- gain recognition that sexual, racial, and domestic violence violate human rights;
- advocate for a comprehensive system of women's healthcare to be included in the Unified Health System (SUS);
- advocate for the decriminalization of abortion and for a woman's right to choose.

The struggle to decriminalize abortion and to give women the right to make decisions about their own bodies is not a trivial one; it faces deep prejudice and opposition from influential sectors of Brazilian society, including the Catholic Church. The Network has played a fundamental role in this struggle, advocating for change and seeking to open minds.

For more than a decade the Network has scrutinized public policy-making and the work of legislative bodies, sponsored research on reproductive and contraceptive technologies, and supported sexuality education and the prevention of sexually transmitted infections and AIDS. With the collective strength of its affiliate bodies, Rede Feminista de Saúde has been able to develop political momentum, to encourage and promote education and training, and to share information and guidance about women's healthcare services and the struggle against gender violence.

The Network has grown with the support of the MacArthur Foundation, which in 2000 gave the organization $150,000 over three years to foster responsible reproductive choices from a human rights perspective.

The Network publishes a newsletter, *Jornal da Rede*, and distributed leaflets on dates of special significance to the feminist movement because of regional or international agreements to dedicate those times to specific themes: on May 28 they addressed maternal mortality, on September 28 the right to decide about abortion, on November 25 combating violence and abuse against women, and on December 1 prevention of AIDS and other sexually transmitted infections. This material has been widely distributed and exceptionally well received all over Brazil.

Recently, the Network also began to publish special issues of *Jornal da Rede* on specific themes, as well as special information packets for print and electronic media professionals, who are desperate to get information on topics such a gender violence and health, women and HIV-AIDS, and racial inequalities in health. The publications are widely used as sources for research, and have gained visibility for the Network and its issues.

The Network also distributes two biweekly bulletins, *Rede FAX* and *Saúde Reprodutiva na Imprensa*, 2,200 by e-mail and 325 by regular mail. *Rede FAX* contains information about events, publications and activities. *Saúde Reprodutiva na Imprensa* summarizes for readers relevant stories from five mainstream newspapers (*Folha de S. Paulo, O Estado de São Paulo, Jornal do Brasil, O Globo and O Correio Braziliense*) and three national weekly magazines (*Isto É, Época and Veja*).

The Network has recently produced a CD with segments on maternal mortality, the right to decide about abortion, the fight against violence and abuse against women, and prevention of AIDS and other sexually transmitted infections. These pieces can be used in local and community radio broadcasts.

Rede Feminista de Saúde has a seat on various health councils, committees, and commissions at the municipal, state, and national levels. Since 2002, the Network has been working with UNFPA to develop a nationwide program to improve the advocacy skills of women who participate in health councils at local and state levels.

The Network was on the Steering Committee for the National Conference of Brazilian Women, held in June 2002. The Association of Brazilian Non-Governmental Organizations (ABONG) has invited Rede Feminista de Saúde to participate in a larger group of national networks encompassing a number of different issues.

SOS-Corpo—Gênero e Cidadania
SOS-Body—Gender and Citizenship

SOS provides leadership and support in the community

SOS-Corpo—Gênero e Cidadania (SOS-Body—Gender and Citizenship) is one of the oldest women's organizations in Brazil, committed to building democracy and eliminating social inequalities. SOS seeks to transform gender relations and eliminate poverty, and works with other organizations to strengthen sustainable human development. A long-term MacArthur grantee with an excellent performance record, SOS has influenced governmental and non-governmental organizations in the health field.

SOS was founded in the northeastern city of Recife in 1979; it works in the state of Pernambuco and across the Northeast region. The organization develops and implements education, research, and other interventions in the areas of women's rights, health, gender, and development. SOS has become a national reference center for gender, sexual, and reproductive rights.

One priority area is advocacy that contributes to the development of public policy and helps ensure that policy is put into practice. SOS holds governmental agencies accountable if they fail to implement policies, and it works with local organizations to establish criteria so that local people can see whether services comply with legal provisions.

SOS also works with local communities in poor areas. The organization has trained 120 community leaders in women's rights. It holds public events on themes such as gender and development, women's rights and globalization, sexual and domestic violence, women-headed households, feminism and the Catholic church, poverty, men and feminism, and social inequalities.

It also works to strengthen other organizations, evaluates women's health services, and carries out research on sexual and reproductive rights.

SOS has been selected as one of nine Brazilian organizations to receive a large "tie-off" grant from MacArthur. The organization will use its final grant to expand its activities in the community to train young leaders and community leaders.

The grant will also be used to improve organizational abilities, so that SOS can sustain itself in the long term. Staff skills will be strengthened to run programs and oversee the financial and administrative aspects of managing an autonomous organization. The money will also provide modern computer equipment and training so that staff can launch and maintain their own Web site. And SOS will develop a social marketing plan for its services and materials.

Themis—Assessoria Jurídica e Estudos de Gênero
Themis—Legal Consulting and Gender Studies

Themis seeks human rights focus for sexual and reproductive rights

Themis is best known for training women to become volunteer advocates for human rights in their own communities. The organization has provided training in law and human rights to almost 1,000 women from urban communities, helping them become Popular Women's Rights Advocates (PWRAs). Of these, 300 have been trained in the organization's home state of Rio Grand do Sul, while other trainees have been part of a program sponsored by the National Human Rights Program.

Once trained, many of the women work in the Women's Information Service in their communities, offering information and support to women whose rights have been violated. The PWRAs work with women who have suffered domestic violence, sexual violence, or discrimination, helping them access appropriate state services—health or police—or the Feminist Legal Advisory Program run by Themis.

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MacArthur has supported efforts by Themis to place sexual and reproductive rights in a broader context of human rights, as outlined by the International Conference on Population and Development (ICPD) in Cairo in 1994, the World Conference on Women in Beijing in 1995, and subsequent landmark events.

However, Themis believes that women still regard sexual and reproductive rights as less secure than their other rights. Campaigns against domestic violence, for example, saw an increase in the number of women seeking help from emergency services and an increase in the number of legal cases. But there has been no such increase in the response to sexual violence. The human rights approach has been held back by lack of self-confidence at the local level and lack of knowledge on the part of professionals.

Themis found that women's organizations at the local level generally do not use the legal system to address sexual violence, because this is not seen as a breach of rights in the same way as other offences. While white, middle-class woman might assert "my body belongs to me," many working-class and black women do not view sexual wrongs, or a failure to provide reproductive health services, as human rights breaches. Further, research by Themis revealed that health professionals do not know what to do in cases of sexual violence—even where there is a risk of potentially fatal attacks, or of sexually transmitted infections, including AIDS.

Themis concluded that the different abilities of women to uphold their reproductive and sexual rights could lead to inequalities among different groups of women even greater than the inequalities between men and women. It concluded that the College of Law must do more work to sensitize the new generation of lawyers to women's reproductive and sexual rights.

In its PWRA training courses, Themis is putting more emphasis on sexuality and sexual rights. Women taking this training are required to visit their local public health facilities to identify the need for services. There is also a greater emphasis within the Women's Information Service to listen to women and identify cases where rights have been abused. It will take time for changes to show, but there does seem to be a greater willingness on the part of newly trained PWRAs to address issues that undermine sexual and reproductive rights, such as sterilization without proper consent, or lack of health services for adolescents. Themis also intends to encourage legal advisors from the Feminist Legal Advisory Program to work more closely with the PWRAs on local problems in health, sexuality, and reproduction.

Work with PWRAs has identified strategies to make them more effective, such as forming partnerships with local health services and using local community radio stations to reach more women.

In the longer term Themis will seek judicial rulings on sexual and reproductive rights and work at an international level to secure an American Convention on Sexual and Reproductive Rights.

Transas do Corpo
Body Matters

Reaching out to young people across cultural barriers

More than one-sixth of all young women in Brazil are pregnant or have had a child by the age of 19. Half the pregnancies in women under the age of 25 are unplanned, and although knowledge of contraceptives is improving, some surveys indicate that today a significant percentage of sexually active young people in Brazil do not regularly use contraception.

The central Brazilian state of Goiás is especially hard-hit. Rates of sexual violence and sexual abuse here are the highest in Brazil, and maternal mortality is twice the rate deemed "acceptable" by WHO. Adolescents are often left unprotected from sexually transmitted infections and unwanted pregnancies.

Transas do Corpo has emerged as the leading group in Goiás responding to the needs of young people in the areas of reproductive health, sexuality, and reproductive rights. Focusing on education and training, Transas do Corpo has become an important resource for sex education; its training helps health and education workers increase access to vital services. The group has an excellent track record in helping to overcome barriers to reproductive health services for young people. And it works at the state, regional, and national levels to ensure that commitments to reproductive health made at Beijing and Cairo are fulfilled. (The Cairo Plan of Action, for example, emphasized the need to overcome cultural barriers that impede young people's access to contraceptives and safe sex services.)

Transas do Corpo was founded in 1987 by four young professional women with backgrounds in public health, education, psychology, and nutrition. They believed that changes for women in society would be closely linked to gender issues, especially sexuality and reproductive rights. Their goal was to shed light on the areas of women's health and women's rights.

In the 1990s Transas do Corpo emerged with a new agenda: to promote equality between women and men by working for a plural and democratic society with solidarity and social justice. The organization showed its strength as a mobilizing force in 1991, when it successfully organized the eleventh National Feminist Meeting in Brazil.

In the 1990s, as AIDS began to affect a growing number of women, Transas also began to work on this issue. Transas now works with the Goiás Health Secretariat to train teachers and community leaders to respond to adolescent health needs. It also works directly with young people through a satellite organization, Transas Adolescentes.

In this context, one of the group's themes has been to encourage a wider range of contraceptive choices and options for women.

Transas do Corpo characterizes Brazil as a conservative society, where discussions about decriminalizing abortion, transforming what girls and boys are taught about sex and gender in schools, and sexual and reproductive rights in general have not yet been transformed into effective policies. In this context, one of the group's themes has been to encourage a wider range of contraceptive choices and options for women.

The MacArthur Foundation first supported Transas do Corpo indirectly, when it selected one of its leaders, Eliane Gonçalves, for a Fund for Leadership Development grant in 1992. MacArthur has supported Transas do Corpo directly since 1996, with grants totaling $330,000 over five years and an exit grant of $210,000 over three years. This final grant will strengthen the group's management, financial planning, and institutional strength, including sharpening its communication and social marketing strategy.

Transas do Corpo will also use the final grant to:

- strengthen its Center for Information and Studies, working with schools in the city of Goiânia to educate adolescents on health, sexuality, citizenship, and ethics;
- train health professionals in the care of women, children, and adolescents living with violence, focusing on prevention, gender roles, and changing attitudes;
- support another NGO, Malunga, to work with young black women in the central region on health, sexuality, gender and race.

A new route to grantmaking in Brazil

MacArthur's withdrawal from a physical presence in Brazil is recognizing that the country has the political will and economic capacity to tackle its problems without such a high level of external support.

At the same time, MacArthur wanted to stimulate the indigenous philanthropic movement in Brazil and to broaden its areas of interest. Local foundations generally prefer to support less controversial issues. They have a track record in funding programs for street children, cancer treatment, education, and people with disabilities, but so far they have done little to support sexual and reproductive health and rights.

MacArthur left the country with a final grant of US$2 million to seed a continuing source of grants, plus US$300,000 for administrative costs. The grants will be administered by CEBRAP and guided by the Commission for Citizenship and Reproduction (CCR), a body made up of leading Brazilian experts in the fields of demography, reproductive health and rights, sexuality, gender equity, gender violence, and AIDS prevention.

The $2 million grant will launch a fund that will continue for at least five years and that is committed to raising at least another $500,000 from within the country over this period. Other international donors may also contribute to the fund.

CCR has established three priorities for funding: public education, research, and training. CCR plans to maintain a dual focus on maternal mortality and morbidity, and on the sexual and reproductive health of young people. Gender, race, and ethnicity will be considered as cross-cutting dimensions of the program. Grants will be regionally balanced, and will typically range from $20,000 to $60,000.

Examples of projects that will be considered for funding are those that support training for health professionals, education for media professionals, research to improve needs assessment, public health campaigns in reproductive health, and special projects to help grantees learn from each other and work together more closely.

The fund has set up strict rules for transparency and financial accountability. Members of the steering committee will not participate in judging grants to organizations with which they have any connection.

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The Foundation makes grants through four programs. The Program on Human and Community Development supports organizations focused upon issues primarily affecting the United States, including community development, regional policy, housing, public education, juvenile justice, and mental health policy. The Program on Global Security and Sustainability supports organizations focused upon issues primarily related to international issues, including peace and security, conservation and sustainable development, population and reproductive health, human rights, the economic consequences of globalization, and initiatives in Russia and Nigeria, particularly concerning improving higher education. The General Program supports public interest media, including public radio and television, and the production of independent documentary films; it also makes occasional large institutional grants. The MacArthur Fellows Program awards five-year, unrestricted fellowships to individuals across all ages and fields who show exceptional merit and the promise of continued creative work.

John D. MacArthur (1897-1978) developed and owned Bankers Life and Casualty Company and other businesses, as well as considerable property in Florida and New York. His wife Catherine (1909-1981) held positions in many of these companies and served as a director of the Foundation.

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