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What is hindering progress? The Marginalization of Women's Sexual and Reproductive Health and Rights in Brazil and Chile

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INTRODUCTION

Current debates have emphasized the need for universal access to health (Vega, 2013), particularly access to sexual and reproductive health and rights (SRHR) (Sen and Govender, 2015; UN, 2013; UN Women, 2013). Advocates have long called for universal health care access to address questions of inequality within health systems – as exemplified in the 1994 International Conference on Population and Development (ICPD). Yet to date, limited progress has been made towards meeting this objective and many women across the world are still systematically denied access to these services.

This has particularly been the case for women in Latin America (ECLAC/UNFPA, 2010) where it is argued that reproductive health systems are among the largest contributors to gender inequality in the world (UNDP, 2010). Moreover, gender differences in access to and use of services are not sufficiently factored into debates around universalism (WHO, 2010). Yet universal access goes beyond mere coverage of services. Structural inequalities by gender - as well as class, race, and ethnicity - can reinforce barriers to access and must be accounted for in any discussion of universalism (Ravindran, 2012). In Latin America, despite shifts towards universalism, inequalities of access continue, with wealthier groups continuing to benefit more from expanded services (Frenz and Vega, 2010; Lloyd-Sherlock, 2009) and access differentiated by gender and race (Diniz et al., 2012; ECLAC/UNFPA, 2010; Ewig, 2010). The need to overcome inequalities thus remains a significant constraint to more equitable access to health care services.

Taking this as a point of departure the paper will draw on the cases of Brazil and Chile to consider the lack of progress towards securing better health indicators for women, particularly in the field of SRHR. The paper draws on the definition of SRHR offered by the ICPD Programme of Action which includes family planning; antenatal and post-natal care; prevention of abortion and management of the consequences of abortion; information, education and counselling as appropriate, on human sexuality and reproductive health and prevention and surveillance of violence against women, (UNFPA, 2008). At the same time we acknowledge the importance of medicalised definitions of health and the importance of allowing women to defining their health for themselves (Inhorn, 2006; Gideon, 2014).

At first glance the poor health indicators for women are surprising given that both Brazil and Chile represent middle income countries where significant progress has been made towards ensuring universal access to health care services. Moreover both governments have approved extensive legislation advancing gender equality and indeed both countries are currently governed by female Presidents who have arguably promoted feminist agendas. Yet despite apparent progress across the region in ‘pro-gender’ policies, particularly in the area of social policy, only limited changes have resulted on the ground (Gideon and Molyneux, 2012). The lack of progress is for example, shown in the high level of teenage pregnancy across the region, which only dropped by around 10 percent during the 1990s and has since remained static; at the same time the overall drop in fertility rates has also remained static. Sex education across the region remains limited (CEPAL, 2013), and this is reflected in the growth of unwanted teenage pregnancies while the use of contraceptives - although rising amongst teenagers - remains low overall and has failed to address the high and growing levels of unwanted fertility (Rodríguez, 2011). Regional maternal mortality rates are lower than the global average, but recent data suggest that some countries have not achieved a reduction of 50 percent in MMR by 2015 as prescribed in the ICPD Programme of Action.

The analysis is informed by a growing body of scholarly attention which seeks to understand this apparent gap between rhetoric and reality and comprehend the diverse ways in which ‘women’s

issues' are marginalized or kept off the political agenda. Work from political scientists such as Franceschet (2010) and Waylen (2014) has sought to uncover the gendered nature of the formal and informal institutional constraints that shape the ways in which gender issues are taken up and promoted by governments and seek to explain the lack of political will to push for more transformative change. The work of Connell also points to the need to uncover institutional gender regimes - that is the structure of gender relations in a given institution (Connell, 2012: 1677). As she notes gendered norms underpin not only the design of health policy itself but also shape the gender regimes found in the range of institutions responsible for health care delivery (Connell, 2012). At the same time work from within the health sector has focused on addressing 'the policy gap' in order to understand why even when policies are put into place they do not necessarily transform into better health indicators. Freedman and Schaaf (2013) advocate the need for a more nuanced analysis of policy implementation and suggest that distinguishing between degrees of implementation is helpful for identifying what is really happening. Together these different bodies of work offer useful insights for understanding the ways in which women's health concerns can be marginalized yet few studies have considered both policy making and policy implementation at the same time, particularly from a gender perspective. Drawing on empirical examples from Brazil and Chile this paper therefore offers some important insights into explaining the on-going marginalization of women's health both in relation to health policies and health indicators. The analysis will specifically focus on the constraints to securing better outcomes for women posed by the policy legacies and gender regimes in three arenas – the development of the health system itself, the Church and finally the medical profession. The paper argues that it is the deeply embedded gendered nature of the policy legacies and the male biased gender regimes within these institutions that continues to limit progress towards securing better outcomes for women, particularly in the field of SRHR. Until this occurs efforts to promote and extend universal access to health care will remain limited.

THE CASE OF BRAZIL AND CHILE

Filgueira (2011) seeks to classify Latin American welfare states into distinct grouping according to levels of development. He distinguishes countries by levels of inequality, the co-existence of demographic transition in child and old-age dependency and finally the level of urbanization (2011: 23-24). According to this classification Chile is placed in the group of countries experiencing high levels of development while Brazil is categorized as having a medium level of development, despite significant progress in addressing the high levels of inequality over the past two decades (Barrientos, 2013).

Both countries present notable parallels in the evolution of the system of social protection. Indeed Mesa Lago (2008: 3) argues that both countries represent ‘pioneer high’ countries where a system of social insurance began in the 1920s–1930s and coverage and level of development of the system remains high. Yet in contrast to European systems, Latin American social insurance funds were directed to specific population strata, grouped by social class, income, occupation, formal employment, ethnic origin, and urban or rural status. As a consequence, health systems across the region were highly stratified and segmented.

Today both countries have well-developed public and private sectors and have made considerable progress towards universal health care coverage (Couttolenc and Dmytraczenko, 2013; Bitrán, 2013). The majority of the populations are covered by the public system – around 75 percent in Brazil (PAHO, 2012: 78) and around 70 percent in Chile (Bitrán, 2013). Yet observers have argued that Latin America has undergone a period of rapid modernization, exacerbating inequalities within and between countries (Blofield, 2011). This rapid change has produced a new set of challenges—associated with more developed countries—but without having solved the existing problems more typical of poorer societies. Within the health sector these challenges are manifest where demographic and epidemiological transitions alongside weak health institutions have produced major challenges (Londoño and Frenk, 2000). Moreover, neoliberal health reforms have failed to address the stark health inequalities that exist within the region (c.f. Cavagnero, 2008; Iriart and Waitzkin 2006; Laurell 2007). While recent social policy initiatives such as Brazil’s *Bolsa Familia* have undeniably contributed to the massive fall in poverty across the region - between 1999 and 2011 poverty in the region fell by 149 percent (CEPAL, 2012: 19) – the impact on gender inequalities remains unclear (Molyneux, 2007;

Gideon, 2014). As the data in Table One illustrates there are still a number of significant gaps in women's SRH health outcomes that need addressing.

Insert table 1 here:

Table 1: Some key indicators of women's SRHR

Concerns have been expressed over the lack of progress in a number of areas of women's SRHR, most notably the failure to address the underlying causes of maternal deaths in Brazil and the lack of progress on securing safe abortions for women in both countries (CEDAW, 2012a and b). In Chile the high number of teenage pregnancies and high rates of school dropout and expulsions of teenage mothers are also notable (CEDAW, 2012a and b).

Despite the relative stability of Brazil's maternal mortality rate, significant inequalities exist, with maternal deaths occurring most frequently among poor black women (Ferraz and Bordignon, 2012). Some of the most significant factors contributing to maternal mortality are the high frequency of caesarean sections, illegal abortions, regional and socio-economic inequalities in health (Victora et al., 2011). In Chile lack of access to women's SRH services, notably to family planning services, abortion and emergency contraception is a major concern. Only twenty per cent of women of reproductive age who receive attention in public health care centres have access to contraceptive methods (Brito Peña et al., 2012: 8). This creates a highly contradictory situation in a middle-income country where, on the one hand, people have access to highly developed infrastructure and a wide choice of consumer goods but on the other, they experience a significant deficit in terms of personal rights more akin to a low-income country (Casas and Dides, 2007: 205). The Chilean Institute of Reproductive Medicine estimate that between 60,000 - 70,000 abortions are carried out each year in Chile, but given the clandestine nature of these there are no confirmed figures. Moreover around 33,000 women end up in hospital with complications resulting from abortions. Practices around abortion also are shaped by class, where economic resources guarantees access to safer abortion with Misoprostol and in private clinics (Casas et al., 2013).

Illegal abortions are also significant in Brazil and efforts to push forward reforms are frequently resisted by conservative groups (Kulcycki, 2014). In contrast to Chile where abortion is not permitted under any circumstances, Brazilian women are permitted to have abortions in the case of rape or if a woman's life is at risk (Galli and Rocha, 2014). In 2012 the Brazilian Supreme Court also made abortion legal in the case of fetal anencephaly¹ (Brasil, 2012), but legal abortion services remain hard to access for the majority of women (Diniz et al., 2014; Kulcycki, 2014).

In Chile, despite recent legislative changes, lack of access to emergency contraception remains a problem. Distribution is governed by the municipality and many are failing to meet the demand (Dides et al. 2011; Franceschet, 2010). In 2011, around eleven per cent of municipalities failed to provide the emergency contraceptive pill, and only around nine per cent provided it to anyone requesting it (Dides et al., 2011). The lack of access to emergency contraception has been linked to the growth of teenage pregnancies (Casas, 2008; Schiappacasse and Díaz, 2012.). Despite legislation, eighty per cent of all teenage mothers drop out of school and in 2010 the Education Ministry received sixty five complaints for failing to respect the right of pregnant students to education (Instituto Nacional de Derechos Humanos, 2012). Moreover, forty eight per cent of teenage mothers live below the poverty line, with many coming from the poorest rural communities (CEDAW, 2012b; Instituto Nacional de Derechos Humanos, 2012).

WHAT IS HINDERING PROGRESS?

The marginalization of women's SRHR is not unique to Latin America and the causes of this have been the subject of considerable international debate (Fonn and Ravindran, 2014; Santhya and Jejeebhoy, 2014; Sen and Govender, 2015; UNFPA, 2010). Building on this literature we seek to identify three significant constraints which are particularly pertinent in the Latin American case but offer important insights for this wider discussion.

Policy legacies and the development of health systems

¹ Anencephaly is the absence of a major portion of the brain, skull, and scalp that occurs during embryonic development.

Despite the importance of power relations in policy processes these are frequently overlooked in most policy analysis, particularly in the context of low and middle income countries (Erasmus and Gilson, 2008). Health policies continued to be couched primarily in technical terms with emphasis placed on measuring and evaluating impacts and outcomes, generally ignoring the policymaking process itself (Bernier and Clavier, 2011). Within the broader social policy literature commentators have suggested that analyzing the institutional arrangements contributing to the sum total of societal welfare is a useful means of demonstrating that power relations are a central element of policy making and that social policy not only shapes but is shaped by these power relations (Abu Sharkh and Gough, 2010). One approach that has generated considerable interest is the application of Esping-Andersen's idea of welfare regimes to the case of Latin America (c.f. Barrientos, 2009; Martínez Franzoni, 2008; Pribble, 2013). In particular the work of Ewig and Kay (2011) has analyzed the process of institutional change that accompanied the most recent period of health reform in Chile from the early 2000s onwards. Their analysis highlights the economic and political strength of relevant policy actors, notably the private health insurance companies, and how in practice this meant that they were able to block more substantive change and maintain the current market-oriented system.

In order to identify the 'relevant' actors and understand the power structures inherent in health sector institutions it is helpful to take a historical view. A number of scholars have sought to understand how social policy shifts have occurred in the Latin American context. Several accounts have drawn on the idea of policy legacies (c.f. Ewig and Kay, 2011; Huber and Stephens, 2001; Pribble, 2013) to understand processes of institutional change and the evolution of welfare systems. The policy legacies approach draws on the work of Paul Pierson (1994) who has shown how the establishment of welfare states in the Global North created vested interests and "armies of beneficiaries" that protected it from attack. These historical interests and policies shape the politics—including the behaviour of bureaucrats and interest groups—that feedback into contemporary reform processes. These analyses have provided valuable insights into policy-making processes in Latin America and shed important light on how policy shifts have occurred over the past few decades. Yet only a few studies have paid much attention to the gendered dynamics of these processes (Ewig, 2010; Ewig and Palmucci, 2012). As Ewig

(2010: 8) argues, “policy legacies feedback in ways that serves to entrench a particular gender, class and race order.”

It is therefore possible to identify which actors have maintained a vested role in the health sector and who seek to shape reform processes in order to protect their interests. At the same time it is essential that we understand the nature of health sector institutions themselves and the ways in which actors access power structures to promote their specific interests (Shiffman and Smith, 2007). However, in order to understand the gendered dimensions of these processes we need to uncover the gendered nature of institutions themselves – this may include their organizational structures, legal framework which may promote or hinder social change, institutional norms and policy networks. Critics have argued that gender regimes – that is the structure of gender relations in a given institution (Connell, 2012: 1677) – within health sector institutions constitute women’s roles as secondary and show preference to men (Gideon, 2014). These gendered norms underpin not only the design of health policy itself but also shape the gender regimes found in the range of institutions responsible for health care delivery, such as hospitals, clinics and private practices (Connell, 2012).

Analysis of the historical development of Latin American health systems reveals their gendered nature and shows how the construction of women’s role as secondary to men has led to a subsequent failure to prioritize their health needs (Roseblatt, 2000). Critics have pointed to the subsequent gendered policy legacies that are deeply embedded within Latin American welfare institutes and continue to reinforce the primacy of women’s maternal role (Ewig, 2010; Gideon, 2014; Molyneux, 2007). The maternalistic focus can be seen, for example, in the policies of the Chilean dictatorship (1973-1989) where maternal health services gained priority over family planning services, representing a significant contrast to earlier periods (Pieper Mooney 2009). In Chile the regime managed to improve indicators on maternal and child mortality, despite a regression in family planning (McGuire 2010, Raczynski 1994), a legacy that is still seen today in Chile’s comparatively better indicators in this area.

It is therefore perhaps unsurprising that the deeply entrenched gender inequalities within the system have not been sufficiently addressed in present day health systems and this remains an on-going

challenge (Gideon and Alvarez, forthcoming 2015). While more women are now moving into the legislative, this has not necessarily led to an increase in women's power - where power means female legislators' ability to transform policy outcomes (Haas 2010). Similarly 'women's issues' such as reproductive rights tend to be promoted by women rather than men (Schwindt-Bayer, 2006). Given women's marginalization within central decision-making arenas in much of the Latin American legislature including Chile and Brazil (Franceschet, 2010; Haas, 2010) this raises significant questions over the likelihood of such issues being taken up as of serious political concern.

This can be seen in Chile where women's groups sought to influence the reform debate surrounding the Plan AUGE, a central element of the health reform package introduced in the early 2000s. The Plan aims to ensure universal access to treatment for a specific number of health conditions (currently 80) but feminists' attempts to influence the design of the AUGE as well as the choice of conditions included to ensure women's health needs were met went unheeded (Gideon, 2014). Analysis has shown that that out of the fifty-six health conditions included in the AUGE between 2005 and 2007, only around one third specifically addressed questions of gender inequality (Vargas and Poblete, 2008). Moreover, attempts to introduce a more redistributive element to the health system which would have had important implications for public sector users, where the majority of poor women are located, were blocked by the private insurance companies (Ewig and Kay, 2010). This clearly illustrates how particular class and gender interests can be maintained through reform processes.

Similarly in Brazil in the mid 1980s, following a protracted transition to democracy (1979-1985) (Alvarez, 1990), a space had been created that permitted the growth of anti-regime activities and the rise of social movements while at the same time fissures in party politics allowed feminists to access the Brazilian Democratic Movement Party structure. This offered an important opening for feminist groups to influence the national family-planning programme (Macaulay, 2010). In 1983 the Ministry of Health introduced a new reproductive health programme - the Women's Integral Health Programme (PAISM - Programa Assistência Integral a Saúde da Mulher) (Vianna and Lacerda, 2004). Although this was a 'vertical' (i.e. stand alone) programme which continued the policy legacy of treating women's reproductive health as an 'add on', the PAISM was seen to encapsulate much of the work of Brazilian

feminists who had introduced the term ‘women’s integral health’ - a concept acknowledging the biological and social dimensions of women’s health - as part of a wider struggle to expand women’s citizenship rights (Corrêa et al., 2006). During the two successive left wing governments of President Lula (2003-2011) the presence of a number of feminists in the state bureaucracy enabled the introduction of a number of new national policies that promoted sexual and reproductive rights. Yet while these policies were seen as important for advancing some aspects of women’s SRHR – for example addressing the ‘feminization’ of HIV/AIDS, the gains were limited because issues such as forced sterilization, abortion and men’s participation in reproductive health were all ignored (Victora et al., 2010). The impact of the PAISM, particularly in relation to its ability to produce transformative change remains subject to debate (Costa, 2009; Corrêa et al., 2006). As discussed below, the PAISM has been further compromised under the current Rousseff administration due to the influence of religious groups on policy making.

The role of the Catholic Church and other conservative vested interest groups

Using a policy legacy approach also highlights the influential role of the Catholic Church in health policy making, particularly in the field of women’s SRHR. Yet it is not only at the stage of policy making that these actors shape policy, they exert considerable influence – at least in the case of Brazil and Chile – over outcomes.

A growing body of work has highlighted the influence of religion, particularly the Catholic Church in the drafting and implementation of policies on sexual and reproductive health (Blofield, 2001; Vaggione and Morán Faúndes 2012). Craske and Molyneux (2002) argue that this influence in Latin American conservative societies has historically been translated into efforts to control women’s bodies, hindering progress on reproductive rights. Even during the early 20th century, the regulation of women’s bodies and sexuality was part of the process of state making of many Latin American nations. Although early liberal states made some concessions to the drive to modernity, they still protected masculine authority and privilege, explicitly regulating the new emerging class of working women and

as well as women that demanded - and enjoyed - more freedom than previous generations (Craske and Molyneux 2002).

Globally the Catholic Church has adopted a more conservative stand and has entered the areas of policy and political influence (Casanova 1994). Scholars have recognized that the papacy of Karol Wojtyla (1978 - 2005) implied a conservative shift within the church (Fleet and Smith 1997) and this had important effects within the hierarchy of Latin American countries. Moreover, the rank and file support for the moral teachings of the church on issues of sexuality, gender equality and family relations have been decreasing, especially since the Encyclical *Humanae Vitae*'s restrictive vision of contraception, reproduction and sexuality (Keely 1994), and Wojtyla's *Evangelium Vitae*'s conservative position on abortion. These official documents show how the Church has been increasingly involved in regulating sexuality, reproduction, family structures and gender roles according to principles posed as natural and of divine inspiration (Casanova 2009). This has clearly reinforced the deeply embedded gender regime within the Church.

According to Hagopian (2008), since the democratisation process of the 1980s and 1990s, the Catholic Church in Latin America has strategically chosen to place emphasis either on the agenda of social justice drawn from the Second Vatican Council of the early 1960s or on the new agenda emphasizing moral concerns around reproduction, sexuality and family life in an effort to influence the public sphere. In Chile, despite having one of the lowest popular adhesions to the church in the region, it has successfully maintained a conservative agenda on issues of reproductive rights, precisely because the decreasing attachment of Catholics to the church's hierarchy has left it with the freedom to generate alliances with conservative business and right wing elites that are quite empathetic to the church's moral teachings. In Brazil the opposite is true and it has focused on pushing the social justice agenda. With its moderate pluralism, the church has been stronger in pushing for a social justice agenda and less adamant in condemning efforts to move policies to strengthen sexual and reproductive rights (Hagopian 2008).

Furthermore, historically in Chile, Catholic ideas of women's sexual and reproductive rights were embedded into policies and legislation of the military regime (1973 -1990), despite the role that the Church also played in confronting the regime's human rights violation. Moreover, the regime used a rhetoric that constrained women to their maternal roles, while highlighting Christian values, women's role in keeping the traditional family in place and their need to sacrifice their lives for "the good of the nation", as per the 1979's National Development Plan which incorporated ideas of nationhood that rested on essentialist ideas of women's roles as mothers. The influence of Catholicism is also present in the 1980 constitution, most notably one of the commissioners responsible for its drafting and a devout Catholic, Jaime Guzmán (Cristi 2000). The constitution set the precedent to criminalize all forms on abortion, established in 1989. Since the return to democracy in 1990 a powerful and religious elite has been able to influence policy implementation on sexual education in schools, access to emergency contraception and abortion. Conservative elites have maintained a close hold over public discussion and economic elites have stepped in when the government has succeeded in introducing progressive reforms, such as in the case of Emergency Contraception. These elites belong to conservative groups within the Church, including Opus Dei, the Legionaries of Christ and the Schoenstatt Movement, and have successfully penetrated elite educational and health facilities, spiritual groups and community churches. Groups like Opus Dei are not only successful in their reach, but also in their hold over members' work and family life, transforming elite members into committed and active advocates with access to resources and power.

Although the presence of the ultra conservative wing of the Catholic Church is not as visible in Brazil it is possible to identify conservative alliances created to prevent SRHR advances. Converging interests from different Christian denominations ignited by the movement of Catholic Charismatic Renewal and led by the National Conference of Bishops of Brazil tried to overcome previous religious competition (for space and followers) in favour of a fight against 'immoral behaviour' (Luna, 2014). Nevertheless, there is a plurality of religious movements and not all are aligned with ultra conservative caucuses. In this sense, only the 'religious movements' within National Congress that found common interests became part of conservative caucuses such as the Evangelical Parliamentary Front,

Parliamentary Joint Front in Defence of Life, National Movement for Brazil without Abortion and Fraternity Campaign in Defence of Life (Galli and Rocha, 2014; Luna, 2014). These are mostly made up of conservative Catholics and Pentecostals. An example of the interference these religious caucuses on SRHR policies can be seen in the proposal for the opening of a Parliamentary Commission Inquiry n. 21 in 2013 (dating back to 2008) submitted by members of the Evangelical Parliamentary Front and Parliamentary Joint Front in Defence of Life to investigate international funding and proposals aimed at pushing for the decriminalisation of abortion in Brazil (Requerimento de Comissão Parlamentar de Inquérito 21/13) (Luna, 2014).

As Kulczycki, (2014: 63) argues, “governments lack the political will to act on far-reaching policy-changes for which societal consensus remains elusive”. Even when leftist governments are in place such as in Chile and Brazil, real progress in SRHR is unlikely as political leaders are either unwilling or unable to accept the potential political fallout resulting from the adoption of a comprehensive and effective SRHR policy. In this sense ‘leftist democratic governments may promote some women’s rights issues while at the same time creating limits to the societal transformation of their status’ (Kulczycki, 2014: 70).

The role of medical professionals: practices of power in reproductive health services

The policy legacies approach can also reveal how the medical profession has been able to maintain their power as a professional body during successive reform periods. Moreover it can uncover the inherent gendered nature of the profession which fails to prioritise women’s own definitions of their health and continues to essentialize women as reproducers. In Chile the development of the medical profession was closely aligned with 19th century ideals of hegemonic masculinity (Zaraté, 2001) and evidence of this policy legacy is still apparent across much of the Latin America medical profession which contains deeply embedded gendered and racialized norms (Witz, 1992). Present-day maternal health care services are often organized around medical professionals (i.e. doctors), rather than ‘semi-professional’ (i.e. nurses and midwives). This has important implications for decision-making processes around childbirth

where power tends to lie with medical professionals rather than the women themselves (Gamble et al., 2007). Moreover, in the context of privatization as notions of professionalisms in health are challenged this can result in medical professionals such as obstetricians becoming increasingly accountable to ‘the market’ rather than the state (Sandall et al., 2009). This is particularly evident around reproductive health care services and especially childbirth. In the Chilean case where the medical profession was one of the main beneficiaries of the public sector reforms of the 1980s, medics acquired the possibility of a ‘dual practice’, i.e. a stable public sector job coupled with private sector responsibilities and revenue. In an analysis of Chilean obstetricians, Murray and Elston (2005) found that dual practice was common but that obstetricians then meted out different treatment to patients depending on the patient’s social status and location.

Yet it is also necessary to understand how these policy legacies shape the opportunities for medical professionals to exert their power at the policy implementation stage. Research has sought to examine the interactions between front line health workers and citizens in order to understand how policies are implemented ‘on the ground’ and benefits and sanctions allocated to citizens (Erasmus, 2014: 71). A recent systematic review highlighted the micropractices of power exercised by front line providers as an important constraint in implementing health policies (Gilson et al, 2014). Health workers frequently use their own discretion to determine whether or not women are offered family planning services and moreover whether or not to restrict contraceptive choices offered to women (Gilson et al, 2014). Research in South Africa has shown how despite the introduction of new legislation permitting abortion in 1997 health staff at the local level were reluctant to comply with the new law (Harrison et al., 2000).

While it is important to recognize that discretionary power is not always used to undermine and subvert policy, there is a clear need to understand how power relations shape outcomes so that it is possible to move towards better ‘policy ownership’ by implementors (Lehmann and Gilson, 2013). In both Brazil and Chile health and medical staff seek to maintain power and control over women seeking health care services. Arguably the process of privatization of health care has also reinforced this relationship, giving medical staff in particular more scope for exerting authority. Empirical findings

from a number of studies point to the ways in which gendered and racialised policy legacies also shape these encounters between health and medical professionals on the one hand and women seeking health care on the other.

Research from Brazil has suggested that lack of regulation in the private sector has led to high rates of medicalization around maternal health and this has had a spill-over effect into the public sector, also pushing up demand for caesarean sections (Barros et al., 2005). Within Brazil the high levels of medicalization of maternal health and the excessively high rates of caesarean sections performed on women are an on-going concern (Béhague et al., 2002; Diniz, 2010; Victora et al., 2011). Indeed the issue of obstetric violence² has become a growing concern among those wishing to limit the number of unnecessary caesarean sections and those performed without obtaining voluntary, expressed, and informed consent from the woman. Yet despite near universal coverage of antenatal care, significant disparities exist in the provision of services, with poor women and black women most likely to experience poor quality care and discrimination (Victora et al., 2010; Béhague et al., 2002). Ethnographic research in North East Brazil found that on the one hand public health workers treated low income women as citizens entitled to rights and ‘self-fulfillment’ but at the same time considered them as irrational and irresponsible and needing their fertility controlled for their own well-being and the broader well-being of society (De Zordo, 2012: 218). Yet while women did not passively accept the ‘knowledge’ embodied by health professionals and at times used ‘non-medical’ contraception, this also exposed them to unintended pregnancies and unsafe abortions (De Zordo, 2012: 219). Similarly other studies have found that low income women are ‘pushed’ into having caesarean sections as they see it as a means of avoiding poor treatment at the hands of medical professionals (Béhague et al., 2002). Studies in both Brazil and Chile suggest that the increase in number of caesarean sections cannot easily be attributed to mothers’ demand (Gamble et al., 2007). In Brazil while the majority of women start of their pregnancy by stating a preference for vaginal births, few in fact finally deliver that way. Moreover, many caesarean sections are scheduled for daytime hours on weekdays, suggesting that they are convenient for doctors to perform (Victora et al., 2011).

² Venezuela was the first country in Latin America to introduce the idea of obstetric violence as a legal term.

CONCLUSION

Discussion around the future development agenda has once again focused attention on the importance of SRHR and its centrality to the wider development process. Yet if governments are serious about their commitments to overcoming inequalities and upholding their commitments to meeting development goals it is essential that SRHR are fully addressed. The cases of Brazil and Chile clearly demonstrate that even in the context of universal health care systems and in countries where economic development has occurred and income levels have been raised, women's SRHR are frequently ignored or even deliberately kept off the political agenda. Our analysis has shown that a range of factors coincide and reinforce one another to maintain and reinforce the gendered status quo. We therefore advocate the importance of making explicit the ways in which institutional gender regimes and policy legacies contribute to the marginalization of women's SRHR. Employing a broader approach illustrates how even where governments commit to promoting women's health concerns if they do not simultaneously address the deeply embedded gendered norms within wider health systems and societies, and in the daily practice of health professionals, then policies will fall short at the implementation stage.

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