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**From Rhetoric to Reality in Improving Maternal Health Outcomes: An Analysis of
Women's Rights Activism in Brazil**

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A thesis submitted for the degree of Doctor of Philosophy,
March 2014

I declare that the work presented in this thesis is my genuine and original work.

Marianna Vargas de Freitas Cruz Leite

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Abstract

This thesis presents the results of an empirically-grounded exploration of the ascendance of maternal mortality as an issue and its neglect by Brazilian public policy. Its purpose is to contribute to the existing scholarly debate on social policy and participation in order to advance knowledge on the dynamics of agenda setting and activism. More specifically, it relies on a case study of political and policy strategies aimed at maternal mortality reduction, to determine whether or not decentralisation has led to processes and environments that are more adequate to the advancement of women's rights. Policy and discourse analyses are used to discuss the continuous appropriation, transformation and re-appropriation of decentralisation by the different policy networks and its influence in the depoliticisation of the wider human rights movement. In-depth interviews with key-actors participating in the 1980s and 1990s health sector reforms in Brazil demonstrate that decentralisation does not live up to its social justice premise and that, as it is not inserted into a wider culture of political measures for positive change, it reinforces existing power hierarchies and elitism. This historical analysis serves as a statement of the voracious power neoliberalism has over all types of policy making as well as its opportunistic advancement of certain political strategies created by different individuals and networks involved in the institutionalisation of human rights-based approaches. This control exerted by neoliberalism over policy and policy discourse is particularly acute in the case of maternal mortality. In its most progressive format, maternal mortality touches upon politically contentious issues that are often resisted by conservative networks supporting neoliberal control over public health sector reforms, principles and practices. Furthermore, in the face of new and multiplying policy spaces created by decentralisation, women's rights networks lose their political leverage as sophistication, capacity and resources become indispensable.

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Chapter I - The Theoretical Framework: Analysing Women's Rights Activism for a Better Policy Praxis

Introduction

Women's movements are increasingly important in policy making and politics in Latin America. Yet, studies on women's movements are often clouded by problematic assumptions impinged upon these movements by the development literature; and the tendency to marginalise discussions on the political and institutional context in which their strategies are inserted into (Molyneux, 1998). Acknowledging this gap in the literature, this doctoral thesis presents the results of an empirically-grounded exploration of the ascendance of maternal mortality as an issue and its neglect by public policy. It particularly focuses on the analysis of policy networks pushing for a maternal health and human rights agenda and the processes of creation, appropriation, transformation, and re-appropriation of these same discourses.

This research relies on Shiffman and Smith's (2007) framework for the analysis of global maternal health initiatives in order to study similar processes in Brazil. This framework is particularly valuable as it brings into the foreground the different political strategies, thus making power struggles more visible and prominent. This framework is key to the deconstruction of the processes of implementation of women's rights in health sector reforms in Brazil, because it provides a scheme for the systematic analysis and presentation of data. More specifically, it is important for the construction and analysis of the wider case study which deconstructs the decentralisation of services and its impact on maternal mortality reduction policies and programmes. The case study allows for a comprehensive analysis of the processes associated with the creation, appropriation, transformation and re-appropriation of the key terms (such as decentralisation) and discourses (such as human rights). It emphasises the role played by academics, policy makers, policy implementers - medical and legal professionals -, activists from the

women's rights movement and members of international organisations and their influence (incidental or not) in the depoliticisation of the wider human rights project in Brazil. The main research question inquires whether or not these processes have contributed to improved health policies and policy praxis. To inform and support this framework, the literature on epistemic communities and policy legacies is used alongside a Foucauldian discourse analysis of power and knowledge.¹ This scheme of interlocking theories and approaches captures the complexities inherent in this highly competitive political process. Moreover, this set of combined theories acknowledges post-structuralist discussions that there is no 'truth' or even 'ideologies'. That is, by using a theoretical framework oriented by a Foucauldian discourse analysis, I recognise that all is discourse and therefore all discourses are representative of a particular political position that benefits a particular group(s) of society. In this sense, the key is to analyse who benefits by the use of certain types of discourse, why and how.

In this sense, this thesis looks at the gaps and obstacles in social policy making and implementation in Brazil. By looking at the policy process, it tries to determine why rhetoric used in social policy making rarely coincides with its implementation. More specifically, this thesis will trace the activism surrounding the use of a 'human rights-based approach' to maternal health and its implication on the use of the different policy discourses. For the purpose of this historical and policy analysis, the thesis focuses on health sector reforms (HSRs) and decentralisation during the past three decades in Brazil. It looks at initiatives aimed at the reduction of maternal mortality rate (usually referred as MMR or maternal mortality rates in international documents such as those produced by United Nations' agencies) locally to map the different discourses informing policy making and implementation in order to show the gaps and differences between the two. Maternal mortality reduction is particularly relevant here as it highlights the difficulties in promoting change while, at the same time, using politically charged terms. That is, the construction of a case study around maternal mortality policies and strategies enables the analysis of the obstacles that are imposed on social policy change. The case study is particular to the Brazilian context but can very well be extrapolated, with all the relevant adjustments, to other Latin American contexts. This is because it serves to establish the disparity in the use and construction of social justice discourses around social policy making and their

¹ See, for example, Ewig, 2010; Foucault, 1980; 1991.

implementation. In sum, this research looks at whose voice counts in social policy making and whose voices are left behind.

The thesis establishes four key arguments. Firstly, and in light of existing literature, the adoption of a political philosophy of rights into development discourse tends to obscure the differences that need to be drawn between human rights and human rights-based approaches. Secondly, the adoption of a human-rights based approach directly associated with mainstream economic concepts tends to divert health sector reforms from their ethical purposes and promote market-oriented results which intensify social inequality. Thirdly, policy analyses of health sector reforms should be shifted from formal to informal spheres as this enables a different kind of reading of the real constraints and possibilities of strategies focused at improving health outcomes. And, lastly, human rights-based models of health promotion tend to rely on discourses that mostly serve to provide moral justification for processes already put in place but whose existence should actually be questioned.

These results come out of a larger case study questioning if decentralisation has resulted in processes and environments that are more adequate to the advancement of women's rights in Brazil. In-depth interviews with key-actors participating in the 1980s and 1990s health sector reforms demonstrate that decentralisation does not live up to its social justice premise and that it reinforces existing power hierarchies and elitism. The larger case study was set out by a series of individual case studies and interviews, leading to methodological saturation. In brief, the thesis presents accounts that have otherwise been silenced. It therefore contributes to existing scholarly debate on social policy and participation because it systematically maps the appropriation of progressive discourses and the impact they have over policy praxis. Furthermore, this scholarly discussion advances knowledge on the dynamics of agenda setting and activism by demonstrating the importance of the interaction (or lack of it) between and within progressive and conservative policy networks. That is, by demonstrating that progressive human rights discourses become appropriated by conservative networks primarily for the purpose of the advancement of a neoliberal agenda, it highlights the overwhelming effects neoliberal contexts have over human rights policy making and praxis. Indeed, its historical analysis serves as a statement of the power neoliberalism has over all types of policy making and

its opportunistic advancement of certain political strategies created by different individuals and networks involved in the institutionalisation of human rights-based approaches.

The Background of the Research

This thesis presents quite unexpected results. This is partially because the research questions have evolved dramatically since the beginning of the research programme and, on the other hand, because the analysis of interviews and the contact with Brazilian literature considerably shifted my understanding of the context and political constraints. This research was formally developed during a visiting fellowship held at the International Gender Studies Centre at the University of Oxford from 2009 - 2010. However, informally, it was stimulated by my professional experience dating back to 2008. At that time, I was working as an intern at an international non-governmental organisation that uses flagship legal cases to push for the implementation of reproductive rights law globally. I came into contact with a (now reasonably famous) maternal mortality case presented against the government of Brazil before the United Nations Committee on the Elimination of Discrimination against Women - CEDAW Committee. This case (known as the 'Alyne case') dealt with a preventable maternal death of a lower class young black woman that occurred on the outskirts of the state of Rio de Janeiro. Her death was a violation of international reproductive rights law. However, the legal battle was not as straightforward as that.² In brief, the Brazilian government argued that it was not responsible for negligence in health services provided by that particular health centre as it was owned and run by the private sector. In contrast, the defendants contended that although the centre was privately run, its funds were public and its users were beneficiaries under public health provision and therefore it did fall under the remit of the State. In response, the Brazilian

² The Alyne Case was filed before the CEDAW Committee in 2007 and decided in 2011. The Committee found, amongst other things, that the government of Brazil was guilty of violating Alyne's right to be free from preventable maternal death. In light of this, and as the decision was not legally binding, the Committee issued recommendations that instructed the government to come to an agreement with the family of the victim in regards to individual reparations and general actions preventing future violations. This agreement was only finalised in the beginning of 2014, almost 12 years after Alyne's death. According to one informant, this delay was mostly caused by the obstruction presented by the governor of Rio de Janeiro who was unwilling to recognise the decision and to admit responsibility for the violation (Interviewee 3, 28.09.12).

government argued that because the health centre was under the supervision of the state of Rio de Janeiro, the responsibility to oversee proper delivery of health services lay with the federal unity and not the federal government. My participation in the legal research counteracting this argument generated an array of personal questions, the most important of them inquired whether or not decentralisation was positive or negative for maternal health outcomes.

For this reason, the initial research project developed at the University of Oxford was set under a one year deadline and looked at the literature on decentralisation and maternal health and mortality. Finding this approach insufficient to answer the research question, the project was transformed into a doctoral proposal. Initially, the doctoral proposal intended to look at the benefits and shortcomings of the decentralisation of health services by looking at the maternal health outcomes. Having worked in international development in Brazil and elsewhere, I got used to replicating the same development jargon I criticise here. All my previous work had a tendency not to deconstruct development strategies and therefore romanticise solutions and essentialise gender roles. Luckily, as the methodology was adjusted and re-adjusted for ethical clearance purposes, so did my perception of where the real problem lies. Moreover, as I waited for ethics approval, and already being in the city of Rio de Janeiro, I benefited from stimulating discussions with Brazilian academics who were very generous in indicating a wealth of local literature exploring the issue. The more I read and the more I discussed, the more I came to realise that the problem could not be merely attributed to decentralisation. For instance, decentralisation was initially implemented in Brazil as part of a wider project for social justice but decentralisation was not fully implemented. And, when and where decentralisation was implemented, social justice values were not carried out to their full extent. I also understood that the language of rights did not always resonate locally. As a result, early on in my fieldwork I changed the research question in order to understand the policy process. More specifically, I wanted to understand the processes that are linked to the policy making and implementation leading to the decentralisation of maternal health services in Brazil. In brief, I was determined to discover more about the policy processes and changes in policy discourses, or discourses aimed at promoting change. I did this in order to understand why the implementation of policies aimed at the decentralisation of health services become so different from the ones proposed by the social movement informing the making of such policies.

In this sense, the main research question and the case study presented here can be said to be a product of dialectics. It was created in conversation with the literature and with academics, policy makers, policy implementers - medical and legal professionals -, activists from the women's rights movement and members of international organisations while in Brazil. The research question and the case study were adapted to better understand the gaps and obstacles that exist between social policy making and implementation. As will be discussed throughout this thesis, these gaps and obstacles in social policy making in Brazil can be explained by the existence of an empty political rhetoric; the participation of activists as workers of an overwhelming bureaucracy and the difficulties of implementing social justice constructs to their full ethical extent. In the case of the latter, the problem is two folded: Brazilian constructs are rarely translated into Western academic discussions and, at the same time, Western academic literary production is often imported into Brazilian hegemonic discourses. The problems of importing foreign terms into Brazil meant that decentralisation (and its philosophical underpinnings) was short lived as a Brazilian construct.³ Furthermore, the new philosophical constructions orienting the reformulation of decentralisation to the Brazilian context were not exported to Western academic production to the same extent as happened with the Western concepts of decentralisation. This meant that the social policy implementation tools used to implement decentralisation in Brazil were more in line with Western concepts than to the one created nationally.

Additionally, the gaps in social policy making and implementation can be understood as a general failure on the part of development theorists and practitioners of understanding the importance of processes associated with the appropriation, transformation and re-appropriation of terms and strategies claiming to promote social justice. These processes of changing social policy concepts are linked to: the development of different concepts; the importation and exportation of concepts and philosophical discussions; and how policy garners widespread support. If the political rhetoric is not associated with the change

³ As will be discussed in an appropriate section, decentralisation was introduced in Brazil by the Portuguese Crown during the colonisation period. However, the term was considerably transformed since its Brazilian inception. For instance, decentralisation was re-constructed by a Marxist social justice movement as a tool towards health equality during the period of transition to democracy. But, in spite of this progressive re-construction of the term, the implementation of decentralisation was considerably dissociated from this particular Marxist construction.

proposed in social policy, then little or no change can be expected. That is because the real attachment to values associated with social equality demands and goals become absolutely necessary for policy change in clientelist and elitist contexts. The gendered character of welfare provision in Latin America - i.e. patriarchal and maternalistic – serves to confirm the inherently unequal character of social policy making. In Brazil, this becomes even more evident. The country's productivity has usually overshadowed and distorted notions of an alleged exemplary social development and positive political environment nurturing a more equitable society. The construction of 'Brazilian myth' has then been replicated in the international fora without much deconstruction of these misleading superlatives and their effects on social justice strategies. In this sense, given the strong presence of clientelism, elitism and patriarchy in Brazil, studying the relationship between policy making and implementation becomes even more necessary in the case of women's rights.

My experience during fieldwork challenged and disproved most of my assumptions of the capacity of decentralisation to deliver on its promise of social equality. Indeed, the history of maternal mortality reduction policies and strategies in Brazil (and globally) is far from what might be logically expected, i.e. a scheme of social policies driving slow but progressive change. In fact, the non-linear influx in women's rights policy has been observed in previous research in the area of human rights but those are mostly focused on the analysis of what occurs at the global level (Sen and Mukherjee, 2013; Yamin and Boulanger, 2013). For example, Yamin and Boulanger (2013) have found that international sexual and reproductive rights have suffered from a strong backlash since 1994.⁴ This, they contend, was mobilised by several right-wing policy networks that felt threatened by the advancement of a progressive agenda (Yamin and Boulanger, 2013). Moreover, the authors stress that the reversal of women's rights achievements (or its attempt) was not only linked to religious backlashes but also to other conflicting agendas such as OECD Development Assistance Committee's (DAC) 1996 campaign for the increase in levels of foreign aid. They note, for example, that OECD's campaign reduced strategies implementing the human right to health by rerouting focus to primary health care access and removing gender equality from the global agenda (Yamin and Boulanger, 2013). This

⁴ As discussed below, 1994 was the year of the International Conference on Population and Development which, thus far, marked the greatest achievement in the history of sexual and reproductive rights globally.

was operated through a DAC blueprint called 'Shaping the 21st Century' which created seven International Development Goals (IDGs) looking at selecting, adapting and replacing targets established by previous UN conferences (Yamin and Boulanger, 2013). Although the IDGs had little impact at the time of their creation, their blueprint widely influenced the Millennium Development Goals (MDGs) (Yamin and Boulanger, 2013).

I was then able to observe that existing empirical studies establish that, at the global level, the advancement of sexual and reproductive rights strategies is not only linked to the efficacy of women's rights strategies but also to their intersection with conflicting strategies appropriating and diverting human rights discourses and resisting the advancement of women's rights or even of a radical human rights agenda (Sen and Barroso, 1996; Corrêa, Alves and Januzzi, 2006; Sen and Mukherjee, 2013). And, I also learned that the negative effects of these right-wing campaigns have been observed throughout Latin America (Almeida et al. 2000; Almeida, 2002; Berry 2010; Morgan, 2014). In fact, through my literature review, I came across studies that traced similar processes while focusing on religious backlashes to sexual and reproductive rights in the region (Corrêa and Piola, 1999; Alves and Corrêa, 2009; Morgan, 2014). The empirical data collected at the local level confirms the data collected at the global level. For instance, Morgan (2014) found that politicians associated with the ultra conservative Catholic *Opus Dei* have designed a strategy to appropriate and transform human rights discourses in Argentina. According to her research, such strategy involved research, publication and lobbying for the establishment of family rights, natural rights and the right of the unborn (Morgan, 2014). This strategy resulted in the publication of numerous historically dubious studies and even the award of a well-regarded human rights prize to a senator for her outspoken opposition to abortion, contraception and sterilisation (Morgan, 2014). The author calls this process the 'strategic secularisation' of human rights which is the use of secular discourses for religious purposes under the clout of the 'dignity of the human person and human rights' (Morgan, 2014: 3). Morgan's (2014) study stands alongside many examples of how Roman Catholic activists have appropriate liberal secular language of human rights to advance pro-family and pro-life agendas (Araújo, 2002; Rosado-Nunes and Jurkewics, 2002). However, my analysis of existing data made me aware of how evident the resistance to women's rights policies are not only motivated by religious conservatism but also by a neoliberal orthodoxy that is ever more vigilant against structural changes to the economic system, i.e. those necessary for the full implementation of all social, cultural and

economic rights. For this reason, and considering the wealth of excellent studies focusing on religious backlashes at the local level, I decided to focus on the effects of the neoliberal policy networks on women's rights activism.

Thus, I depart from the assumption that all social policy making and praxis are constrained by neoliberal policy networks either because it challenges neoliberal economic interests or because they are positioned as a part of a competing agenda. While studying the Brazilian case, I discovered that the processes for the implementation of women's rights policies in health, particularly in health sector reforms, suffer from resistance from conservative sectors of society almost to the same extent as they benefit from progressive advances in social policy. In addition, most importantly, as will be demonstrated, mechanisms reversing social policy advances often operate in an invisible manner. That is, differently from strategies promoting progressive discourses and approaches, conservative resistance usually works through informal spaces that are restricted to certain individuals and networks. As a result, policy change occurs in a non-democratic manner. This becomes more visible in strategies implementing women's right to health. In particular, this control exerted by conservative networks (representing and/or supporting a particular set of neoliberal policies) over policy and policy discourse is acute in the case of maternal mortality. In its most progressive format, maternal mortality policies touch upon politically contentious issues that are often resisted by conservative networks supporting neoliberal control over public health sector reforms, principles and practices. Moreover, in the face of new and multiplying policy spaces created by decentralisation, women's rights networks lose their political leverage as professionalism, capacity and resources become indispensable (Alvarez, 1999; 2009).

What is the Maternal Mortality Rate?

Maternal mortality ⁵ rate is statistical measure that provides an average for the number of maternal deaths that occur in a given period per 100,000 live births registered in the same timeframe (WHO et al., 2012). It is an indicator that attempts to measure the level of inequality in a health system by translating the quality of health services, particularly

⁵ The terms maternal health and maternal mortality are loaded with political interests and socially created constructions.

concerning emergency obstetric care, into numbers (Volochko, 2010). This indicator, as any other, serves to give an insight into the current state of affairs by generalising the status of maternal mortality in a given place at a given time. It is only useful if combined with multiple indicators or with relevant qualitative data. This is because maternal health and mortality relate to different groups and individuals in different ways. Subsequently, only in-depth analysis of intersecting categories of analysis such as location, class and ethnic group can provide an approximation of social reality. What is more, maternal mortality rates only cover women in relation to pregnancy and birth - not the general state of women's mortality (such as other cases of deaths amongst women and their incidence according to class) or a comprehensive picture of women's health (such as maternal morbidity arising out of complications due to low quality care). Therefore, maternal mortality rates are important in mapping the status of women in a particular place and during a specific period of time, but must not be analysed in isolation (Araújo, 2002). Notwithstanding, the indicator serves to reveal the social exclusion suffered by women and can map out the reasons for exclusion such as class, status, race, age, disability, geographical location and nationality (Araújo, 2002; Volochko, 2010).

In sum, the maternal mortality rate is a quantitative social indicator used to measure a social phenomenon (Araújo, 2002). It translates the abstract social concept of maternal health and mortality (although not necessarily problematizing its construction) but places it into the area of research and praxis (Corrêa, Alves and Jannuzzi, 2006). Nonetheless, the indicator is circumscribed by many limitations such as the availability and reliability of data (Valongueiro, 2000). This often means that the indicator only represents an estimate for the number of deaths rather than effective numbers actually observed (Valongueiro, 2000). Likewise, depending on the country and the area subjected to analysis, the indicator can only be used to measure social inequality comparatively when other social data is available. In this case, it is possible to link existing data on the inequality of service provision to political influence and/or discrimination contributing to social inequality. Nonetheless, when this sort of social data is unavailable, maternal mortality rates can only be used to measure inequality in service provision rather than social inequality. However, despite the indicator having considerable limitations, it is still to this date the best quantitative methodological instrument used to deepen the understanding of maternal health, maternal health care and public policies regulating them (Corrêa, Alves and Jannuzzi, 2006).

The Importance of Maternal Mortality Rates

It is widely established that gender is a significant marker of social and economic vulnerability which is manifest in inequalities in access to health care (Standing, 1997; WHO, 2008). Global progress in terms of achieving Millennium Development Goal 5 of reducing 75 per cent of the maternal mortality rates globally - from 400 maternal deaths per 1,000 live births in 1990 to 100 maternal deaths per 1,000 live births by 2015 - has been seen as crucial for the effective integration of gender perspectives to health policy making and monitoring (Victora et al., 2011). Regardless of its reductionist character, the Millennium Goal 5⁶ could potentially have created political momentum in favour of a systematic (although not comprehensive) implementation of women's rights into health sectors (Corrêa and Alves, 2005). Nonetheless, in 2010 the rates were still quite high, 210 maternal deaths per 1,000 live births (Women Deliver, 2012). Although this represents a remarkable progress in the reduction of 1990's rates by half, the progress towards 2015's ideal rates is far from desirable.

Thus, in spite of this global demand for government to expediently reduce maternal mortality deaths as required by the MDGs, governments reportedly lack enthusiasm and commitment to the goals (Corrêa and Alves, 2005; Berry, 2010; Cottingham, et al., 2010; Diniz, d'Oliveira and Lansky, 2012; Yamin and Boulanger, 2013). The UN asserts that the maternal mortality data is an important aspect of wellbeing (UNDP, 2010). However, 287,000 women still die every year from treatable or preventable complications of pregnancy and childbirth globally (Women Deliver, 2012). The importance of these numbers cannot be underestimated. Wellbeing means surviving, leading a long and healthy life, being well nourished, living decently and having the ability to fulfil life plans (Sen, 2002; Alkire, 2005). When enjoyed to its fullest, wellbeing creates a better environment for the improvement of health status on an individual basis (UNDP, 2010). Indeed, the notion of wellbeing analyses the individual's status in society by focusing on

⁶ The Millennium Development Goals originated from the Millennium Declaration. Both have been criticised for their reductionist approach to reproductive rights. However, it is important to note that the Millennium Declaration is less restrictive than the MDGs. In this sense, a large part of the critique lies in arguing that the MDGs fail to establish comprehensive links with international reproductive rights law.

people's basic entitlement to live life with dignity and according to every person's limitations and capabilities (Nussbaum, 2001). As will be further discussed in the next sections, maternal mortality rate as a concept is more fundamental than wellbeing as it serves to guarantee the right to life by addressing a context where being a woman of a particular social group (such as class and ethnic group) may be a death sentence (Martin, 2001). Yielding insights on gender, class and race gaps in health policy making and reform may help overcome systemic failures to address social inequality (Nussbaum, 2001).

The Importance of Global Maternal Mortality Reduction Strategies

Maternal health strategies have been at the core of development practice, in particular since the United Nations Decade for Women in the 1970s (UN, 1993). Globally, the maternal mortality rates have been reduced by 47 per cent in the last couple of decades, from 400/100,000 in 1990 to 210/100,000 in 2010 (UN, 2013a). These significant improvements in indicators on maternal mortality are partly due to this new set of strategies and partly due to improvements in health access and quality, as well as improvements in the social conditions that affect health and illness (UN, 2013a). Still, progress in promoting maternal health as part of the wider women's rights framework has been far from perfect (Victora et al., 2011). The framework imposed by global strategies is often perceived to alter individual subjectivities⁷ to the detriment of context specific policies that are better equipped to effectively tackle maternal mortality causes locally (Berry, 2010). For example, in the rural community of Santa Cruz La Laguna located in the Solalá district of Guatemala, maternal health used to be a family affair, i.e. all pregnancy-related matters were seen as a responsibility of all family members (Berry, 2010). However, with the introduction of the Safe Motherhood Initiative's blueprints to the Guatemalan context, maternal health was re-conceptualised in terms of liberal and individualistic Western

⁷ Discourses that promote the 'neoliberalisation of the family' urge for extreme levels of individualism and self-governance which usually mean shifting collective subjectivities to individualistic subjectivities. As it is discussed in Chapter VII, this is a rhetorical tool that aims to depoliticise and remove the responsibility of government's for certain social issues.

concepts of autonomy (Berry, 2010). Berry (2010) affirms that this shift created tensions within families which ended up placing pregnant women at higher risk of death than before the introduction of international interventions which date back to 1994. This suggests that international development blueprints can lose their relevance and suitability when translated and implemented in local contexts.

According to the Inter-Agency Safe Motherhood group, globally, out of all maternal deaths, 80% are due to pregnancy-related complications,⁸ 99% take place in developing countries and 90% occur among those women who earn two minimum wages or less per month⁹ and live in the peripheral areas of big cities (WHO et al, 1999; 2012). This means that most maternal deaths registered today across the globe are preventable (WHO et al, 1999). Preventable maternal deaths are often a violation of the right to life and other human rights that are necessary for the highest attainable standard of health (Galli, 2002; Hunt and Mesquita, 2007). More specifically, the existing data demonstrates that the deaths of women are not only intrinsically related to the quality of services available in the public health systems, but also indirectly influenced by malnutrition, illiteracy, poverty, lack of transportation, lack of sanitation and other underlying health causes that are more explicit in marginal sectors of society (Araújo, 2002). This means that preventing maternal deaths requires efforts that go beyond the quantity, coverage and quality of health services in order to promote structural changes affecting and promoting health inequality and vulnerabilities.

Strategies aimed at reducing maternal mortality rates globally often rely on international law on sexual and reproductive rights. Although normally closely linked, reproductive rights and sexual rights are different in content and scope (Cook, Dickens and Fathalla, 2003). Sexual rights aim at guaranteeing freedom from intrusion in all aspects of an individual's exercise of sexual identity, determination and enjoyment (Mattar, 2008). Reproductive rights, on the other hand, were developed as legal entitlements to create a framework for

⁸ Pregnancy-related deaths are those that are directly linked to the pregnancy and occur during pregnancy, at delivery, or soon after delivery (WHO et al, 1999; 2012). The major causes of death by pregnancy-related complications (or direct causes) are: severe bleeding (postpartum or not); infections (usually after delivery); hypertensive disorders in pregnancy (eclampsia); obstructed labour; and complications after unsafe abortion (responsible for 13% of maternal deaths) (WHO et al, 1999; 2012). The indirect causes of maternal deaths are those that are influenced by causes that pre-exist pregnancy such as malaria and HIV/AIDS (WHO et al, 1999; 2012).

⁹ The minimum wage varies dramatically across countries. In the United Kingdom, the minimum wage was £940.60 per month in 2012.

the full exercise of freedom of choice in terms of family planning for men and women regardless of their identity and social status (Cook, Dickens and Fathalla, 2003; Mattar, 2008). So, sexual and reproductive rights were not conceptualised to only advance women's health but, in fact, were created to guarantee equal treatment leading to equality in health outcomes.

As will be demonstrated, contrarily to what is normally expected, the global framework provided an unstable and non-linear development of sexual and reproductive health policies (Alves and Corrêa, 2009). This had serious and negative effects on the current state of sexual and reproductive rights. In fact, a recent interactive map created by the Slate and the New American Foundation tracing reproductive rights laws around the world, points to the persistence of conservative approaches to women's rights in the global south (Kirk et al., 2013). In the Latin American and Caribbean regions, for example, only Cuba and Guyana have laws authorising abortion regardless of reason (Kirk et al. 2013). And, in the countries where limited legal abortion is available, only a handful of exceptions are available for women (Kirk et al., 2013). As a result, maternal health becomes one of the worse affected by the persistence and/or re-enactment of conservative policies related to sexual and reproductive health in the region.¹⁰

The Critique of Global Maternal Mortality Reduction Strategies

Global commitments such as those put forth by the United Nations agencies (such as the Safe Motherhood Initiative) recommend that countries strengthen maternity referral systems in order to promote the reduction of worldwide deaths (Murray and Pearson, 2005). For example, this recommendation trickled down to a series of measures at

¹⁰ For example, while in 2012 Uruguay lifted all bans on abortion during the first three months of pregnancy, Nicaragua passed a law in 2006 prohibiting all abortions without exception (Kirk et al., 2013). In the case of the latter, the new law replaced an older one which made abortion legal in cases of rape or when the mother's life was in danger (Kirk et al., 2013). The same type of strict neoconservative policies exist in countries such as Chile (since 1989) and Honduras (with a ban on all contraceptive methods since 2009) (Kirk et al., 2013).

national levels aimed at improving formal arrangements for the achievement of specific indicators of good referral¹¹ as expressed by the Safe Motherhood Initiative. However, as Murray and Pearson (2005) note, little or no effort is put into discovering the referral care needs of poor and marginalised women, nor the effects that existing models have on them (i.e. indirect and direct maternal mortality causes and their predominance in one particular area at a specific moment in time). This lack of appropriate information and misguidance leads to all sorts of negative health outcomes. For instance, availability and access to emergency obstetric care is known to reduce maternal mortality (Murray and Pearson, 2005). However, the lack of information on the effects of policies solely aimed at improving obstetric emergency care leads to a series of blueprints that rarely dialogue well with local contexts in which these policies are inserted into.

Despite the introduction of a variety of models aimed at addressing maternal health, such as the WHO pyramidal structure - which creates multiple levels of facility and treatments - many do little to actually improve maternal health outcomes (Murray and Pearson, 2005). This is because vertical structures might be efficient in targeting problems in referrals (such as overcrowding or emergency obstetric care), but do little to advance transversal care (across the different sectors of the bureaucracy that influence the underlying determinants of health) or an intersectional approach to health (McCall, 2005; Victora et al., 2011). Sub-optimal care, poor technical abilities, outnumbered referral facilities and overcrowding are among some of the reasons of the failure (Murray and Pearson, 2005). Moreover, in several cases where international models are applied nationally, WHO referral system blueprints are bypassed or non-complied with; the high level of non-compliance is proof of users' lack of confidence in the quality and/or efficiency¹² of care (Murray and Pearson, 2005: 2207). Decentralisation in this instance may weaken the links between high-end technical facilities and rural health establishments (Murray and Pearson, 2005).

¹¹ Referral here means the ability to transfer a patient from a primary health care establishment (low complexity care) to a secondary or tertiary health care establishment (higher complexity care) in the case of complications arising out of specific procedures. For instance, if a woman is having a natural birth in a health centre but soon finds herself struggling to deliver the baby, then she needs to be referred to a hospital that has emergency obstetric care.

¹² Efficiency of care is here used in reference to the World Bank's definition which is intrinsically related to economic proficiency, i.e. a cost-benefit analysis of the use of financial resources.

Furthermore, although maternal mortality has been on the international agenda for three decades, our understanding of the effects of the global strategies on the ground is limited (Béhague and Storeng, 2013). The analyses that exist tend to look at the positive effects of the international legal frameworks, but do not look at the discourses legitimising these frameworks at national levels (Cook, 2013). Nonetheless, the few studies problematising the use of international blueprints at the national level tend to argue that global maternal mortality reduction strategies and campaigns have created barriers to reducing mortality rates and threatened to make the target communities even more vulnerable (Berry, 2010). Berry (2010) finds from her experience in Guatemala that maternal mortality has been reduced to a purely medical issue, i.e. pregnancy and birth are understood through the binary life-death when in fact the spectre of the phenomenon of death is substantially larger than what is used in these strategies. It has in this sense become a technical issue which: results in the overuse and abuse of biomedical jargon; orients much of the strategies implemented; and also alienates everyone who is either not part of the development elite or has not appropriated the discourse used by this elite (Berry, 2010). This is problematic because maternal health is then transformed in a depoliticised area whereby policy making and implementation become detached from reality (Flinder and Buller, 2006; Swyngedouw, 2008). This means that maternal mortality policies and programmes are built to reach out only to a chosen few (i.e. benefiting women that have access to already existing health facilities) or to support a framework that reconstructs motherhood that only aims to benefit the chosen few (i.e. good mothers as those that fit the neoliberal model of individuality and re-packaging of patriarchy).

It is therefore imperative to broaden the conversation of maternal mortality and its causes through the deconstruction of discourse. That is, discourses used by the very successful but yet fragile sexual and reproductive rights community and international human rights movement tend to legitimise one another without deconstruction or in-depth critique (Berry, 2010). But, the deconstruction of discourses and their effects on maternal health outcomes and processes is paramount for the advancement of a human rights agenda as a social justice and ethical construction. This should be done, in my opinion, with the aim of setting the human right to life and the human right to the highest attainable standard of health as the parameter for policy making and implementation at all levels. In order to do that, it is

important to challenge the notion of global citizenship¹³ as defined by international human rights and the more restrictive rights-based approach (Berry, 2010).

Global Approaches to the Right to the Highest Attainable Health

The right to health or the human right to the highest attainable standard of health is defined by the UN Committee on Economic, Social and Cultural Rights General Comment 14 and was subsequently developed by Paul Hunt¹⁴ (Hunt and Leader, 2010). According to the UN General Comment 14, “the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment” (UN, 2000: 3).

It includes both freedoms (i.e. the freedom from discrimination or non-consensual medical treatment and experimentation) and entitlements (i.e. the provision of a system of health protection that includes minimum essential levels of water and sanitation (Hunt and Leader, 2010). Freedoms and entitlements can also be divided into negative rights and positive rights i.e. freedom from action that violates rights as well as entitlements to affirmative steps towards fulfilment of rights (UN, 2000; Beracochea et al, 2010).

Distinguishing practices have been put in use at national levels for implementing the right to health (Hunt and Leader, 2010). Some practices involve the use of human rights-based approaches for judicial (or quasi-judicial) and policy-oriented purposes (Hunt and Leader, 2010). These judicial methods aim to promote and protect the right to health via the

¹³ Global citizenship has been defined in various ways. Berry (2010) refers to global citizenship when describing the political philosophy of human rights. That is, the notion that social justice commitments and responsibilities transcend geographical borders.

¹⁴ The UN Commission on Human Rights (now the UN Human Rights Council) Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health from 2002 to 2008.

elaboration of rules and principles derived from case law, building up general guidance from the lessons learned via the resolution of particular disputes (Hunt and Leader, 2010). Given the wide use of judicial methods by the scholarship (Galli, 2002; Cook, Dickens and Fathalla, 2003; Yamin, 2005; Cook, 2013), this research relies on policy analysis to explore the use of the right to health and the instrumentalisation of the rights-based approach to development in health sector policies and programmes. Policy-oriented methods bear upon and integrate the right to health into all relevant policy-making initiatives (Hunt and Leader, 2010). It explores the importance of applying the language of human rights to health policy strategies and the state's responsibility to promote and protect the human rights of individuals and communities (McIntyre and Klugman, 2003). Nevertheless it also analyses individual's capacity to claim rights and the structural causes of the non-realisation of rights (Beracochea et al, 2010).

Needs-Based Approaches and Human Rights-Based Approaches

The use of a human rights-based approach gained momentum in the early 1990s (in the post-Cold War) the 1995 Copenhagen Summit of Social Development (UN, 1995a). It originated from the colonial and post-colonial struggle for social justice as a way to merge development strategies with the post-World War II international human rights paradigm (Yamin, 2008). Human rights-based approaches opposed the utilitarian (i.e. cost-benefit) and needs-based approaches (i.e. charitable distribution of additional resources) (Cornwall and Nyamu-Musembi, 2004). Rights-based approaches aimed to politicise or re-politicise the ethical and legal obligations to social justice (Cornwall and Nyamu-Musembi, 2004).

There are several rights-based approaches with different definitions and implications for praxis (Cornwall and Molyneux, 2006). Essentially however, a rights-based approach, as opposed to a 'needs-based approach', claims to shift away from utilitarian ideals as a way to give voice and power to all people including those at the margins (Beracochea et al, 2010). Instead of prioritising problems based on need and charity work, it asserts individual rights to everyone irrespective of their status, class, race, gender, sexual orientation, age or disability (Beracochea et al, 2010). Therefore, the rights-based approach claims to frame health disparities as legal violations while shying away from

utilitarian and market-oriented notions of health (Meier et al, 2010). In this case, health and health care policies, instead of providing health care as a commodity or a public good, are to be grounded upon social justice principles (Rudiger and Meier, 2010). Nevertheless, previous research suggests that both need-based and human rights-based can both be, when put to in practice, individualising (Berry, 2010).

The individualising tendencies of rights-based claims are certainly problematic when transported to the health sector. That is, claiming individual health rights can be quite unlike arguing for public health interests (Tobar, 1991). Conceptual underpinnings of health and rights emerged from different historical contexts and premises (Cornwall and Nyamu-Musembi, 2004). The discourses and disciplines of public health and human rights both emerged in Western Europe in the 18th century as part of a new vision of nation-State (Yamin, 2005). It ties in with the notion that an abstract social contract gives legitimacy to the State over individuals and groups (Hobbes, 1651; Locke, 1677; 1690; Rousseau, 1762). However, the public health tradition fosters the prevalence of social policies (that portray the interest of the majority) which collide with the individual rights ideal advanced by the human rights project (Yamin, 2005). It is also inherently related to the social contract as it determines that the rights of the collectivity must prevail over those of individuals (Rousseau, 1762). Therefore, social contract premises of public health conflict with individualistic premises of human rights (Yamin, 2005). Thus, although individual rights can be and are reason to mobilise for common collective rights, their different underlying premises make it difficult for us to equalise them. In this sense, the adoption of a political philosophy of rights into development discourse can be problematic. This is because development approaches utilise human rights language in a way that tends to obscure the differences that need to be drawn between human rights as an ethical construct versus its depoliticised and instrumental use by development - currently embodied in the dichotomy between human rights and human rights-based approaches (Gready and Ensor, 2005). Mainstream development practice fails to distinguish between the instrumental use (almost if as a value in itself) of the rights-based approaches versus the intrinsic value of human rights and their capacity to advance the human rights project (Cornwall and Molyneux, 2006).

Hence, although I do agree that not all HSRs based on a human rights-based approach will lead to the elimination of structural inequality, I think that human rights as a social justice construct can indeed be important as a step towards equality. That is, I think that human rights do not in themselves challenge unequal power hierarchies but they have the potential to serve as enablers of change. In this sense, I agree with scholars challenging human rights discourses such as Berry (2010) and Morgan (2014) but only in so far as acknowledging the harm caused by the misuse of human rights and human rights-based discourses.

Externally imposed human rights-based approaches often ignore contextual complexities and restrictions inflicted upon the duty-bearers and right-holders (Unterhalter, 2010). Also, international aid agencies and practitioners tend to treat discourse and terminology as if they were themselves capable of acting as agents of change (Standing, 2004). In addition, structures of gender inequality within society profoundly condition attitudes towards the human rights-based discourse and initiatives related to it (Unterhalter, 2003; Standing, 2004). The wider conditions of gender injustice associated with masculine and feminine identities such as negotiations between partners, family members and others beyond the family may make change particularly challenging (Greany, 2008). This all goes to confirm that the existing international framework is not enough.

Theoretical Approaches to Maternal Health

This section will outline existing approaches to maternal health and mortality, their purposes and their relation to this thesis. This will be done as a way to identify the approach that is most useful for this research. This section will then explain in detail the theoretical approach used in this thesis and the standard of analysis established by this particular framework. At the end, this section will link the importance of the chosen theoretical approach for my work and the dialogue that is established throughout this thesis with this particular approach. This dialogue will become even clearer in Chapters II and III, in particular when setting out the research questions and the research hypothesis.

Maternal health strategies have received a fair share of attention from scholarship. Epidemiology, for example, has a long history of studying maternal mortality as a way of understanding the biological, social and economic determinants of health (Béahgue and Storeng, 2013). This research has rejected the excessive focus policy makers put on cost-effectiveness and targeted health programs (Béahgue and Storeng, 2013). Epidemiology scholars point to the importance of not marginalising other types of evidence that take into account the many processes associated with healthy behaviour and a healthy life (Amaral et al., 2011). Epidemiological studies have also been able to successfully address problems in the registration of maternal mortality rates in developing countries by providing the area with pragmatic reviews and solutions for optimal measurements (Graham et al., 2008)., In addition, most notably, this field of research has established the significant role of strong health systems in the interplay between maternal health, mortality and morbidity (Amaral et al., 2011). This approach is particularly relevant as it draws attention to the importance of quantifying health outcomes while at the same time noting that indicators are only general to the overall state of health and equality.

Another alternate view is presented by public health specialists exploring the role of globalisation on health policy making and implementation. This part of the scholarship focuses on the role transnational policy networks play on health sector reforms at the national level (Ewig, 2010; Weyland, 2007). It extensively explores the nuances behind collective efforts driven by global human rights strategies and the limits these efforts impose on national policy makers' freedom in the choice, design and implementation of reforms (Koivusalo, Schrecker and Labonte, 2009). It argues that global players are the main power holders of health policy making and are therefore responsible for the creation, transformation and dissemination of mainstream discourses (Koivusalo and Ollila, 1997). There are various strands within this scholarship, all looking at the relationship between blueprint makers and implementers. One particular strand notes that these constraints imposed on national governments by international commitments can be both formal and informal (Baptista and Mattos, 2011b). This part of the scholarship notes that the inability to understand the power of actors and discourses in challenging or maintaining the status quo can critically impair gender equality strategies (Doyal, 2000). This approach makes a crucial dissociation between mainstream and non-mainstream discourses. It notes that mainstream discourses often use gender policies to legitimise unequal power as they tend

to ignore the unequal context in which gender strategies are inserted into - such as those replicating patriarchy and/or elitism.

Human rights scholars, on the other hand, tend to look at the judicialisation of maternal mortality cases in order to determine the effectiveness of strategies focusing on the interplay between human rights and maternal health (Cook, Dickens and Fathalla, 2003; Cottingham et al, 2010). This scholarship has been important in establishing the definition of reproductive health and rights as well as consolidating it as a prestigious field of study (Cook, Dickens and Fathalla, 2003). Human rights experts have been successful at using this framework to establish the right to be free from preventable maternal death as a fundamental right (Yamin, 2005; Galli, 2002). However, the predominant part of this scholarship particularly departs from a human rights-based approach as a means of assessing as well as guaranteeing the implementation of the human right to health (Yamin, 2005). As noted above, the problematic use of human rights-based approaches by the hegemonic development community impairs the ability to use this part of the scholarship in answering the concerns raised by my research. A slightly varying approach within this scholarship is presented by Cottingham et al. (2010). Their strategy departs from a standpoint that defines maternal mortality as a public health concern (already established by Galli (2002) and Cook, Dickens and Fathalla (2003)), but also argues that maternal mortality often needs to rely on more forceful international human rights law to argue for its implementation (Cottingham et al., 2010). The latter is particularly useful for my work as it provides a better understanding of the specificities of maternal health and mortality in the face of general human rights rules. This literature claims, as I also do, that more forceful laws and policies aimed at equal health maternal health outcomes must be centralised - i.e. with strong guidelines that reject claims based on moral grounds - and move beyond primary health care - in other words, that incorporate praxis and properly include actors and institutions outside the health sector (Cottingham et at., 2010).

Conversely, Shiffman and Smith (2007) attempt to analyse why some health initiatives prevail over others. They do this by creating a theoretical framework to systematically determine priority setting in development at the global level. Here, political priority is the type of political activity that guarantees: an expression of sustained concern from political leaders; enactment of policies to address the issue; and creation of resources that are commensurate to the severity of the issue (Shiffman and Smith, 2007). The scholars trace

the processes related to policy making and implementation in order to look at the different interests involved in the construction and implementation of a global maternal health programs (Shiffman and Smith, 2007). They particularly focus on the 1987 United Nations Safe Motherhood Initiative to establish what and whose interests prevailed over others and why that occurred (Shiffman and Smith, 2007).

The Main Theoretical Framework of the Thesis

Shiffman and Smith's (2007) framework is divided into four aspects or descriptions which are then subdivided into eleven factors that may in some way be responsible for the inclusion or exclusion of maternal health as an issue by the mainstream development agendas. The four aspects are: (i) the strength of actors involved in a particular initiative; (ii) the power of strategies (ideas and discourses) used to portray an issue; (iii) the nature of the politico-historical context; and (iv) the characteristics of the issue itself. Each aspect is subdivided into sub-categories called factors which are then able to precisely determine the scope of the main categories of analysis. The strength of actors is defined by: policy networks cohesion; leadership; guiding institutions; and civil society mobilisation. The power of strategies is framed by: the internal understanding around the issue (i.e. the consensus-building capacity); and the external portrayal of the issue (i.e. the capacity to acquire political support). The context is observed through: political moments and/or opportunities; and the governance structure that determines a platform for collective action. Finally, and most importantly, the characteristics are set out by: the indicators; the severity of the problem (in relation to similar health problems such as child mortality); and the effectiveness of interventions (in relation to other proposed means of addressing the issue).

Indeed, in terms of the last aspect, the characteristics of the issue, Shiffman and Smith (2007) identify three factors that in their opinion impede the success of international maternal mortality initiatives: (i) accurate measurement of maternal mortality is technically difficult (indicators); (ii) maternal deaths are not as common as other high-burden disorders such as HIV/AIDS and malaria (severity of the problem); (iii) the interventions to

avert maternal death are not as simple and cheap as other health-related problems such as diseases preventable by vaccines (effectiveness of interventions).

There is however a crucial point that is not included in this list which relates to the inability of the international community to afford real value to health initiatives that benefit women only. That is, initiatives that value women and their rights without dealing with them as an only valuable if instrumental to something else such as childbirth or childrearing. Health systems' frameworks emerge from specific discourses and these discourses have the potential of sedimenting or challenging socially constructed roles and concepts (van Olmen et al, 2012). Maternal mortality reduction programmes and policies can be potentially limited by the co-existence of an ideal of health systems as promoters of social justice and targeted approaches that rely on an instrumental use of women's rights for legitimation (van Olmen et al, 2012).

Although limited by the study of agenda setting at the global level, this revised framework, which builds on the work of Shiffman and Smith (2007), is capable of analysing all the complexities that are normally related to women's rights activism on maternal health. It therefore differs from epidemiological; international human rights; and political economy perspectives by opting for a more comprehensive model for testing empirical material in the face of cases where maternal health as an issue suffers from cycles of ascendance and neglect (Shiffman and Smith, 2007). Shiffman and Smith's (2007) characterisation of the problems faced by maternal mortality activists will be used as the theoretical framework of this research. The framework will serve not only as a means of testing the empirical findings of this research but also as the basis for the structure of the thesis. The chapters of this thesis will be organised in terms of the four key aspects indicated by Shiffman and Smith (2007). All of the thematic chapters will also integrate the Shiffman and Smith (2007) framework with a Foucauldian discourse analysis of power and inequality (Foucault, 1980; 1991; 1994). In this sense, the framework will nevertheless also take into account the discursive elements that orient and/or legitimate this limited space for political action. More importantly, it will deconstruct the use of women's rights and social justice discourse and classify them in terms of their rhetorical and real values. The Brazilian case of maternal mortality reduction strategies illustrates my argument. The critical theories used to inform the theoretical framework will be discussed in the section dedicated to the literature review. See Table 1 below for the theoretical framework - my

adaptation of Shiffman and Smith’s (2007) framework in bold - used in this thesis to flag the determinants of political priority for maternal mortality initiatives:

Table 1 - Theoretical Framework

Aspects	Description of Aspects	Factors Shaping Political Priority	Description of Factors
A. Actor Power	A. The strength of individuals and organisations dealing with the issue	1. Policy Community Cohesion 2. Leadership 3. Guiding Institutions 4. Civil Society Mobilisation	1. Degree of coalescence among networks of individuals that are centrally involved in the issue at the global level 2. Presence of individuals capable uniting the policy community and acknowledges as particularly string champions for the cause 3. Effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative 4. Extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue
B. Ideas	B. The ways in which those involved with the issue understand and portray it	5. Internal Frame 6. External Frame	5. Degree to which the policy community agrees on a definition of, causes of, and solutions to the problem 6. Public portrayals of the issue in ways that resonate with external audiences such as political leaders or organisations that control resources
C. Political Context	C. The environment in which actors operate in or dialogue with	7. Policy Opportunities 8. Governance Structure	7. Political moments when conditions align favourably for an issue, presenting opportunities for advocates to influence decision makers 8. Degree to which norms and institutions operating in a sector provide a platform for effective collective action
D. Characteristics of Issue	D. Particular features that help and/or compromise strategies related to the problem	9. Credible Indicators 10. Severity of Occurrence 11. Effectiveness of Interventions 12. Values	9. Clear measures that show the severity of the problem and the tools that can be used to monitor progress 10. Size of the burden of the problem in relations to others, as indicated by objective measures such as mortality levels 11. Extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive in relation to the resources available 12. Indications of whether policy makers to afford real or merely rhetorical value to initiatives addressing the problem

(Adapted from: Shiffman and Smith, 2007: 1371)

Understanding Policy Change through Health Sector Reforms in Brazil

Public health policies geared towards social justice have no effect if not inserted into a wider culture of political measures for positive change (Mackintosh, 2002). In this sense, a historical analysis is critical to understanding to what extent and why women's rights were marginalised in reform processes in Brazil's health sector over the past three decades. Research in Brazil from the 1980 to 2000s demonstrates that strategies for the reduction of maternal deaths were largely mediated by organised social groups (such as feminists, health and democracy advocates, religious organisations and urban workers' trade unions) either through the creation of new political concepts such as women's right to integral health care, or by prioritising or targeting issues (Almeida, 2002; Osis, 1998). All social movements, whether in health or not, changed as the political scenario changed (Costa, 2009). In health, all these diverse groups initially formed a platform in opposition to the authoritarian government, then took part in open dialogues with the State during the democratic transition and later acted on institutionalised instances of participation (Costa, 2009).

As stated above, considering these contingencies, and to this end, this research undertakes a historical analysis of the different discourses used in policy making and political strategies implemented by different actors promoting the institutionalisation of human rights in public health sector reforms principles and practices. More specifically, this research considers the extent to which reproductive health services have been marginalised by the reform processes in Brazil's health sector over the past three decades. This marginalisation has had significant implications that are reflected in the country's continued failure to effectively tackle high maternal mortality rates despite renewed emphasis placed on these goals, for example via the Millennium Development Goals (MDGs). Moreover, discourses surrounding the capacity of a rights-based approach to fulfil these goals continue to ignore underlying social structures that influence power, agency and context, consequently grounding the notion of rights (Standing, 2004). Thus, I would argue that current mainstream discourses, adopted since the period of transition to democracy, use a human rights-based approach that ignore these underlying factors. They also cloud progressive discourses that were created during the transition to democracy but

have been marginalised ever since. For example, and as explained later on in this chapter, Marxist constructions (such as collective health) put forth by the movement for health and democracy (movimento sanitaria) have thus far been marginalised by mainstream agendas for health reforms, in particular by those creating and/or implementing international blueprints.

Drawing on a process of policy analysis, the research seeks to determine why reproductive health services have not benefited from the expected advantages of decentralisation in Brazil (Rondinelli, 1981; Souza, 1996; Bossert, 1998; Almeida et al, 2000; Bossert and Beauvais, 2002). A Foucauldian discourse analysis is utilised in order to assert the power dimensions and relations related to the creation, dissemination, appropriation, transformation and re-appropriation of knowledge (Gasper and Apthorpe, 1996; Van Dijk, 2001).¹⁵ Moreover, the mapping of epistemic communities and policy legacies¹⁶ is done in such a way so as to trace the evolution of the different discourses and real meaning attached to them by different policy networks (Ewig, 2010). It particularly seeks to differentiate between the objectives, effects and political dimension of the use of human rights discourse as a social justice project and human-rights based approaches as depoliticised technical strategies (Cornwall and Nyamu-Musembi, 2004).

The Brazilian case study is situated within wider debates of health sector reforms in Latin America, inequalities of access to health care and its implications to women's health and gender equity (Bossert, 1998; Atkinson et al, 2000; Ewig, 2010). It explores how policy networks have influenced the use of a reproductive rights discourse while in fact promoting a population control agenda (Doyal, 1998; Shiffman et al, 2004; Bloom and Standing, 2008; Ewig, 2010). It evaluates the extent to which human rights approaches have been transformed over time and, to a great extent, co-opted by the hegemonic development discourses, embodied in mainstream human rights-based approaches, and how far it contributed to the marginalisation of reproductive health in Brazil. Rather than evaluating the current status of reproductive health, this thesis seeks to understand the processes

¹⁵ Foucault (1980; 1991; 1994) provides a framework of analysis of the discursive regime based on power and knowledge. Bhabha (1990), Mohanty (1991), Agamben (1995) and Escobar (1995) supply analysis of processes of marginalisation of discourses and articulations of forms of difference.

¹⁶ Epistemic communities and policy legacies are both policy networks but are nonetheless very different from one another (Ewig, 2010). The differences and specificities of each of these categories is discussed in detail later on in this chapter.

behind the policies and strategies that shaped the 1980s and 1990s public health reforms. The current status of maternal health in Brazil reflects my analysis in terms of the status of maternal mortality as an issue versus the processes claiming to implement a human-rights based approach to maternal mortality.

In brief, the previous sections discussed the importance of studying maternal mortality and human rights-based discourses claiming to advance maternal health. It presented academic discussions addressing the issue and establishes the most useful one as its theoretical framework (with all the appropriate changes). In the following sections, I will extend on the pertinence of the research by discussing the background of the problem, the purpose of the study, the nature of the study, the research questions, the hypothesis and the theoretical framework. Thereafter, I will present the outline for all chapters giving a brief description on how each chapter contributes to answering the research question. Chapter II will assess the existing scholarly debate in more detail while Chapter III will explain the methodological problems as well as the tools and literature review used to orient the purpose of this research.

Health Sector Reforms as Reproducers of Inequality in Brazil

The gendered character of welfare provision in Latin America - i.e. patriarchal and maternalistic – serves to confirm the inherently unequal character of social policy making (Guy, 1990). Indeed, most current social policies in the region rely on poverty reduction programmes that reinforce gendered constructions and tend to re-traditionalise gendered roles and responsibilities (Molyneux, 2007). It has been argued by United Nations agencies that Latin America and Caribbean reproductive health country systems are among the largest contributors to gender inequality in the world (UNDP, 2010). Conspicuously, Brazil is reported as the paradox of the region (UNDP, 2010). This is reflected and justified by the country's heterogeneous model of development. The government of Brazil has often focused on industrialisation and agrarian competitiveness without considering their consequences or the regional disparities in its physical

environments and historical legacies (Henshall and Momsen, 1974). As a result, its unprecedented economic growth was not accompanied by a comparable commitment to regional equality and social justice (Henshall and Momsen, 1974; Victora et al., 2011). However, the country's productivity has usually overshadowed and distorted notions within the mainstream development community of an alleged exemplary social development and positive political environment nurturing a more equitable society (Cohn, 1995). This 'Brazilian myth' - of an example of social justice policies - has then been replicated in the international fora without much deconstruction of these misleading superlatives (Henshall and Momsen, 1974; Teixeira, 2003). As it will be observed throughout this thesis, the 'Brazilian myth' is nothing more than a selective model of development that benefits only the chosen few.

First and foremost, although United Nations agencies construct this critique of inequality in terms of gender equality (which often means creating policies that benefit only women), the real issue lies in the differences and imbalances in class and race (see discussion on intersectionality explained in detail in Chapter II). For example, while studying stratification - race, class and gender - and economic crises, Seguino (2013) notes that globally low class black men suffer more from the long-term effects of unequal distributional dynamics than any other social group. Similarly, Hawkes and Buse (2013) have found that globally, there is a higher death rate and a higher burden of disease amongst men than women but, at the same time, men are rarely taken into consideration by actors shaping global health blueprints. However, in spite of Hawkes and Buse's (2013) alarming finding, working class black women die more frequently from preventable deaths when compared to men - even when compared to men of the same class and race (Seguino, 2013). So, this is not only a gender issue, but one of class and racial justice. In this sense, global strategies not only fail to deconstruct erroneous symbols such as the 'Brazilian myth' (Henshall and Momsen, 1974; Teixeira, 2003), they also leave out the gender dimensions and the real health problems impinged upon people of lower classes and historically marginalised races (Hawkes and Buse, 2013). As a result, understanding that global health strategies are inherently political, it is important to challenge interests perpetuating not only gender norms (and the perception of gender as a women-only affair) but also class and race norms (or their absence).

The same patterns observed at a global level also exist at a national level in Brazil. Since the beginning of the 2000s, with the rise of the Worker's Party (PT) to the presidency, the Brazilian government has implemented a series of policies aimed at the reduction of social inequality (Sánchez-Ancochea and Mattei, 2011). These policies are part of a wider political package proposing poverty reduction measures (Sánchez-Ancochea and Mattei, 2011). For example, the most widely known policy, the Bolsa Família (Family Grant), provides conditional cash transfers to 13 million people and supports (as its main condition) one third of all children attending primary school (Barrientos, 2013). The promises and expectations of the capacity of these programmes to tackle the poverty gap in the country are numerous (Barrientos, 2013). However, the rhetoric of change has not been accompanied by a comparable positive development mostly because Bolsa Família does not present any challenge to structural poverty (Sánchez-Ancochea and Mattei, 2011) which is absolutely necessary for the substitution of an effective and inclusive social policy (Chant, 2006). One of the many shortcomings of conditional cash transfers, and the poverty reduction packages promoting them, is that they perpetuate inequality by reinforcing socially constructed roles, in particular asymmetrical gender roles (Molyneux, 2007). Thus, although Brazilian poverty reduction packages have been named as an example of success by some international actors such as the World Bank, thorough research has established that these policies will only result in long term and structural change if coupled with a real commitment to the reduction of inequality in health and education (Sánchez-Ancochea and Mattei, 2011).

Bolsa Família is a social assistance programme and, as part of a three-pronged social security system which aims to guarantee basic services to all citizens, is aimed at attending the individual needs of vulnerable citizens (Fleury, 2000). Nonetheless, “[s]ocial assistance as an institution is ultimately a reflection of shared social values and objectives” (Barrientos, 2013: 888). That is, if social assistance packages and/or policies are built and promoted for purely rhetorical reasons (to attain legitimacy and political adherence but with not commitment to change), then no substantial change will ensue if this is not combined with a real commitment to reducing inequalities. In terms of rhetoric, although social assistance institutions are underdeveloped in Brazil, Bolsa Família successes have been instrumental in the re-election of Lula as president in 2006 (Barrientos, 2013). Unfortunately, in terms of a real commitment to equality, not much research has been able to demonstrate that programmes such as Bolsa Família are reflective of an egalitarian

political will (Sánchez-Ancochea and Mattei, 2011). In sum, poverty reduction packages will only work if populist attitudes are drastically changed in favour of politically inclusive strategies benefiting lower classes and historically marginalised groups.

Moreover, social assistance policies are supposed to be combined with equitable health and pension strategies in order to guarantee the enjoyment of fundamental rights (Fleury, 2000). However, the new rise and sharp focus on social assistance programmes has diverted funds from pension schemes and the public health system (Barrientos, 2013). This not only weakens progress achieved in pension and health systems, (such as universalism), but also strengthens historic patterns that guarantee access to resources to a selected group of individuals (Hunter and Sugiyama, 2009). Although social assistance programmes are valuable, in particular at times of crises, focusing on them is short-sighted and insufficient in overcoming unequal power structures that reproduce persistent poverty (Barrientos, 2013). Moreover, social assistance programmes can lead to stratification and path dependency which can be conceptualised as a catalyst, or even a type of violence in itself (if understood in broad terms) (Colen, 1995). Rather than liberating people out of poverty, social assistance programmes can increase the level of dependency on hand-outs, facilitate clientelism, and fragment social service provision (a negative 'policy feedback') (Barrientos, 2013). In this sense, it is therefore important to guarantee investments in sectors such as health which are really able to deliver long-term results to help remove and maintain people out of poverty.

As Molyneux (2007) found with social assistance, political activism for the reduction of health inequality has been oriented by egalitarian philosophical constructions such as universalism. The literature on this suggests that despite the introduction of regulatory measures to increase efficiency and reduce inequalities in the health sector, health care access and provision remains extremely unequal across the country (Diniz, d'Oliveira and Lansky, 2012). Some research even suggests that recent reforms have in fact contributed to the increase of inequalities and problems in the health sector (Almeida et al., 2000; Almeida, 2002). Theoretically, Brazil's Unified Health System should guarantee equal

access and quality of services to all citizens (Victora et al., 2011).¹⁷ Over the past decades health interventions reached almost universal coverage, yet quality of service was not universal (Diniz, d'Oliveira and Lansky, 2012). However, people in vulnerable and lower income groups experience more difficulties in getting access to quality services and women are still disproportionately affected (Diniz, d'Oliveira and Lansky, 2012).

Brazil is well known for improving some health indicators and benchmarks (Paim et al., 2011). It has made significant progress in tackling challenges in some areas of the health sector; some indicators have improved and benchmark standards met (Almeida et al., 2000). In particular, successful policies have been identified in areas dedicated to programmes such as HIV/AIDS, immunisations and child mortality (WHO, 2003).¹⁸ Indeed, Brazil has experienced broad economic growth and a public budget that grows accordingly, but reproductive health indicators have remained poor compared to the progress observed in children's health indicators (WHO, 2010). Access to most maternal health interventions increased sharply while regional and socio-economic disparities decreased notably, yet these changes have not benefited all women equally (Diniz, d'Oliveira and Lansky, 2012). Although the country has the capacity of reducing maternal mortality rates, it has not expressed a sincere commitment to dealing with the maternal mortality affecting lower class black women (Almeida, 2002).

Official statistics show that maternal mortality rates have been stable in Brazil for the past ten years (Victora et al., 2011). While Brazilian scholars give a variety of explanations for the slow reduction of maternal deaths over the last decades. Nonetheless, all agree that progress has been unjustifiably slow and burdensome for lower class black women. Although there were changes in socio-economic and demographic status and non-sector specific interventions, some say that the stability has been a product of improved death

¹⁷ Access through citizenship is very complicated as, contrary to what is normally argued publicly, citizenship is not really that universal in itself. Moreover, citizenship excludes those people that are not formally associated with a particular government. Nonetheless, Sepulveda (2005) has demonstrated that the feminist concept of citizenship used in women's rights activism in Brazil differs considerably from North American and European constructs. In Brazil, feminist citizenship relates to political participation as a premise for the enactment and exercise of rights (Sepulveda, 2005). In this sense, with some exceptions, citizenship may pull women's rights activists together while obliterating the differences within the members of each particular group.

¹⁸ Brazil has, for example, been very successful in reducing child mortality rates and increasing child vaccination in the last three decades (Victora et al., 2011).

registration procedures and increased number of investigations into deaths of women of reproductive age (Volochko, 2010). This is due to the presence of maternal mortality committees in all 27 states, 172 in sub-state regions, and 748 in municipalities (Victora et al., 2011).¹⁹ Slow improvements may also be due to the fact that the indicator (MMR) was not always considered as a general indicator of living standards, as it was perceived as a costly and difficult measurement to operationalise (Corrêa, Alves and Januzzi, 2006). That is, maternal deaths were not considered as harmful to women's wellbeing, or considered so unimportant that no efforts were put in place towards the investments of adequate tools to trace its development over time. Moreover, maternal health programmes (such as the National Programme for the Humanisation of Antenatal Delivery and Post-Partum Care of 2000) have always been implemented in parallel to the mainstream health system (Osis, 1998; Diniz, 2010). This might not seem relevant at first glance, but the symbolic meaning of the question must not be ignored. Maternal deaths were not a public policy priority and for this reason, programmes addressing the issue were also set aside in marginal positions and with marginal budgets. For that reason, although there was the reduction of absolute inequality, there was little increase in the relative inequality (Paim et al., 2011). In this sense, poor, vulnerable and disadvantaged women continue to suffer the most in terms of preventable maternal deaths (Diniz, d'Oliveira and Lansky, 2012).

More specifically, according to the WHO, 4,100 maternal deaths take place each year in Brazil (WHO, 2010). The country has one of the largest rates of maternal deaths in the world, accounting for over a quarter of Latin America's maternal deaths – not proportional to its population size (WHO, 2003). While globally, the number of women dying due to complications related pregnancy and birth has decreased by 34 per cent between 1990 and 2008 (WHO, 2010), Brazil's rate only decreased by 3.9 per cent (Horton, 2010). In Brazil, the main causes for maternal mortality are, in order of relevance: (i) hypertensive disorders (23%); (ii) indirect causes (17%); (iii) other direct causes (14%); (iv) sepsis (10%); (v) haemorrhage (8%); (vi) complications of abortion (8%); (vii) placental disorders (5%); (viii) other complications of labour (4%); (ix) embolism (4%); (x) abnormal uterine contractions (4%); and (xi) HIV/AIDS related disorders (4%) (Victora et al., 2011: 1866).

¹⁹ Maternal Mortality Committees (Comitês de Mortalidade Materna) are inter-institutional organisations that are responsible for investigating all maternal deaths and proposing policy changes for their prevention. They were created in 1931 in the State of Philadelphia, United States, and then replicated elsewhere. The first Brazilian maternal mortality committees were formed in 1988 in the State of São Paulo and with the support of women's rights movement (Brazil, 2007).

Major challenges lie in high frequency caesarean sections, illegal abortions, pre-term births and regional and socio-economic inequalities in health (Victora et al., 2011).

Moreover and of particular importance, in Brazil, maternal deaths occur more frequently within groups of lower class young black women (Ferraz and Bordignon, 2012). Maternal mortality rates are acute amongst: (i) single women (53.1%); (ii) black or mixed race women (42.7%); and (iii) women with low levels of literacy (23.8%) (Ferraz and Bordignon, 2012: 531). The regional variation in maternal mortality rates demonstrate severe levels of inequality suffered by lower class black women in the country (Brazil, 2007). The North and Northeast regions, historically poorer and disadvantaged, register higher maternal mortality rates than the South and Southeast regions, historically richer and resourceful (Victora et al., 2011). The North and Northeast are, unsurprisingly, the regions with the largest number of people from Afro-descent (Ferraz and Bordignon, 2012). This serves to demonstrate how the issue of class and race are almost inseparably intertwined in the Brazilian context. They are almost inseparable in all contexts in fact.

Furthermore, values and evidence of the determinants and consequences of health and illness used in health reforms are male biased (Standing, 1997). Values and evidence may be used to influence policy implementation and/or as part of a wider governmental rhetoric (Koivusalo and Ollila, 1997). Therefore, values and evidence (or lack of it) are used to orient policy decisions and discourses in a gendered manner (Walt and Gilson, 1994; Koivusalo and Ollila, 1997). The fundamental variation lies in valuing women's health intrinsically – i.e. as a good in itself – or instrumentally – i.e. as a value towards other more valuable goals (Koivusalo and Ollila, 1997).

In fact, with the rise of the global economic crisis, market-oriented institutions issued new calls for further structural reforms in Latin America (Powell, 2013). Yet, these calls neither deconstruct reformist concepts and interests nor assess the underlying causes of such type of crisis (Powell, 2013). From June 2013, there have been several widespread urban social uprisings across Brazil denouncing the distribution of the costs and benefits of progress including the effect of aggressive economic policies on the public health and education sectors (Santos, 2013). As a result, the government of Brazil is now attempting to address some of the uprising's many social demands, such as the shortcomings of the 1980s and 1990s health sector reforms.

In this sense, and as stated before, this research will attempt to determine the impacts of decentralisation reforms as a rhetorical tool, specifically in terms of maternal health reduction strategies and policies. It will be important to know: (i) if coordinated social policy making, implementation and state institutional capacity account for a real or merely rhetorical²⁰ interest in using rights-based approaches to women's rights and reproductive health; (ii) if processes related to the implementation of health policies at the municipal level do occur as envisaged by the decentralisation programme and health sector reforms; and (iii) whether the different institutional contexts (national, state and municipal) affect the specific characteristics of the reform's policy programme, and its overall social effects - in terms of the nexus between reproductive health, human rights, and equity.

Crises, Reforms and Decentralisation of the Health Sector

The effects of health crises and reforms are normally evaluated in terms of the organisational aspects and principles of social security (Mesa-Lago, 2010). As a result, structural economic reforms implemented at country level tend to focus on restructuring the delivery of and access to health care (Ewig, 2010; Mesa-Lago, 2010). Grindle (1996) argues that the State's response to crises can be divided into the: (i) reasserting of institutional capacity through new rules and institutions; (ii) taking advantage of increased participation of technocracy to advance market interests and insulate economic policy making; (iii) compensating of weak administrative capacity through policy experimentation; and (iv) increasing political capacity to respond to social demands.

²⁰ Throughout this thesis, the words real, intrinsic, essential and inalienable will be used interchangeably to mean the genuine commitment to human rights as a social justice project. Similarly, the words rhetoric, instrumental and subordinate will be used to mean the opportunistic use of human rights language for other purposes. This research acknowledges that there is not 'truth' but only different positions that are portrayed differently through discourse. This separation between intrinsic and instrumental aims in this sense to determine who benefits from the use of specific discourses, in this case human rights-based discourses.

As a response to different economic crises, organisational reforms oriented by efficiency interests were implemented throughout Latin American countries in the 1980s and 1990s (Iriart, 2005). An attempt at improving existing health conditions including women's basic reproductive health indicators – i.e. maternal mortality ratio and adolescent fertility rate - has been implemented through the decentralisation of public health systems throughout Latin American countries (Mesa-Lago, 2010). Decentralisation was usually introduced as part of a wider package to avert and/or counteract economic and health crises (Rondinelli, 1983). In Latin America these reforms mostly meant the partial or total privatisation of the public health sectors (Mesa-Lago, 2007). This was largely due to the historical presence and power exerted by the United States in the region (Mesa-Lago, 2007).

In Brazil, the provision of public health services was decentralised in 1984-1988, in order to: (a) transfer responsibilities, administration, and implementation of social programmes from the national to State and Municipal levels and to private providers; (b) create social control of the allocation of public social expenditures to better reach minority localities and groups; (c) enable increase participation in decision-making; (d) to guarantee the equal enjoyment of the benefits of growth; (e) integrate regions; and (f) to efficiently use resources to promote the development of poor or minority areas (Rondinelli, 1981; Iriart, 2010). These points are not analysed in detail in this thesis as this research sets out to understand the discursive tools used to replicate existing unequal power structures and not the specific effects of decentralisation as a political construct. The point here is to flesh out the differences in the rhetoric that re-constructed decentralisation in the 1980s in order to set out the grounds for discussion on the gaps in the empty rhetoric used for its implementation in the following decades.²¹

As will be developed in Chapter VII, although decentralisation is not necessarily a market-oriented term, it has been used as part of first and second-wave neoliberal reforms in Latin America (Ewig, 2010). First wave reforms were shaped by structural adjustment

²¹ Classical debates on rhetoric, persuasion, truth and knowledge define rhetoric as the ability to use language to effectively please or persuade (Aristotle, 2010). According to this definition, the simple use of rhetoric as the art of persuasion is not necessarily negative or leading to a negative outcome (Aristotle, 2010). Here, I distinguish the classical meaning of rhetoric from empty rhetoric. Empty rhetoric is used as a synonym to empty and malicious discourses; those that use otherwise benevolent words and concepts to actually advance an elitist cause.

programmes²², whereas the second wave were a response to criticisms against the first wave which, in spite of representing a change to the neoliberal's approach, nevertheless increased the same problems posed by the first wave of reforms such as targeting and the reduction of budgets of specific social policy arenas (Ewig, 2010). Neoliberal reforms have the potential to widen the gender inequality gap by replicating embedded power distributions particular to health sectors (Almeida, 2002; Ewig, 2010). In this sense, and given that Brazil is discussing ways to guarantee the success of its public health system, this research will attempt to determine the impacts of decentralisation reforms specifically in terms of discourses addressing maternal health policies and their processes of implementation.

The Research Questions and Hypothesis Deconstructing Maternal Mortality Reduction Strategies

This thesis aims to answer to the following question:

How did the different policy networks pushing for a women's rights agenda participate in the framing and use of social justice discourses during the 1980s and 1990s health sector reforms in Brazil and how did it affect maternal mortality reduction strategies?

Focusing specifically on maternal mortality, the thesis explores:

- (i) if coordinated social policy making, implementation and state institutional capacity promoted any change in maternal health activists' discourses;
- (ii) if implementation at the municipal level happened as set out by the decentralisation programme as part of philosophical constructions created by social movements or as part of neoliberal reforms' rhetoric; and
- (iii) how the different institutional levels (global, national and municipal) affected the specific characteristics of the reform's policy programme, and its overall effects in the

²² Structural Adjustment Programs, SAPs, are economic policies set out in the 1980s and the 1990s by the World Bank and the IMF to Third World countries. These policies were essentially attached to conditional financial loans that demanded the reduction of State investment and participation in favour of the private sector.

interplay between the human rights-based approach as a technical tool and its ethical origins, i.e. human rights as a political project for social justice.

The hypothesis of this research is that the use of social justice discourses in mainstream policy debates and by women's rights policy networks contributed to the marginalisation of reproductive health and impaired the implementation of maternal mortality reduction strategies in Brazil in the last three decades.

To address the questions exposed above, it was necessary to conduct a historical mapping and policy analysis of health policies related to women's rights, maternal mortality reduction strategies and decentralisation in Brazil. In addition, to test the hypothesis on the policy implications of using social justice discourses to decentralisation of maternal health and women's rights, this research draws on an in-depth case study of political activism related to the processes of decision-making and implementation of maternal mortality reduction policies and programmes.

Unpacking of Terms and Deconstructing Discourses

Language matters (Petchesky, 2003). The use of specific language carries concepts that legitimate and/or advance the interests of certain fields and networks. Language, therefore, serves to advance the power of particular discursive fields (i.e. development, planning or medical). Language limits or advances the power of particular discourses over other within discursive fields. It also serves to create legitimacy by creating threads of discursive practice that reaffirm one another. For example, particular concepts may gain hold within fields (which will also be divided to varying degrees) and then penetrate to the wider population without much deconstruction or challenge. Expertise in fields knowledge and participation in policy networks controlling the use and spread of concepts require control over the key concepts (and all their variations and transformations over time) and over the way these concepts are used to further a particular political agenda. In this sense, concepts used in policy making - and certainly in development - dictate the hegemonic culture through the persuasive mainstream of values as facts, which in short initiates and installs support for interventions based on a particular ideology (Massey, 2013). As soon

as new words are developed or assigned new meaning, they are appropriated by particular policy networks becoming intelligible to others (Cornwall, 2010). Words are awarded with an arguably 'scientific' and 'technocratic' status in discourse which shields it from any questioning or unpacking (Leal, 2010; Uvin, 2010).

The process of creating, disseminating, appropriating, transforming and re-appropriating discourses is key to this research (Foucault, 1980; 1991; 1994). The analysis of discursive processes considers key policy positions that shape certain policy interventions in terms of their approach to a particular issue and their capacity to promote change (Massey, 2013). Development policy intends to persuade through the means of 'polar words' artificially dividing opinions in binaries (Gasper and Apthorpe, 1996: 7). The use of binaries suggests certitude when in fact dealing with highly complex issues and contexts (Leal, 2010). The analysis of the processes creating, disseminating, appropriating, transforming and re-appropriating particular discourses contends that paradigms are deliberately constructed in terms of carefully framed concepts and sophisticated rhetoric supporting each choice (Foucault, 1980; 1991; 1994; Gasper and Apthorpe, 1996).

The evolution of and use of discourses by the hegemonic policy networks working or participating in health sector reforms will be discussed throughout this thesis. This is done because, as established by the Foucauldian (1980; 1991; 1994) approach, as discourse evolves, power dimensions are similarly created and evolving. For the purpose of this introduction, collective health and public health, health equity and equality, health sector reform, municipalisation and decentralisation and rights-based approaches will be discussed in order to unpack and? trace how the different terms are used to mean different things to different people or networks in different contexts. That is, I will be mapping the flows (convergence and divergence) of meaning and establishing the meanings that will be associated with each term in the analysis.

Lost in Translation: Brazilian Discourses on Collective Health and Global Discourses on Public Health

Chapter VI discusses in detail the historical context in which collective health was inserted into. It sets out the political, economic and health regimes that led to the creation and marginalisation of the concept. In brief, 'collective health' is a term used by some social movements (such as health and democracy activists and feminists) in Brazil and indicates a field of knowledge and praxis that recognises health as a social phenomenon (Paim, 2003). It involves a group of technical, ideological, political and economic practices developed within academia, health organisations and research institutes involved in public health reform projects (Paim e Almeida Filho, 1998; Paim, 2003). It was created in the 1970s in Latin America as part of a critique of European and American public health reforms (pushing for public health and hygiene, family medicine and community medicine) and the health paradigm perpetrated by the regional office of the WHO in the Americas, the Pan American Health Organisation, or PAHO (pushing for preventive medicine and primary health care) (Paim e Almeida Filho, 1998).

The Brazilian initiative contended that the 1950s and 1960s PAHO-backed practice of including preventive and social medicine in the curricula of medical schools was incapable of promoting real change (Paim, 2003; Campos, 2006a). Preventive medicine was seen as a successor of public hygiene discourse, i.e. an individualistic neoliberal rhetoric aimed at colonising other public health systems (Paim, 2003). The public health model of care originated in 1900s USA was perceived as narrowly structured towards the provision of preventive care services and disease control strategies (usually provided in health centres and associated with poverty and marginalisation, in the sense that is that they fragmented and marginalised health services for the poor and marginalised) (Campos, 2006a; Mattos, 2006). In this sense, collective health was created as a political term aimed at challenging all existing healthcare models (Arouca, 1975; Donnangelo, 1975).

Thereafter, collective health activism expanded the use of collective health from a political term to a symbol of a broader movement that would then provide the basis for social demands for health sector reforms. In Brazil, the institutional protagonist of the collective health discourse was a leftist think tank called the Brazilian Centre of Health Studies

(CEBES - Centro Brasileiro de Estudos de Saúde) (see chapter V (iii) a)) (Rodrigues Neto, 1997). CEBES was conceived in 1976 and since its genesis pushed for the expansion of the concept of health while simultaneously acting in diversified arenas such as in the wider movement for democratisation (Rodrigues Neto, 1997). The strategy was to opportunistically participate in 'empty' political spaces to create a momentum for democratic reform (Rodrigues Neto, 1997). That is, collective health activists used health issues to mobilise action from collective health to health reform. This clever strategy was very successful in gathering support against the military dictatorship and effectively furthering the democratic cause (Paim, 2003).

The collective health movement relied on Marxist political philosophy in order to present an alternative to the framework created by the liberal model of economic development instituted by the military government in Brazil in the 1960s (Merhy et al., 1992). The collective health movement transformed the public health field redirecting it towards the model of integral medicine that combines the state of health of the population, health services and health epistemology (Paim, 2003; Camargo Junior, 2003; Campos, 2006a; Mattos, 2006). Collective health as a term encapsulates the study of: health conditions of different sectors of the population (epidemiologic, demographic, socio-economic and cultural); the processes of health provision (social organisation of services, policy making and implementation, monitoring and accountability); and historical, sociological, anthropological and epistemological research (scientific knowledge and traditional health practices) (Paim e Almeida Filho, 1998).

Collective health relies on Arouca's (1975) and Donnangelo's (1975) theory of health as a discourse and challenges the old concept of preventive health which, since derivative of social hygiene, is seen to be incapable of promoting social justice. Collective health, as a political construct, calls for changes in the management, organisational and operational models of health systems through: the capacity building of personnel; the scientific and technological development; and the critical participation of all social actors (Paim e Almeida Filho, 1998; Paim, 2003). Collective health assigns to the government ultimate responsibility for the effective, efficient and holistic provision of health services and for the improvement of life standards and the reduction of social inequality (Paim and Almeida Filho, 1998; Paim, 2003). Mattos (2003) argues that collective health, as opposed to public

health, recognises the tensions in liberal approaches to health and does so by making use of a human rights-based approach.

In Brazil, the collective health movement was crucial to the establishment of a momentum towards a reform based on egalitarian principles (Paim, 2003). It articulated the interdisciplinary use of epidemiology, administration and planning in health and social sciences of health (Arouca, 1975; Donnangelo, 1975). It emphasised the promotion of health, the prevention of its risks and aggravations, prioritisation of the needs of patients and the improvement of quality of life (Arouca, 1975; Donnangelo, 1975).

Since the mid-1970s, a debate strived between those claiming for a system with public health as disease control and those arguing for public health as a model for service provision in terms of collective health principles (Baptista, 1996; Mattos, 2003). Although some progress was achieved in terms of introducing collective health to the medical curricula and social sciences research, this side of the debate only gained strength in the 1980s, particularly from 1985 when the movement campaign for reforming the health system was intensified (Baptista, 1996; Paim, 2003). Milestones were reached in the campaign with the considerable articulation and leadership of the collective health movement at the 1986 National Health Conference and the elaboration of the social security chapter of the new democratic constitution of 1988 (Paim, 2003).

Interestingly, when the basic principles for the new health system (the Unified Health System or SUS) were established in the 1988 Brazilian Constitution, public health terminology was used with the incorporation of most of the collective health values (Baptista, 1996). That is, in spite of all the campaigns put in place by collective health activists, the new legislation (i.e. the Constitution and all the laws regulating it) structuring the health sector disregarded the collective health terminology. A paradoxical system was then created using liberal terminology (public health) but claiming to implement Marxist values (collective health). So, conservative language was put in place concealing and marginalising more radical values. In fact, newly developed groups of meanings or political or cognitive tendencies such as collective health itself and integrality (comprehensive care across all sectors beyond health and for all underlying determinants of health) were introduced as part of SUS (Mattos, 2003; Camargo, 2003). This happened as a result of political struggles for policy power in the new democracy in which social justice discourse

had to compete with, and at times be compromised by, market-oriented rhetoric (Fleury, 2003). To an extent, this research serves to clarify exactly why and how public health terminology can co-exist with collective health values.

Yet, as will be discussed in the next chapters, the effectiveness of the implementation of the values was hindered by the institutional and historical context in which the consolidation took place (Baptista, 1996). For now suffice to say that collective health served as an ideological, political and institutional basis for the creation of the new national health system (Baptista, 1996). At the same time, the collective health agenda had to co-exist with the first and second wave of neoliberal reforms which considerably influenced the use of the movement's language and/or values (Almeida, 2002). This dissertation will depart from collective health values as it is most commonly used by Brazilian researchers and health activists, but not by policy makers (most of them representing the interests of a market-oriented elite). This differentiation with public health values might also come to light in some of the interviews with collective health activists - who were also members of the reformist movement.

Promoting Social Justice and Health: Equity or Equality?

The 1988 Constitution established equity as one of the principles of the Brazilian Health System (Paim et al, 2011). However, the use of language that refers to equity is perceived to be more conservative and less effective than language based on equality (Gideon, 2012). This is because equity intends to set out equality of opportunity or access while equality aims to promote equality of outcome. Moreover, the way the concept of health equity is applied is contested particularly from Gideon's (2012) perspective in the sense that, despite claiming to promote gender justice, equity simultaneously depoliticises the issue of social justice. A vast scholarship argues that equity is based on ethical values of distributive justice based upon human rights principles (Almeida, 2002; Diniz, d'Oliveira and Lansky, 2012). Health equity would promote equality through inequality of provision, i.e. it would take into consideration the different needs in order to promote different care which would eventually put people on equal grounding (Diniz, d'Oliveira and Lansky,

2012). The focus therefore would be not to eliminate health differences through policy but to reduce or prevent unjust disparities and different health outcomes (Diniz, d'Oliveira and Lansky, 2012). In other words, equity would require a subjective approach to the definition of just and unjust disparities. Sen's (1999) capabilities approach provides an alternative social justice theory whereby it advances an individual's capacity to enjoy substantive freedoms according to each individual's perspective as a basis to determine what leads to social justice or not. This is then opposed to utilitarian and libertarian theories that either define justice in terms of the utilities (capable of promoting happiness or satisfaction) available to each individual, or in terms of formal liberties and rights, respectively (Sen, 1999a).

This discussion is particularly significant to this thesis as it demonstrates the context in which women's rights strategies and associated policies are inserted into. Each particular approach to equity and/or equality in health sediments the governance structure put in place. It establishes a parameter that determines the degree to which maternal health strategies and policies can promote change and/or replicate injustice. That is, also taking into account the discussion above, a governance structure based on equity as equality in access as standard is problematic as it is vulnerable to the reinforcement of existing power structures and historical inequalities (Gideon, 2012).

Nonetheless, the term equity is often used by development institutions but rarely associated with a theory of social justice or, more importantly, with a social justice praxis (Almeida, 2002). For example, equity has emerged as the primary guiding principle for technical cooperation in health advanced by PAHO in the Americas (Alleyne, 2001). A superficial analysis of PAHO's official position expressed in its 2001 report "Equity and Health" may indicate at first glance that the term equity is used in a manner that takes into account not only the ethical dimensions of material imbalances, but also the importance of underlying determinants that reflect upon health statuses (Alleyne, 2001). However, a more in-depth reading reveals that, in spite of the use of a social justice discourse, PAHO's priority still emphasises WHO's Health for All Strategy, which focuses on systematic reviews concentrated on targeted action, skilled attendants and universal coverage with the promotion of a basic health package supported by primary health care (Alleyne, 2001). These strategies fail to promote equality of outcomes as they stigmatise and marginalise health services for the poor (by placing them only within primary health care) and leave all

underlying determinants of health (such as inequality in access to nutritious food) unaddressed.

Whilst it is important that international development players acknowledge the importance of using social justice language, using it simply for legitimation purposes is not enough. Moreover, the problem of using social justice language purely for legitimation purposes usually means advancing universal health, while actually only promoting pro-poor primary health care through fragmented programmes. Targeted policies are seldom well implemented and mostly serve to only advance one particular discourse of the elite (Mills, Bennett and Gilson, 2008). Targeted approaches have higher financial costs than universal approaches but little social benefit (Bennet, 2008). In most cases, target groups are left feeling marginalised from the programmes which they should benefit from (Mills, Bennett and Gilson, 2008). Yet, at the same time, the mere existence of targeted programmes serves to reiterate the mainstream rhetoric. That is, there is a real danger in using social justice discourse for mere rhetorical purposes, in that it hides the real interests and the networks pushing particular issues forward and conceal others. Secondly, people or groups making use of empty rhetoric select which demands are made visible and invisible while doing so in a non-transparent way. And, thirdly, the use of empty rhetoric marginalises and diminishes social movements by co-opting the language used and created by them, and removing from that language its real and ethical value.

For example, in PAHO's report, the terms equity and equality are defined and contrasted but this is done in an unclear way (Bambas and Casas, 2001). Also, some chapters use equity and equality interchangeably (Alleyne, 2001; Finkelman, 2001). When the terms are contrasted, equity is preferred over equality as if the language of equity was more capable to advance social justice than the one of equality (Bambas and Casas, 2001). Even in these cases (using equity over equality), distributive justice is only dealt with under a conservative framework, i.e. only applied progressively and when possible (Bambas and Casas, 2001). This elusive criteria for the implementation of equity - only in a progressive manner and only when possible - affects the distribution of resources, creates a framework that is difficult to grasp and, most importantly, creates a framework that recognises and praises certain types of inequalities (Bambas and Casas, 2001). The use of mainstream definitions of equity in praxis demonstrate that social justice definitions and differentiations are only seen by hegemonic development practitioners as necessary airbrushes for the

achievement of legitimacy of an elitist agenda. This empty rhetoric - embodied in the use of the term equity over equality - shields international development practitioners from any criticism (Harriss, 2002). In this sense, any approach making use of equity as a term is held as an absolute 'truth' and used to effectively depoliticise gender justice as an issue by removing any possibility of contestation of values, which in itself is essential to radical political activism (Harriss, 2002).

Indeed, Gideon (2012) argues, by analysing gender equity policies in Chile, that it is the way that mainstream development actors use and advance equity (and not equity in itself) that is problematic. The argument here is not only one of equity of opportunity versus equality of outcome but also of the depoliticisation of gender justice strategies (which can be applied to all social justice strategies). That is, the contemporary use of equity is pushed forward by actors who use the term in order to create strategies based on a general definition leading, primarily, to the adoption of policies based on technical content, rather than the social and political factors that shape reform processes (Gideon, 2012). Gideon (2012) notes that equity points to the equal provision of services for people with equal needs when equality focuses on eliminating all forms of discrimination. Adopting health equality instead of health equity means giving preference to a policy analysis and implementation that sees health institutions as inherently gendered (Elson and Evers, 1998; Mackintosh and Tibandebage, 2005). Understanding this conceptual difference between equality and equity is crucial for the analysis of the Brazilian case. As noted above, the 1988 Brazilian Constitution adopts the term equity as one of its guiding principles. This is not only problematic because of the depoliticisation of social justice as an issue but also for the fact that equity is chosen over equality. Equality is not only more progressive and inclusive than equity, but also, it is a better fit with collective health and agenda created by the social movement pushing health reforms on the basis of Marxist values of equality. This very basic difference in approaches to social justice discourses is the cornerstone of this analysis and, as argued, it is one of the main reasons for the progresses and retrogresses in maternal mortality reduction strategies.

Almeida (2002) elucidates that using a notion of equity enables the gathering of political consensus around development strategies among the different political and ideological networks as it does not challenge individual interests. As opposed to equality, it guarantees a progressive but extremely slow advancement of social justice causes that is

removed from its use and any political significance (Almeida, 2002). In conclusion, the scholar argues that the use of the term equity collides with the radical politics of human rights as a social justice project (Almeida, 2002). Even though most countries have signed international agreements in which they are bound to provide for measures targeting equality, international organisations, as demonstrated above, such as PAHO, IADB and the World Bank, seem to promote, through a series of technical documents, a discourse based on equity (Alleyne, 2001; Gideon, 2012; Powell, 2013). This gap between rhetoric and reality in all discourses, not only in terms of equity and equality, seems to be particularly crucial to understanding health sector reforms successes and failures in terms of addressing health inequalities (Gideon, 2012).

Putting Discourses into Practice: Health Sector Reforms as Processes of Change

Health sector reform (HSR) is understood by Koivusalo and Ollila (1997) as a set of processes that should ideally lead to organisational and functional changes in health services, and are aimed at the improvement of the performance of existing systems and of assuring efficient and equitable responses to changes. In contrast, Petchesky (2003) says that perceptions about HSR discourses can be divided into two, those based on: (i) notions of efficiency and cost-effectiveness (conceptually and philosophically); and (ii) values of gender/race/class equality and human rights. These have two different objectives, respectively: to restructure health financing and achieve ultimate financial efficiency; and promote better health outcomes (Petchesky, 2003). There is no reason why these two discourses could not be compatible. Efficiency would be desirable if not conceptualised by and in favour of the market place. However, in practice, in most cases the 'efficiency race' trumps anything and everything that comes as an obstacle to its short-lived goals (Koivusalo and Ollila, 1997). In terms of reproductive health (such as fertility control practices), this often means the deepening of gender divisions and the political imposition of socially constructed gender roles (Petchesky, 2003).

Reproductive health is in itself a politically controversial issue that polarises opinions and generates reactionary responses from all sorts of people and groups aligned with a conservative right-wing political view. When reproductive health policies are coupled with health sector reforms, they are not only potentially subject to controversies but also at risk of marginalisation. This is because the majority of actors exercise their politics in an incrementalist manner; they frame politics and policy to cope and deal with crises as they arrive and only adjust at the margins (Grindle, 2000). Actors promoting public reforms however tend to advocate profound change and do so by the creation of new systems and institutions based on notions of efficiency and cost-effectiveness while also using the gender/race/class equality and human rights language to gain legitimacy (Bakker, 1994; Berer, 2002). Indeed, Grindle (2000) finds that, despite the rhetoric of notions of efficiency and cost-effectiveness discourses, governments and politicians in Latin America (and the elites supporting and supported by them) are the ones that benefit the most from HSRs. Reforms rarely really mean relinquishing power and promoting social justice (Abel and Lloyd-Sherlock, 2000). And, in this context, HSRs only serve to entrench existing inequalities while using the privilege of enabling a progressive rhetoric (Doyal, 1995). For example, in Brazil collective health rhetoric was used to advance an agenda for the decentralisation of health without associating the implementation of decentralisation with collective health's ethical values. In such cases, local participation and influence on decision making is usually marginalised and accountability systems reduced to bare minimum (Atkinson, 1995; Cornwall, 2002). Thus, although decentralisation is supposed to improve local influence for the achievement of social equality, influence is normally only increased within local elites. As local elites take hold of local power, new institutions are introduced embodying market-led interests (Grindle, 2000). Although mostly focused on institutions and formal rules, Grindle's (2000) findings indicate that political motivations for policy change in HSRs are considerably more complex than often perceived.

HSR encompasses the context, the content and the process by which these changes are made (Walt and Gilson, 1994; Koivusalo and Ollila, 1994). Therefore, HSRs incorporate and replicate built-in values characteristic of the health sectors and institutions being reformed such as gender bias (Goetz, 1997; Gideon, 2000). Albeit the creation and implementation of gender-sensitive policies, HSR may still produce gendered outcomes due to existing processes, practices and ideologies that result in the exclusion or unequal distribution of power and status between men and women (Mackintosh, 1992; Elson and

Evers, 1998). Standing (1999) defines HSRs as a group of political and ideological agendas distributed between the binary economic efficiency/good governance, i.e. based on efficiency and cost-effectiveness discourses. Some elements of HSRs, such as health financing, are put in response to economic crises and are part of structural adjustment policies (Standing, 1999). Other elements, such as institutional reforms, are associated with good governance (Standing, 1999). Therefore, HSR is not to be defined as one agenda but multiple agendas linked to the political economy of health (Standing, 1999).

HSRs as defined by World Bank and WHO's global health reformers are in direct contrast with women's health advocates' ideas of social and gender justice and the use and distribution of resources (Turshen, 2007). In the World Bank's definition, HSRs have two main objectives: to restructure health financing and delivery based on efficiency and access; and to promote public health care only in areas where the market is absent (World Bank, 2001). For instance, the 2000/2001 World Development Report focuses on catastrophic illnesses and disabilities leaving the so-called 'minor illnesses' aside, most of which encapsulates sexual and reproductive health needs (World Bank, 2001).

Even more worrisome, neoliberal HSRs have transformed health into a consumer commodity which rejects the conceptualisation of it as a basic human right (Turshen, 2007). Actors promoting neoliberal HSRs have reduced HSRs to mere technical and managerial activities that do not take into account the different needs and interests of users and their different contexts (Bloom and Standing, 2001). Both men and women are prevented from realising their full health potential since their ability to act upon their choices in an informed and satisfying manner over extended periods of time is limited by cost-efficiency models (Doyal, 1995). Mackintosh and Koivusalo call this the 'commercialisation of health care'; that is, the provision of health services is framed in terms of users' ability to pay for services, invest in the market or produce economic resources, flagging out private and public sector provisions (2005: 3).

Municipalisation and Decentralisation: Localising Social Justice Discourses

The definitions of municipalisation and decentralisation are not mutually exclusive; in fact, both overlap. Municipalisation of health is understood here as the decentralisation of health services based on the transfer of decision-making power - limited to federal and state powers on raising and allocating funds - to the municipalities and a focus on primary health care (Cordeiro, 1991; Baptista, 1996). Decentralisation can be defined as devolving management and service provision not necessarily accompanied by policy and allocations (Atkinson, 2000). Decentralisation can take many forms such as: the devolution of health decisions to the local level with the reinforcement of clientelist and elitist public administration; the privatisation of decision-making to the private sector; or the rerouting of health priority setting to democratic bodies representing civil society (Petchesky, 2003). In Brazil, the wider decentralisation project - which refers to the decentralisation of all governmental spheres as a way to increase the autonomy of federal entities - is operationalised through municipalisation (Protti, Marques and Righi, 2004). As a result, decentralisation not only affects the traditional functioning at the local level, but also affects all spheres of government (Gideon, 2000). Therefore, the challenge lies in the asymmetries in the different local and regional realities (Protti, Marques and Righi, 2004). Moreover, municipalities are complex spaces that not only implement policies but also produce them and the situations regulated by policy (Tendler, 1997).

Decentralisation models are usually reproduced from pre-conceived and non-consolidated models of management and care (Tendler, 1997). In this sense, decentralisation can have many forms and concepts; all of which lead to very different outcomes. The same happens to municipalisation as a political construct. That is, in all sectors including in the health sector, both decentralisation and municipalisation can be portrayed in terms of the two discourses mentioned above - in terms of efficiency and cost-effectiveness; or in terms of gender/race/class equality and human rights (Petchesky, 2003). It is therefore important to separate decentralisation proposals that see municipalities as a place of change (aimed towards gender/race/class equality) from those that understand municipalities as a strategic place to reduce the cost of social policies and accelerate privatisation processes (geared towards economic efficiency) (Protti, Marques and Righi, 2004). It is this tension that orients this analysis. The most significant changes to social policy in Latin America in

the last quarter of a century had to do with pensions and HSRs in which case decentralisation (and not necessarily municipalisation) became the rule in organisational changes (Mesa-Lago, 2007).

Although apparently paradoxical, the neoliberal State has a tendency to favour decentralisation over centralisation (Mesa-Lago, 2007). Decentralisation, as envisaged within neoliberalism, tends to enhance primary health care (as opposed to secondary and tertiary health care) and universalisation, and it also centralises the financial resources in the federal sphere of government (Gideon, 2000). In a neoliberal model of minimum State intervention, there is the tendency to promote the devolution of competence and functions to other levels of government and to strengthen central authority and clientelistic activities (Weyland, 2007). Under this scheme, there is a voracious delegation of functions to the local level, but the transfer of financial resources does not occur at the same pace (Baptista, 1996). This may accentuate the poverty and the inefficiency of public policies in poor municipalities (Cornwall, 2002). This is because decentralisation without democracy or institutional development means only the transfer of responsibilities to municipalities and less accountability to the central government - a shedding of political risk (Kaufman and Nelson, 2004).

As a matter of fact, decentralisation has been one of the most popular health sector reforms amongst developing countries (Mesa-Lago, 2007). However, its implementation is paradoxical. It is usually driven by groups of interests beyond the health sector that see it as instrumental to local autonomy and/or regional equality (Bennett, 2008). In short, this leads to a clash between those that believe in the municipalisation and the promotion of local autonomy versus those that defend the regionalisation and the creation of integrated clusters within municipalities that share similar characteristics, interests and needs. This will become evident in the analysis of interviews in Chapter VI. However, to put it simply, the decentralisation's push for accountability and efficiency removes the direct hierarchical relationship between the central government and citizens; adopts performance-based evaluations and agreements and; enhances target programming; none of which are directly related to the enhancement of democratic participation (Cornwall and Shankland, 2008). Nonetheless, decentralisation is often presented as 'the magic bullet' for promoting equity or reducing inequality by governments and activists alike (Weyland, 2007). And, it is exactly because of these rhetorical tools put at the disposal of actors pushing for

decentralisation that the differences between its modes of implementation - i.e. municipalisation or regionalisation - and its purposes - based on effectiveness or social justice - become unclear.

This lack of clarity is problematic as it does not respect basic democratic values of transparency and informed participation. It is not that one mode or purpose (for implementing decentralisation) is more 'truthful' than the other; but that the different political positions presented by each one of them must be presented in a fair and open manner. Despite the use of a highly technical term or a more politically driven one, decentralisation does not have social equality as its core values (Kaufman and Nelson, 2004). Evidence suggests that decentralisation tends to strengthen local elites and exacerbate regional and social inequalities (Atkinson et al., 2005a). The exceptional success comes when combined strategies for health reforms are included in the decentralisation process, such as stronger activism on the part of the central governments (including governments with neoliberal tendencies) (Tendler, 1997). That is, decentralisation (irrespective of its mode and purpose) will not in itself amount to greater democratic participation and social justice. This thesis demonstrates, particularly through Chapter VI, that municipalisation's processes and outcomes do not happen as envisaged by the decentralisation programme nor the neoliberal reforms' promises and the reasons that justify the implementation of municipalisation strategies. In this sense, two issues arise: the problematic use of decentralisation discourse in practice (based on human rights as intrinsic or instrumental values); and the effects of the use of these different discourses.

Neoliberal Policies and Health Sector Reform: Inappropriate Appropriations

Contrary to popular assumptions, Brazil is not always perceived by academics as a successful case of HSRs (See Atkinson, 2000; Atkinson et al, 2005a). As in Chile, its restored neoliberal democracy prioritises economic growth and democratic consolidation to the detriment of social policy and social protection (Abel and Lloyd-Sherlock, 2000; Atkinson, 2000). These neoliberal reforms are influenced by international market-oriented models characterised by a specific language, terms and concepts imbued with special meaning - i.e. decentralisation, gender equity and human rights may have very different

meanings (from their ethical and philosophical constructions) under the neoliberal programme (Sikkink, 1991). This literature argues that importing ideas and blueprints for a desired future not only disregards particularities in local contexts and knowledge, but it also ignores in-country differences (such as regional inequality). In this sense, HSRs can serve to legitimate an agenda that is not necessarily transparent (Sikkink, 1991). Moreover, for legitimation purposes, these ideologies usually rely on the use of legal rules that are often divorced from reality either for being too elusive and abstract, or for being incapable of transferring the dynamic changes in society to the scope of policies and programmes (Hunt and Leader, 2010).

Harriss (2002) demonstrates in his study of social capital discourses that well-intentioned scientific work may be co-opted by an hegemonic machine that instrumentally uses social sciences in order to obscure power inequalities and advance a particular political agenda. That is, what is important in policy analyses is not really related to what is included in development discourses, but what is excluded from them and how it occurs (Harriss, 2002). Mainstream development discourses and policies tend to select concepts and scientific data that are found suitable to its interests while ignoring everything else (Vera-Sanso, 2010). For example, counter hegemonic contributions to social capital were and are still ignored up to this date (Harriss, 2002). Very well grounded theories such as Bourdieu's (1984) notion of social capital are often ignored by mainstream development strategies as if inexistent.²³ This not only disregards intellectual capacity and gains of rich theoretical constructions, but also conceals the meanings associated to each specific concept informing policy making and framing. In Brazil, decentralisation was initially part of a wide collective movement for health and social justice informed by well-established academic Marxist theory (Mattos, 2006). However, the findings of this research indicate that, as will be demonstrated throughout the remaining chapters, decentralisation was at some point appropriated by neoliberal policy networks. The appropriation and

²³ Bourdieu (1984) affirms that culture fulfils the social function of legitimating social differences. In this sense, by focusing on how society is reproduced through cultural capital, economic capital and social capital, Bourdieu (1984) defines social capital as physical and non-physical resources that increment an individual's or group's capacities to participate in particular networks. In his opinion, social capital is the means by which systems of subjugation and trappings are made possible. More specifically, he argues that social capital is used to reinforce existing power hierarchies (Bourdieu, 1984). In opposition to that, social capital is defined and streamlined by the World Bank (1994) as norms and networks that determine the existence, quality and frequency of collective action. As per this definition, social capital is perceived as neutral and even positive (World Bank, 1994).

transformation of a social justice discourse for the purposes of legitimating market-oriented interests can have drastic effects on equality (and equity followed by equality), and therefore women's rights and wellbeing (Almeida, 2002). This was certainly the case of decentralisation and HSRs in Brazil.

Research Innovation: Deconstructing Discourses in HSRs and Maternal Mortality

As already mentioned earlier in this chapter, this study is devoted to discovering the use of rights-based approaches as rhetoric and/or reality in terms of the discourses used by the key actors acting upon maternal mortality reduction initiatives. It expands on existing literature demonstrating the importance of language and meaning in discursive praxis and the replication of existing power structures and social inequality through the use of discourse. It nevertheless gives a special focus to social justice discourses within women's human rights practice which, to this date, has not been done in the context of Brazil. In this sense, this research is innovative because it develops a specific comparative framework of analysis of reproductive health that addresses the use of human rights-based rhetoric examining the relationship between decentralisation definitions, structures and processes and their impact on the achievement of better maternal health outcomes in Brazil.

Gender analysis of public health, monitoring and evaluation is very important to this study. It develops critiques of the use of a human rights-based framework in order to effectively identify public health challenges and their gendered impacts. At the same time, it briefly looks at the history and context of the promotion of reproductive rights in Brazil and how they intersect with feminist scholarship and critical debates on religious beliefs, female body politics, and reproductive rights in terms of control of reproduction. Drawing on the above-mentioned rationale and methodology, the following chapters will present an in-depth critique of the framework of health sector reforms, uncovering the different meaning associated with decentralisation strategies and revealing the instrumentalisation of the human rights-based approach by international development discourse and national discourses using international development blueprints. These new contributions to knowledge provide the analytical framework for this thesis.

Innovative Focus of Research: Policy Networks during Crises and Change

The new contribution to knowledge becomes more evident through the use of existing methodology (discussed in Chapter III) to previously unexplored areas of social policy making and implementation. That is, and alluding to previous sections, by applying a Foucauldian discourse analysis to the effects of HSRs in maternal mortality, this research reveals the instrumentalisation and co-optation of social justice discourses - in particular those relying on human-rights based approaches. This instrumentalisation and co-optation were made possible by a series of factors, one of them being due to the period of political transition and economic crisis. The political reforms of the 1980s and 1990s in Latin America were the result of economic crisis triggered by the development policies of previous decades and external shocks, such as the oil crisis of the 1970s (Grindle, 1996). Structural Adjustment Programmes (SAPs) challenged and often redefined political-economy and society (World Bank, 1993). The SAPs created new models of institutional, technical, administrative and political structuring (World Bank, 1994). These models were put in place in order to challenge and undermine the role of the state (World Bank, 1994). This thesis addresses the processes related to the implementation of health sector reforms in moments of crises and the discourse or rhetoric associated with them in order to assess the extent of their implications in terms of reducing maternal mortality rates.²⁴

Since the 1990s, the government of Brazil has been pushing for a stronger protection of economic, social and cultural rights internationally (Hunt and Leader, 2010). However, as will be discussed in chapters IV and V, internally, intrinsic and instrumentalist arguments in health policy making and implementation are still used simultaneously as a strategy to repel radicalism and mask inconsistencies, as well as to push for further neoliberalisation of public health (Hunt and Leader, 2010). In order to identify intrinsic and instrumentalist

²⁴ There is a wide literature analysing HSRs in Latin America. See, for example, Mesa-Lago, (2007; 2008; 2010); Atkinson (2000); Grindle (1996); Ewig (2006; 2010); Tendler (1997), Abel and Lloyd-Sherlock (2000); Almeida (2002); Bossert et al. (1998); Buss and Gadelha (1996); Cohn (2008); Fleury et al. (2000); Gideon (2000).

arguments, Chapter VI noted the importance of understanding cogently the dynamics of health sector reform in these processes and the gendered relations of reproductive health public policies in Brazil. Furthermore, Chapter V crucially outlines, in terms of population policy in transitional Brazilian politics, the types of gendered struggles faced by feminist movements and the interests that conflicted with the reproductive health policy agenda. Chapter II discusses the bodies of literature that inform the main theoretical framework. Aiming at displaying the importance of each separate chapter, the next section presents the structure of the thesis, the subject of each chapter and its purpose in serving the overall research question.

Structure of this Thesis: Chapters and their Purposes

Chapter I offered Shiffman and Smith's (2007) framework as the key to understanding the power dimensions existent within the discourses used by the different policy networks promoting decentralisation in health sector reforms in Brazil. It identified Shiffman and Smith's (2007) model as its theoretical framework by noting the importance of analysing maternal health and priority setting through the scholar's list of four aspects explaining the complexities related to political activism around this issue. The four aspects are related to: (i) the strength of policy networks; (ii) the ideas supporting their political activism; (iii) the context in which this activism is inserted into; and (iv) the characteristics of the issue they seek to address (Shiffman and Smith, 2007). These aspects are the key to this analysis and for this reason will be the main themes of the remaining chapters of this thesis. This chapter also presented the hypothesis of the research which assumes that reproductive health services have been marginalised by the reform processes in Brazil's health sector and that this affected the maternal mortality reduction initiatives over the past three decades.

In this sense, all of the main chapters are oriented towards identifying three main characteristics that determined the success or failure of maternal mortality initiatives: (i) maternal deaths are not as common as other high-burden disorders such as HIV/AIDS and malaria; (ii) accurate measurement of maternal mortality is technically difficult; (iii) the

interventions to avert maternal death are not as simple and cheap as other health-related problems such as diseases preventable by vaccines (2007). Additionally there is a crucial point that is not included in this list that will also be used for the purpose of establishing a comprehensive framework. It relates to the inability of the international community to afford real value to health initiatives that benefit women only without dealing with women as an instrumental value to something else such as childbirth or childrearing.

Chapter II assesses the existing scholarly debate in order to highlight the importance of unpacking the use of human rights approach in discourse and strategies for the reduction maternal mortality. Drawing on a process of interpretative social policy and Foucauldian discourse analysis, the research seeks to determine why reproductive health services in Brazil have not benefited from the supposed advantages of decentralisation. It situates the Brazilian case study within wider debates of health sector reforms in Latin America, inequalities of access in health care and its implications on women's right to health and gender equity (Bossert, 1998; Atkinson et al, 2000; Ewig, 2010). It explores how transnational, national and local policy legacies and epistemic communities may have influenced the use of a reproductive rights discourse while in fact perpetuating a population control agenda (Doyal, 1998; Shiffman et al, 2004; Bloom and Standing, 2008; Ewig, 2010).

Chapter III complements the first chapter by explaining the methodological tools that were used to test the aforementioned research hypothesis. It explains that a case-based study was the method chosen for collecting empirical data that provides the empirically-grounded explanation for the marginalisation of reproductive rights from health sector reforms designs (Mitchell, 2006; Small, 2009). It also notes that feminist standpoint epistemology and interdisciplinary feminist research (or feminist theories of intersectionality) is used for the analysis of the data collected (Martin, 1987; Haraway, 1991; Harding, 1993; Letherby, 2002; McCall, 2005; Hesse-Biber, 2007).

Chapter IV analyses the strength of maternal health policy networks, factor one of Shiffman and Smith's (2007) framework. It discusses the international and regional maternal mortality initiatives particularly in terms of feminist political strategies and participation in policy making or demands for policy change. This chapter traces the different political strategies implemented by the women's movements aimed at institutionalising women's integral health care principles and practices globally. In the first

section, there is an outline of the global context and the efforts towards maternal mortality reduction, mainly the key United Nations conferences and strategies and the new approach created with the Millennium Development Goals.

Chapter V attempts to understand the role of ideas in building consensus internally and in gathering external political support, factor two of Shiffman and Smith's (2007) framework. It outlines the Brazilian context, the current status of women, its demographic transition, the national programmes and feminists' political strategies. It discusses Brazil's public policy agenda and discourse versus the real effects it has on overall public health and more importantly on maternal mortality rates. It relies on the results collected from interviews performed with key actors of the public health movement. It argues that in spite of their best endeavours, feminists' late engagement with maternal mortality discourse and policy making allowed space for expansion of conservative politics and a step back in the health and human rights agenda, which in itself led to a slow reduction of maternal deaths. Its final section concludes that despite formal legal measures put in place, maternal mortality rates reduce at an incredibly slow pace. It argues that feminists' late engagement with the issue of maternal health has allowed for a considerable political space that was populated by conservative religious caucuses, which in turn led to public health measures that essentialise women and therefore fail to tackle the real problems behind health inequality.

Chapter VI attempts to demonstrate the importance of the social, political and historical context, factor three of Shiffman and Smith's (2007) framework. It presents the history of the pre-1980's as well as the 1980's and 1990's health sector reforms, its policy networks and policy making. It seeks to compare the objective of health sector reforms with the real impacts they create. In the period of HSRs between the 1980s and the 1990s, welfare state practices oriented by solidarity principles were replaced by neoliberal theories emphasising individual interests (Koivusalo and Ollila, 1994). In Latin America, this meant the pursuit of cost-effectiveness and the change of service delivery by including public-private initiatives, private companies and non-governmental organisations (Mesa-Lago 2008). In Brazil, SAPs rhetoric influenced the decentralisation of the provision of public health services in 1984-1988, so to: (a) transfer responsibilities, administration, and implementation of social programmes from the national to State, Municipal levels and private providers; (b) create social control of the allocation of public social expenditures to better reach vulnerable localities and groups; (c) enable social participation in policy

making and implementation; (d) to promote economic development in an equitable manner; (e) integrate regions; and (f) use limited resources more efficiently (Rondinelli, 1981; Iriart, 2004). This chapter looks at interviews with key actors of the public health reform movements in order to establish that the feminist movement was marginalised from mainstream health sector reforms' policy making and implementation, including decentralisation processes.

Chapter VII traces the characteristics of maternal mortality as a political issue, factor four of Shiffman and Smith's (2007) framework. It enquires who benefits from decentralised maternal mortality strategies. It discusses the partial privatisation of health particular to the Brazilian context in order to situate the knowledge acquired on health sector reform to understand the implementation of decentralisation as the 'magic bullet'. This chapter demonstrates through the analysis of interviews with key actors that decentralisation of health led to the transfer of responsibility from the national to the local levels, reducing the levels of accountability and creating more space for the participation of private companies in the provision of health care. As explained in the methodology, this thesis does not have the purpose of analysing neoliberalisation and health sector reforms in Latin America. However, it must engage with scholarly materials written on the subject as a way of situating the current research in a wider context. For this reason, Chapter VII deconstructs neoliberalism and its different phases of implementation as a way of understanding how market-driven forces and projects such as the Washington consensus and post-Washington consensus have influenced new neoliberal policies and health sector reforms in Latin America. It also addresses emerging discourses on pro-poor economic policies, federalism and fiscal retrenchment and positions these issues in terms of the current Brazilian health system and wider distributive social policies. This chapter demonstrates through the use of literature review and the analysis of interviews with key actors that the blind support gathered around decentralisation strategies failed to acknowledge the indirect consequences of implementing it in a country as diverse and unequal as Brazil.

Chapter VIII summarises the findings and presents the overall conclusion by not only recapitulating all four factors of Shiffman and Smith's (2007) framework - strength, ideas, context and characteristics - but also by considering the way forward in social policy research. In light of the research findings, Chapter VIII advances four key arguments which are the core of this thesis. Firstly, human rights discourses are plural and heterogeneous and must be understood in that way. Secondly, some human rights

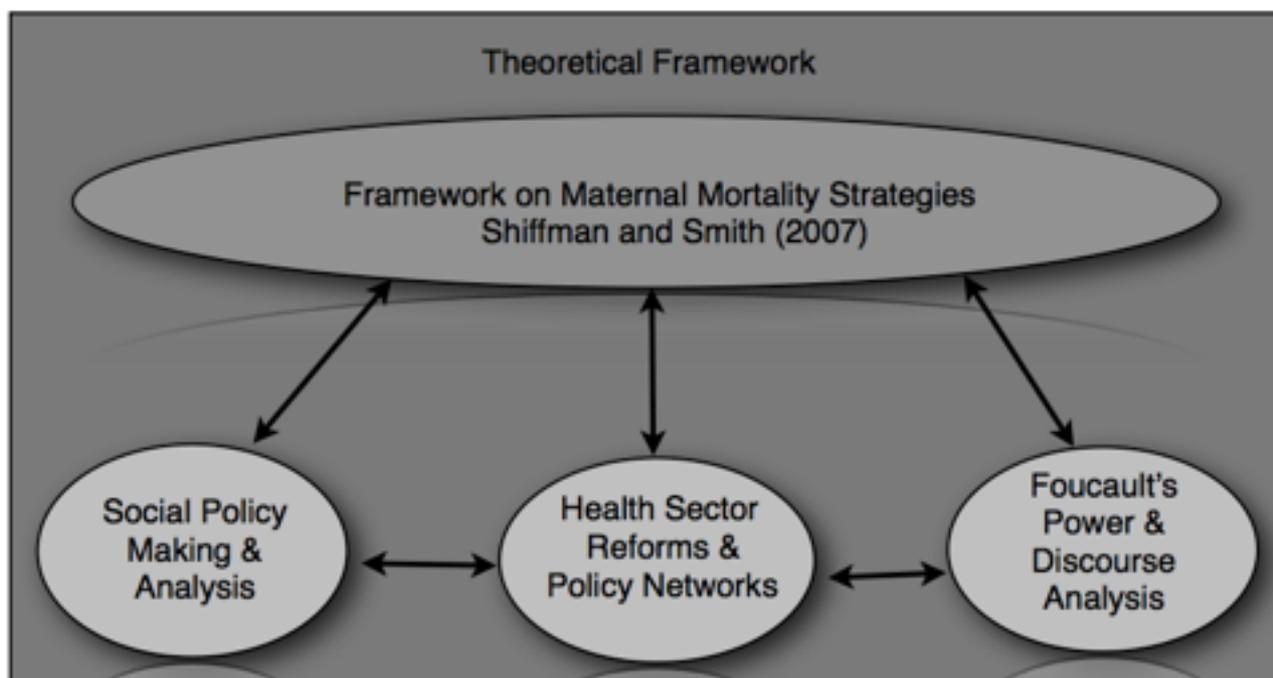
discourses are susceptible of appropriation by conservative networks. When this appropriation occurs, conservative networks adopt human-rights based approaches for legitimacy purposes while diverting health reforms from their ethical purposes by promoting market-oriented results which intensify social inequality. Thirdly, discourse appropriation often occurs in a barely perceptible and non-transparent manner. Therefore, policy analyses of health sector reforms and human rights discourses must look at formal and informal spheres of power in order to provide a more comprehensive reading of the real constraints and possibilities available to human rights advocates. And, lastly, human rights-based models of health promotion are only valid if connected to the progressive values that created these models in the first place. In this sense, all analyses of human rights activism must always contrast mainstream discourses against these progressive values so as to make sure human rights discourses are not providing moral cover for processes already put in place but whose existence should actually be questioned.

Chapter II - Literature Review: In Dialogue with Scholarly Debate on Social Policy, Health Policy Framing and Participation

Analytical Structure: Theories Informing the Main Theoretical Framework

Shiffman and Smith's theoretical framework outline in Chapter I is essential to the structure and analysis of the research data presented herein. However, this framework is not able to, by itself, answer all of the concerns raised by the main research question and hypothesis. For example, it is not able to explain the role of empty rhetoric in the creation and implementation of different maternal mortality initiatives. It inquires whose voices count in global maternal health strategies and blueprints, however, because of its scope (global health), it is not capable of encapsulating all the differences in national contexts and the specifics of social policy making and implementation in Latin America. In this sense, alongside Shifman and Smith's (2007) framework discussed above, this research draws on the following bodies of theory: 1) literature on social policy making and analysis (e.g. Guy, 1990; Doyal, 1995; Molyneux, 1998; 2001; 2007; Boesten, 2010; Baptista and Mattos, 2011a); 2) literature on Latin America's neoliberal health sector reforms and policy networks (e.g. Atkinson, 1995; Gideon, 2000; Ewig 2010; Iriart 2011; Mesa-Lago 2010); and 3) literature on Foucault's approach to power and discourse (e.g. Foucault, 1980; 1991; 1994; Bhabha, 1990; Mohanty, 1991; Escobar, 1995; Agamben, 1995; Cornwall 2010). This web of combined theories explores the consequences of different economic, social and political positionings among policy networks on the production and reproduction of social policy. See Figure 2 for a visual representation of the wide theoretical framework:

Figure 1 - Visual Representation of Theoretical Framework



As can be seen above, all theories serve to inform one another while contributing to the wider scholarly conversation. For example, Foucault's (1980; 1991; 1994) theory orients my understanding of how health sector reforms replicate existing inequalities, while at the same time the literature on social policy expands my analysis of health sector reforms and policy framing by the different policy networks. In this sense, the purpose of this wider theoretical framework is to contribute to the existing scholarly debate on social policy and participation in order to advance knowledge on the dynamics of agenda setting and activism. More specifically, these interlocking theories are used to discuss the continuous appropriation, transformation and re-appropriation of terms by the different policy networks and its influence on the depoliticisation of the wider human rights movement.

This historical analysis serves as a statement of the voracious power neoliberalism has over all types of policy making and its opportunistic advancement of certain political strategies created by different individuals and networks involved in the institutionalisation of human rights-based approaches. This control exerted by neoliberalism over policy and policy discourse is particularly acute in the case of maternal mortality. In its most progressive format, maternal mortality touches upon politically contentious issues that are often resisted by conservative networks supporting neoliberal control over public health

sector reforms, principles and practices. Also, in the face of new and multiplying policy spaces created by decentralisation, women's rights networks lose their political leverage as sophistication, capacity and resources become indispensable.

Social Policy Making and Analysis

Policy making is a domain of state action aimed at the expedient pursuit of a specific agenda (Molyneux, 2007). It is designed through a series of debates and conflicts between groups and individuals with particular positioning and interests (Baptista and Mattos, 2011a). It is the expression of temporary and dynamic agreements that represent the historic context of a particular society (Baptista and Mattos, 2011a). There is a growing body of literature on the area of social policy making and analysis. Pierson (2004), for instance, argues that social policies are the result of political struggles rather than merely their outcome. That is, Pierson (2004) considers the processes by which policies are made and implemented to be just as important as their outcomes. This is because new policies bring about new politics which often change the social, political and economic landscape quite dramatically (Pierson, 1993). Formal and informal rules are put in place by policy makers to regulate and determine the policy change capacity of each policy network (Baptista and Mattos, 2011a).

Mkandawire (2005) defines social policy as all concerns with social development that are translated into social justice instruments and are integrated as part of other governmental action. This definition is problematic as it sees all social policy as leading or being about social justice. Mackintosh and Tibandebage (2005) expand by saying that, as governmental and non-governmental action shape the provision of social service, social policy serves to influence distributive outcomes. This is, as I already pointed out, difficult to accept as it does not deconstruct all the motivations behind social policy making and implementation. Molyneux on the other hand, identifies "social policy with the state practices and institutional forms that directly influence the welfare and security of the citizens of a particular society" (2007: 1). According to the scholar, social policy is the

division of policy designed, at least in theory, to secure, in its broadest sense, social reproduction (which in most cases mean the reproduction of social inequality) (Molyneux, 2007). Social reproduction being the capacity of giving continuity to social and historical constructs, i.e. reproducing specific social formations and all its Marxist underpinnings (Molyneux, 2007).

New competing interests face 'barriers of entry' meaning that a considerable amount of resources and sophistication will need to be put in place to guarantee an entry point into the mainstream policy making arena (Pierson, 1993: 603). This condition for participation in policy making shapes the development of policy networks and therefore the outcome of their strategies (Pierson, 1993). All actors have to deal with the complexity and uncertainty characteristic of all political systems (Pierson, 1993). Additionally, the weakness and strengths of a particular policy network, and/or the issue put forth by it, determine its capacity to generate change and to populate a particular policy space (Pierson, 1993).

In Mackintosh's (1992) words, the State is the central point for social policy and welfare practices, and therefore is understood to be serving and aiming at advancing public interest. This definition is also problematic as many left-wing academics understand the State to be advancing and protecting the interests of capital and privileged social groups - so by no means public or democratic (Žižek, 1989; Vera-Sanso, 2010). By contrast, some political crises and democratic transitions may weaken political leaders and institutions, even in regions like Latin America, that experienced growth of civil society and social mobilisation (Grindle, 1996). This can result in new political coalitions, leaderships, institutions and projects (Boesten, 2010). Indeed, after democratic transitions in Latin America, there was an increase in the influence of international economic technocrats in the social policy agenda which then led to the polarisation of discourses of technocratic versus participatory policy making (Tendler, 1997). International technocrats' arguments used in 1980s and 1990s Latin America were adamant on technocratic approaches as more 'scientific', and pushed for efficiency-based development, weakening administrative and delivery capacities (World Bank, 1993). However, as Grindle (1996) states while making a comparison of good governance literature, crises and political instability posed a threat to legitimacy and capacity of State institutions and corroded public systems in contemporary Latin America. Furthermore, political pluralism and the sophistication of policy analysis and decision making made it impossible for the Latin American States to

effectively respond to the various sets of social demands (Grindle, 1996). As a result, Latin American governments adopted a more traditional definition of social policy - one which leads to social reproduction but not necessary to social justice (Grindle, 1996).

Social policy makers often ignore that all policies are inserted into gendered dimensions (such as health and education sectors) and that the absence of an appropriate challenge to these existing gender inequalities only engenders more inequality (Doyal, 1995). The gendered character of welfare provision in Latin America, and the omnipresence of patriarchal and maternalistic values, serves to prove this assumption (Guy, 1990). Most social policies in the region introduce poverty reduction programmes that reinforce gendered constructions and tend to re-traditionalise gendered roles and responsibilities (Molyneux, 2007). For example, since the mid-nineteenth century, social policy in Latin America has been targeting motherhood as the object of regulation (Boesten, 2010). Resisting these maternalistic stereotypes became even harder in the wake of social hygiene and eugenics movements (Hahner, 1980). Eugenics, for instance, was aimed at modernising childrearing practices and promoting economic development, but at the cost of singling out historically marginalised groups such as the poor and/or black or mixed race people (Hahner, 1980).

In this sense, with the restricted reach and scope of social policy, the adoption of human capital theory - that categorises people in terms of their competences and ability to perform in the labor market - and the complexity arising out of welfare provision, disadvantaged women and men could not and did not access the State for anything beyond minimum provision of basic services (Molyneux, 2007). The fragmentation and marginalisation of public services to 'the poor' was not exclusive to social hygiene and eugenics movements. Their legacies live on up until this date. In fact, in the 1980s and 1990s, social policy became firmly anchored in a discourse of development priorities trying to replace eugenics and social hygiene, but instead actually reinforcing some of their mottos, such as provision of basic health care only. Therefore, mainstream international development became clearer and in spite of the progressive rhetoric, the response or the pursuit of the interest of certain policy networks and/or political institutions staffed by self-seeking individuals (Lipsky, 1980; Mackintosh, 1992). That is, instead of benefiting all, it benefited a chosen few. This is not to say that there were no benefits arising out of the development rhetoric. International development actors have been responsible for

affording visibility and gathering funds for many important, and otherwise invisible, social issues. Nevertheless, it is important to deconstruct this same rhetoric in order to determine the way forward based on informed decisions and data on the effects of this same rhetoric on all development outcomes. Moreover, the complex design of institutions and the use of expert persuasion by networks make the deconstruction of the design and implementation of international development policies absolutely crucial (Mackintosh, 1992).

Furthermore, the policy process can differ widely at each level of implementation (Gideon, 2000). It varies according to the different contexts, actors and processes (Walt and Gilson, 1994). The content and in particular the implementation of policy will reflect some or all of the above dimensions at one, some or every level (Gideon, 2000). The policy and implementation changes at the different levels need to be taken into consideration when engaging in policy analysis, especially in the case of decentralisation and consequences coming from strategies alike. Indeed, the policy making process is affected by actors, their position in power structures, their own values and expectations (Elson and Evers, 1998; Gideon, 2000). Actors are influenced by the context within which they live and work in, and the context is affected by many factors such as instability or uncertainty created by changes in political regime, ideology and/or culture (Elson and Evers, 1998; Gideon, 2000). Elson (1994) argues that, as all social policies operated in a gendered terrain, the operation of social policy reforms at all levels are male-biased, and, therefore, have a tendency of generating or replicating gender inequality. This particularly affects lower class black or mixed-race women who become the target of pro-poor policies and therefore undergo the most profound type of exclusion (Boesten, 2010). This will be further explored in Chapters IV and V, but essentially, pro-poor policies tend to essentialise women's roles while creating, at the same time, a dual system of stratified reproduction (Colen, 1995). This is because, in the political arena, policies defining and dealing with motherhood are embedded in sexist and racist values (Boesten, 2010). Thus, the deconstruction of social policies not only demonstrates the gendered terrain in which policies operate, but also a more nuanced account of a historical marginalisation, racism and elitism.

Considering the complicated and unequal contexts in which policies operate in, Baptista and Mattos (2011a) explain that one must analyse and comprehend 'the backstage politics', i.e. attempt to understand the invisible negotiations and conflicts related to official positions and processes. In this sense, for a thorough policy analysis, one must

acknowledge the different narratives that construct the different demands (progressive and conservative) orienting and/or resisting or justifying policy change, and their respective responses (Baptista and Mattos, 2011a). This means that looking at unexpected and non-official spaces is absolutely necessary (Baptista and Mattos, 2011b). It is of course difficult to find and determine what the unofficial spaces are that influence policy making, implementation and change. Nevertheless, searching and understanding the power of invisible actors may help unfold the hidden meanings of a particular policy, actors' intentions and incoherencies (Goetz, 1995b). Therefore, to analyse the content of a policy is not only to analyse how it is defined, but also to understand how a policy is presented and debated by different groups and how it is implemented (Gerschman, 2011).

Social Policy Analysis and Health Sectors

Health sectors, health outcomes and social inequalities mutually impact each other (Doyal, 2000). That is, "unequal legitimate claims upon a health care system, and unequal experiences of seeking care, are important elements of poverty and social inequality in people's experiences" (Mackintosh, 2002: 175). Health care systems and institutions are built and build upon existing social inequalities (Boesten, 2010). And, in turn, as a key place for the contestation of the existing social structure, offer an opportunity for reworking the underlying forces responsible for the status quo (Grindle, 2000). Nonetheless, health sector reforms are usually prescriptive in content and for this reason disguise the relationship between reforms and inequality (Doyal, 1995). In addition, mainstream policy networks driving reforms tend to ignore (purposefully or unintentionally) the importance of greater institutional inclusiveness for the contestation of inequality and exclusion (Almeida, 1999). Therefore understanding the social, economic and institutional characteristics of the context of a specific reform policy programme is absolutely necessary (Goetz, 1995a).

As will be discussed below, it is equally important to understand the formal (such as political parties and politicians) and informal (such as multinationals) actors²⁵ that participate in institutional reforms (Atkinson, 1996). During policy making and the process of implementation of reforms, there are competing networks with conflicting discourses on rights, priorities and principles (Atkinson, 1996). All networks compete to legitimate their discourses and fight for what, how and who will be at the forefront of a particular reform (Bloom and Standing, 2001).

As will be explored in the following chapters, in some cases, health sector reforms can be strongly driven by international models of reform (Berry, 2010). In fact, “reforms are locally managed, and driven in many countries by fiscal crisis; but their form – and especially the emphasis on decentralisation – owes a great deal to donor pressure” (Mackintosh, 2002: 180). These approaches are usually taken for granted as if undoubtedly advancing equality (Abel and Lloyd-Sherlock, 2000). This tendency to take reform objectives at face value can affect and obscure the results of the implementation process (Baptista and Mattos, 2011a). The next section assesses in light of the existing literature the extent to which different discourses affect the specific characteristics of health sector reforms’ policy programmes, and their overall effects on women’s rights.

Health Sector Reforms and Different Discourses

As mentioned earlier in this thesis, health policy is inherently subjected to conflict in terms of solidarity versus individualistic concepts as well as in terms of the appropriate policy choice for health promotion and equality (Walt and Gilson, 1994). In this case, according to Walt and Gilson (1994), the content of the reform has come to be less important than the context, process and the actors involved in policy reform (at the international, national and sub-national levels). Walt and Gilson argue that “[f]ocus on policy content diverts attention

²⁵ Formality and informality will fluctuate depending on who defines it and what type of formality is sought. It is important to note that formal networks may also operate informally. For example, in Latin America, the conservative wings of the Catholic Church are known for working in both fronts, particularly when attempting to revert progress in terms of women’s rights (Correa, 2010).

from understanding the processes which explain why desired policy outcomes fail to emerge” (Walt and Gilson, 1994: 353).

This problem is clear in the case of the DALY, Disability-Adjusted Life Year. The DALYs were created as methods of measurement of the gaps between current and ideal health statuses in terms of the life-years lost due to each disease (Shiffman, Beer and Wu, 2002). Although it was imagined as a tool for health equality, it was unable to overcome biases in policy making. Indeed, development praxis proved the DALYs to be a part of a complicated calculations system that presume rationality, linearity and neutrality in social policy making (Shiffman, Beer and Wu, 2002). This type of intervention (assuming an equal terrain for action) not only silences women’s experiences and necessities, but also has the capacity to further marginalise disadvantaged women and the men that rely on these women.

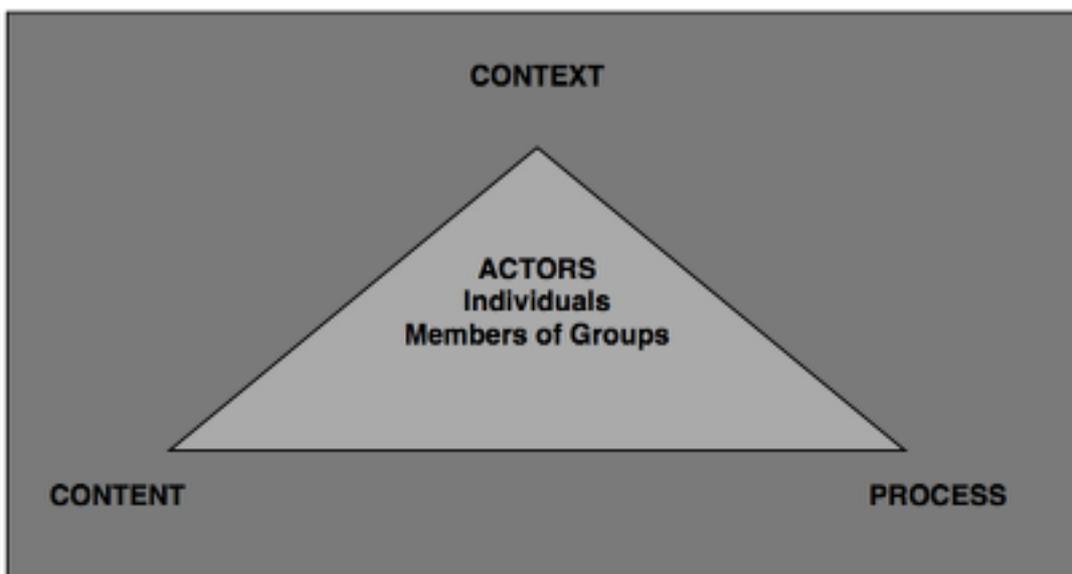
This is where human rights and human-rights based approaches come in place. As already stated, human rights as a political project for social justice, i.e. as a position and not ‘truth’, can expand the possibilities for challenging unequal power structures. Indeed, methods using human rights values and concepts have the potential to change legislation and policies by improving awareness of governments’ obligations towards individuals that can eventually lead to social justice (Cottingham et al, 2010). In its ethical and radical format, human rights in its real rhetoric sense (i.e. rhetoric leading to change and social justice which is different from the widely used empty rhetoric of rights) have the potential to expand the pursuit of health as a fundamental social value indispensable to equality and distributive justice (Koivusalo and Ollila, 1997; Hunt and Leader, 2010). For instance, and as will be explored in chapter V, in Brazil family planning was promoted during the 1960s as a means of controlling the fertility of poor women (Costa, 2004). This total divorce from the philosophical underpinnings supporting family planning as a reproductive right needs to be at the core of policy analyses and deconstructions. Not because it must be deemed more ‘truthful’, (since ‘truth’ does not exist), but because transparency in positionality (and demands pushing or resisting change) is an absolute mandate of democracy.

Moreover, as explained previously, the reasons behind a particular health reform will be highly informed by the policy networks participating in its design and deliberation process (Mackintosh, 1992). The success or failure of a reform will depend not only on its design but also on the actors and the recipients of its implementation (Mayhew, 2003; McIntyre

and Klugman, 2003). At times, internationally idealised health strategies fail to acknowledge that there are also huge gaps in bureaucratic cultures and discretionary decision-making at the time of local implementation of reform policies (Lipsky, 1980; 1997; Walt and Gilson, 1994). In this case, to understand the factors influencing the effectiveness or ineffectiveness of health policy change, one must understand the policy process (White, 1990; Mackintosh, 1992; Walt and Gilson, 1994; Gilson and Stephens, 2002; Walt et al, 2008). This means to position the policy environment in terms of internal, cross-border and international networks and the relationship between them (Walt et al, 2008).

Walt and Gilson's (1994: 359) approach to policy analysis serves this purpose as it "is concerned with the processes of policymaking, [...] with the behaviour of actors in formulating and implementing policy and the context within which policies are promulgated". It offers a broad framework for thinking about health reform and its policy process by arguing that policy is not simply about prescription or description, nor does it develop in a social vacuum (Walt and Gilson, 1994). Policy change is the outcome of complex social, political and economic interactions which embraces a set of institutions, organisations, services, funding arrangements and individuals (Walt and Gilson, 1994; Walt et al, 2008). See Figure 3 for Walt and Gilson (1994) analytical model:

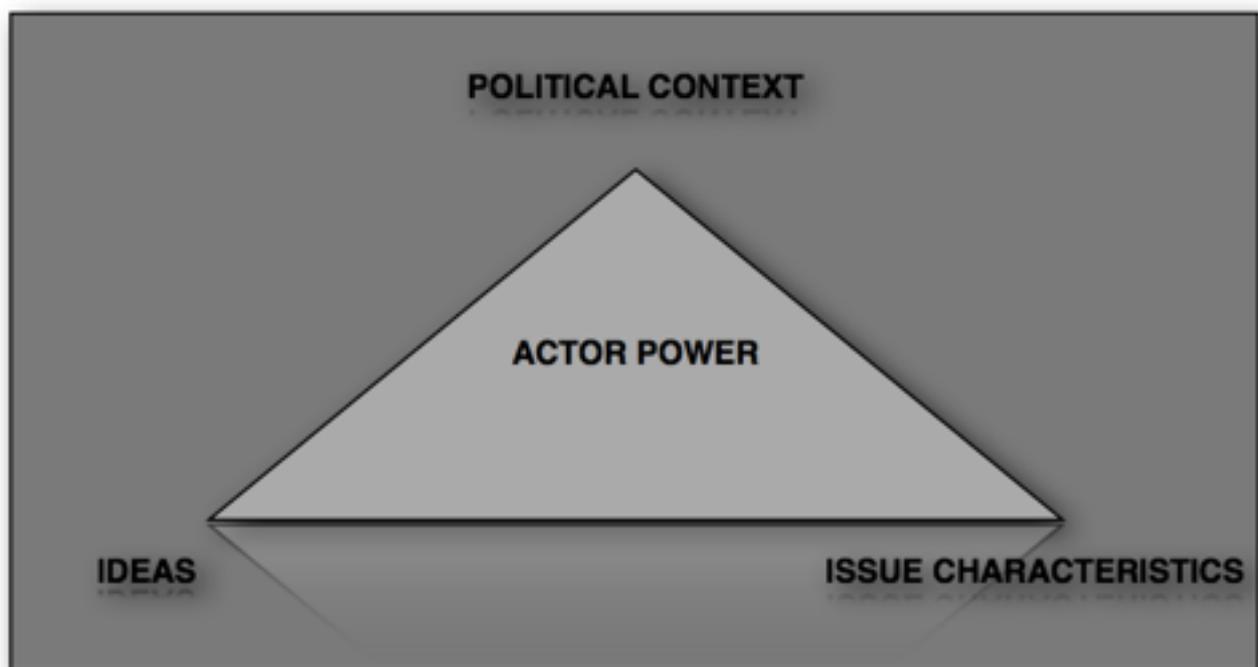
Figure 2 - Walt and Gilson's Analytical Model for Analysis of Policy Change



Source: Walt and Gilson, 1994: 354

This analytical framework looks at the relationships between state and society, political actors such as governments, foreign donors and interest groups drawing on historical, cultural and sociological analysis (Walt and Gilson, 1994). It focuses on historical traditions, socio-structural determinants, self-interest of political networks, entrenched characteristics of the political system, formal structure of institutions, the influence of ideologies, sequential processes and a variety of context-specific conjuncture considerations. When combining Walt and Gilson's (1994) model with the four key aspects of Shiffman and Smith's (2007) - the strength of actors; the ideas and discourses; the nature of the politico-historical context; and the characteristics of the issue - we get a more intricate model for evaluation of policies. See Figure 4 below for my adaptation of Walt and Gilson's (1994) according to Shiffman and Smith's (2007) framework:

Figure 3 - Adaptation of Analytical Model for the Analysis of Maternal Policy Change



Adapted from: Walt and Gilson, 1994: 354 and Shiffman and Smith, 2007: 1371.

This system of combined models and frameworks politicises or re-politicises policy by taking it from the technical realm and putting it at the centre of the ethical discourse advanced by international human rights (Cornwall and Nyamu-Musembi, 2004). It highlights the growth of global interdependence and of international and bilateral strategies in health, and their relationships with national policy change (Walt et al., 2008). That is, by

discussing local actors and their relationship with global ones, the framework of this thesis explores the relationship between global political rhetoric, power and the realisation of the human rights-based discourse (Walt et al, 2008). In this sense, the use of a policy analysis approach is directed towards questioning the reasons and manners by which change came about, as well as how it is linked to the discourses presented by actor promoting reforms (Gideon, 2000; Gilson and Stephens, 2002; Baptista and Mattos, 2011a; b; Gerschman, 2011).

Policy Legacies and Epistemic Communities

Health sector reforms in Latin America are particularly difficult because they affect a great number of people; they intend to result in a wealth of benefits (immediate, mediate and long-standing); their provision of services is complex; their clientele is diverse and; the market that they deal with is highly imperfect and unequal (Mesa-Lago, 2008). In all cases, policy makers engage in some form of difficult decision-making when engaging with complex policy choices, often dealing with diverse contexts and with partial data on contexts and outcomes (Simon 1983; 1985; Haas, 1992). Furthermore, considering the complex policy problems generated by HSRs, policy makers tend to reach for simple and previously used and/or tested solutions; often accessible from models used in neighbouring countries (Weyland, 2007; Ewig, 2010).

Actors designing and implementing global health policies rarely consider the historic context in which these policies will be implemented (Pierson, 2004). Pierson says that 'causal chains' (or the series of causes leading to long-term consequences in policy) can considerably change our understanding of social policy making and implementation (2004). He also notes that it is important to not underestimate bureaucracy autonomy and discretion (Pierson, 2004). Once networks of institutions and interests develop, historical constructions become more complex which completely affects the whole policy process (Pierson, 2004). Therefore, understanding the historical underpinnings of a particular policy is crucial to comprehending policy success and failure and to producing new data to avert failure and promote change (Pierson, 2004). Pierson contrasts historical

institutionalism and rational choice theory to map the “dynamics of self-reinforcing or positive feedback” in policy processes which he calls ‘path dependence’ (2004: 10). Here, I look at the discursive aspects of historical ‘path dependence’ to establish why health sector reforms have not improved women’s health outcomes.

Ewig (2010) uses the theory of policy and legacies and epistemic communities to explain the processes involved in HSRs policy making in Peru. Policy legacies and epistemic communities’ theory argues that international and internal networks from all sorts of backgrounds and locations play – to different degrees and form – an important part in intricate policy making processes (Pierson, 1994; Huber and Stephens, 2001; Ewig, 2010). This theory will be used for the purpose of this analysis.

A discussion raised by Pierson (1993) complements my earlier discussion on individuals and interest groups. More specifically, Pierson uses the concept of policy feedback taken and adapted from historical institutionalist analysis to study the historical evolution of processes and structural constraints of policy to determine what amounts to political and policy change (1993). Policy feedback as defined by Pierson lies in assuming that “policies produce politics”, i.e. it is the study of policy change with a particular focus on the change in politics over a particular period of time (Pierson, 1993: 597). Political systems create resources, material or not, and incentives that define the alternatives available to actors or policy networks (Pierson, 1993). These incentives and resources serve as a trigger for either success or failure of particular policy networks, their goals, and capabilities (Pierson, 1993). This dynamic also works in the other direction. Interventionist policies may rely upon a particular group of interest for certain resources such as information or personnel, which in turns serves to strengthen this particular group and their bargaining power before governments (Pierson, 1993). Therefore, policy feedback will be more acute in times of political transition or in places where policy networks are not yet well established and organised (Pierson, 1993). That is, policy is not only framed by the interaction between individuals and interest groups, but also tied to transitional or uninformed policy networks based on biased data.

Moreover, Pierson suggests that policy feedback locks in “a particular path of policy development” (Pierson, 1993: 606). In this sense, the establishment of a mode of development seems to be more important for social justice than its ability, in comparison

with others, to achieve its pre-established goals (Pierson, 1993). These lock-in effects tend to depoliticise policy spaces (Pierson, 1993). In brief, the constant increase in government's responsibilities and complexity of public affairs leads to the specialisation and fragmentation of the policy making process (Smith, 1997). Policy networks are formed as a way to provide specialist knowledge from groups to governments (or between themselves) (Smith, 1997). This exchange of information occurs in many different levels and forms and may or may not impact state autonomy and policy outcomes (Smith, 1997). This is embedded in a discourse of the alleged need for 'technicality' in policy making which then divides policy scopes within: technical and political; an artificial and unrealistic binary.

Most governmental decisions "are made within small groups which include the key congressional subcommittees, government agencies and interest groups" (Smith, 1997: 77). 'Bounded rationality' leads policy makers to opt for tried and tested policy options that they have used in their own countries in the past (Ewig, 2010: 62). As a way to influence in-country choice, political constituencies are formed in their defence and the beneficiaries of their policies (Huber and Stephens, 2001). This multidirectional mode of working through internal networks to pressure for interest specific policy making is called policy legacies (Ewig, 2010). Although Ewig's (2010) theory on policy legacies and epistemic communities seems opposed to Pierson's (1993) theory on 'causal chains' and 'path-dependency'; these theories in fact complement each other. That is, historical patterns determining and affording power to a selected group of individuals and networks are, in effect, responsible for lock-in factors in policy making, change and resistance which then lead to the continuity in unequal power relations and social inequality.

Policy legacies can be formed by various individuals oriented by diverse common interests such as labour and medical unions, learning legacies and Malthusian groups pushing for population control (Ewig, 2010). Policy legacies mediate interest groups and therefore play significant roles in permitting or obstructing Latin American social policy making (Smith, 1997; Ewig, 2010). Latin American countries are subjected to and may in fact make use of policy legacies to different extents depending on the context by which policy issues are positioned (Ewig, 2010; Costa, 1996). For example, policy makers may rely on medical doctors' opinions and experiences in order to define the scope of a new policy regulating medical interventions on child birth. A positive and/or negative policy outcome will depend

on the position of this medical union which can advance their individual or professional group interest (such as competing with nurses for responsibility over birth interventions) or their collective interest in promoting social wellbeing and justice (such as reducing the excesses of biomedical practices on child birth). Whereas policy legacies may at times be better positioned to articulate constituencies internally, international forces have increasingly been playing a role in such processes (Ewig, 2010). These international mechanisms are enabled by epistemic communities (Ewig, 2010).

Epistemic communities are networks of “professionals with recognised expertise and competence in a particular domain” that share the same causal beliefs, knowledge base and common interests (Haas, 1992: 3). More specifically, epistemic community experts are bounded by normative and principled beliefs, beliefs regarding policy actions and effects, shared notions of valid knowledge, and a general (but not necessarily always present) ‘common policy enterprise’ (Haas, 1992: 3). Epistemic communities have, at least in theory, a common agenda though may have strong disagreements regarding policy and likely policy outcomes. These international networks use their knowledge-based expertise towards creating, articulating and maintaining international policy coordination. It is important to note that some scholars use policy diffusion rather than epistemic communities to explain this phenomenon in Latin America (Mesa-Lago, 2008; Weyland, 2007). Whereas policy diffusion emerges from central coordination surrounding cross-national exchange of utilitarian policies, epistemic communities are grounded in a multitude of communities not necessarily coordinated (Hass, 1992; Ewig, 2010; Weyland, 2007). These are not mutually exclusive explanations. Both theories on epistemic communities and policy diffusion recognise that various international and cross-national networks play to various degrees a part in HSRs and health care policy models (Ewig, 2010; Weyland, 2007).

Policy networks – policy legacies and epistemic communities – can or cannot depend on each other and/or create a certain level of sub-ordinance or over-reliance on them by governments (Smith, 1997). However, if there is a momentum towards the achievement of specific policy goals and an interest to influence this particular policy outcome, networks and governments tend to become mutually dependent (Smith, 1997). See table 2 below to see the main characteristics of policy legacies and epistemic communities:

Table 2 - Main Characteristics of Policy Legacies and Epistemic Communities

Policy Legacies	Epistemic Communities
Network of individuals or groups of interests	Networks of professionals with expertise in a particular domain
Diverse and common interests	Bounded by normative and principled beliefs
Significant role in supporting and/or vetoing policies	Common 'policy enterprise' in policy making and implementation
Better positioned to articulate nationally	Better positioned to exert influence through international mechanisms

The major dynamics inherent in highly bureaucratic HSR, i.e. uncertainty, interpretation, and institutionalisation - lead to the over-reliance of States on each other's policies and on international strategies and principles (Haas, 1992; Costa, 1996). This closes down space for human rights as a social justice discourse and creates a system whereby blueprints are implemented without much deconstruction of its overall effects on social justice goals. Nonetheless, at the same time, these dynamics in HSRs also open up space for human rights discourse in a technical, i.e. depoliticised, sense which results in a reshaping of the policy outcomes. Policy legacies' and epistemic communities' influence on policy and their lock-in effects (such as blueprints), are determined by the perceived urgency and technical expertise needed for HSRs (Haas, 1992). Patterns of cooperation are then established to 'diffuse' policy ideas across borders operating through internal, cross-national and/or international policy networks (Haas, 1992; Ewig, 2010). This can prove to be influential in policy coordination and making (Haas, 1992; Ewig, 2010).

Costa argues that international epistemic communities may work their way into each national agenda in an obtuse fashion (1996). International organisations often exercise their influence through informal actors (Costa, 1996)., Frequently, the norms and values of international organisation's hegemonic discourses are then internalised and transferred to the discourse of national elites (Costa, 1996). This demonstrates that the separation between the discourses being created and mainstreamed by epistemic communities and policy legacies is not always visible or possible. By this means, deep philosophical beliefs and public policies are appropriated and internalised in the national agenda without a clear

division of what is an internal creation and what is not (Costa, 1996). In order to fully appreciate the outcomes of policy legacies and epistemic communities in HSRs in Latin America one must understand the role of public and international organisations (and their interconnections) and the process by which policies are translated into practice (Elmore, 1997). That is, a more nuanced analysis of epistemic communities must take into consideration the outward facing discourses (disciplinary ‘truths’) and inwards facing struggles, manifested in competing discourses which may take hold sufficiently to become a disciplinary ‘truth’ for some time.

Foucault’s Power and Discourse Analysis: Rhetoric versus Reality

In ‘Power/Knowledge’, Foucault associates discourse with what he calls the ‘general politics of truth’ or the ‘political economy of truth’ (1980: 131). The author rejects any sort of ‘truth’ claim and argues that ‘truth’ is neither universal nor a privilege (Foucault, 1980). ‘Truth’ (or what is deemed to be ‘truth’; at any point in time), he argues, is not a singularity but a system that is the result of multiple forms of constraints and power struggles that exist differently in each society and time (Foucault, 1980).

In ‘Politics and the Study of Discourse’, Foucault (1991) determined that the individualisation of discourse, i.e. the promotion of a particular discourse over another and its diffusion into the mainstream, masquerades the fact that the episteme, a justified belief or ‘truth’,²⁶ is a pluralistic space whereby dispersion, openness and doubtfulness is the rule. Foucault (1991) affirms that in the promotion of individual epistemic discourses, the ignoring or concealing of this unstable characteristic of knowledge is not only misleading but also dissimulating as it attempts to convey the existence of one universal history (or

²⁶ Foucault (1991) explains that the individualisation and hierarchisation of discourse is based on two concepts: episteme and doxa. Episteme is thereby defined as justified belief (‘truth’) and doxa as common belief (opinion) (Foucault, 1991). The episteme is the basis for Foucault’s method of analysis of discourse and should be seen as a space of dispersing and complex relationships of successive displacements (Foucault, 1991).

'truth'). As a consequence, a discourse that achieves the status of a monument may only be described in its intrinsic configuration but never effectively challenged (Foucault, 1991).

Foucault's theory on the dynamics of discourse and power in the representation of social reality have been instrumental in various studies unveiling the mechanisms by which a certain order of discourse produces permissible modes of being and thinking while disqualifying and even making other discursive practices impossible (Escobar, 1995; Agamben, 1995). Foucault (1991) challenges claims of universal 'truths' by discursive remnants - the vestigial traces of a discourse that has already been challenged and replaced by another one - and transformations given a particular historic trajectory. He singles out claims of 'truth' as social constructs legitimised by the use of language and sets them against the context of the struggle for control of a particular discourse (Foucault, 1991). This theory permits analysing the central construct or key words in order to expose the arbitrary character of the concepts, their cultural and historical specificity and the dangers that their use represents (Foucault, 1991). It relies on a systems knowledge approach and the dominance of a specific knowledge system as dictating the marginalisation and disqualification of other knowledge systems (Foucault, 1991). It has been responsible for the development of insightful analyses of the practices of dominant development institutions in creating and managing their client populations (Bhabha, 1990; Escobar, 1995; Agamben, 1995).

For example, Bakker agrees with Foucault and defines discourses as not only the constructs and concepts but also the process of their creation (Bakker, 1994). SAPs discourses have embedded reforms with a praxis that leads to the 're-privatisation of interests' which primarily benefits the reconstruction of the private sector (Bakker, 1994). These discourses are framed in terms of a reinforcement of the male standard of political and economic citizenship (Bakker, 1994). These discourses have, more recently, been expanded via the appropriation of human rights-based discourses (Gready and Ensor, 2005). This appropriation then serves to legitimise SAPs discourses as social enablers of change while, in fact, precisely securing the opposite.

For this reason it is essential to deconstruct these claims of universality associated with discourse by looking at the systems which regulate their emergence, their condition of existence, their functioning and their transformation (Foucault, 1980; 1991; 1994). It is

important to analyse the power relations related to discourse through the different antagonistic strategies, the forms of resistance and attempts made to promote change (Foucault, 1994). More specifically, it is not a question of looking at positive or negative language but at processes of 'subjectification' - the creation of hierarchical systems whereby a discourse has precedence over others - made possible through stereotypical discourse (Bhabha, 1990: 71).

Foucault (1991) notes that every discourse is constantly transformed, appropriated and re-appropriated. In this sense, he proposes three categories of analysis for the systematic study of discourse: 1) the criteria of formation to determine what individualises discourse; 2) criteria of transformation or of threshold to look at the set of historical concepts and the theoretical options available to discourse; and 3) the criteria of correlation to establish the set of relationships which define and situate a particular discourse among others (Foucault, 1991).

Therefore, it is important to (i) detect the changes that affect a given discursive formation in terms of its objects, operations, concepts and theoretical options; (ii) detect the changes that affect the discursive formations themselves in terms of new boundaries, position, function and localisation; and (iii) detecting the different and simultaneous discursive formation (and transformation) in terms of their interaction with each other (Foucault, 1991). In terms of the latter, the author advises the study of 'dependencies between transformations' through the following categories: (a) 'introdiscursive', the study of the relationships within the same discursive formation; (b) 'interdiscursive', the study of the relationships between different discursive formations; and (c) 'extradiscursive', the study of the connections between discursive transformations and transformations outside of discourse which takes into account the economic, political and social changes (Foucault, 1991: 58).

The study of discursive transformations must also take into account the particular context of the society in which they are inserted in (Foucault, 1991). It must be aware of the set of rules that limits what can be said; the forms of discourse conservation; the forms of memory associated with it; and the forms of appropriation (and re-appropriation) and 'struggle for control of discourse' (Foucault, 1991: 59). This research makes use of a Foucauldian discourse analysis to study the following types of discourses: (i) neoliberal

deterministic rational; (ii) gender and social policy; (iii) health and democracy (human rights and human rights-based approaches); and (iv) social participation and decentralisation.

Conclusion

Recapitulating previous discussions is useful here. As pointed out in Chapter I and Chapter II, the use of the language of rights has grown rapidly amongst development policy and practice (Cornwall and Molyneux, 2006). Notwithstanding, the rhetoric of formal rights as advocated by international development bodies have not always improved the everyday reality of women (Cornwall and Nyamu-Musembi, 2004; Cornwall and Molyneux, 2006; Vaughan, 2010). Externally imposed rights-based approaches often ignore contextual complexities and restrictions inflicted upon the duty-bearers and right-holders (Cornwall and Nyamu-Musembi, 2004). Likewise, international aid agencies and practitioners tend to treat discourse and terminology as if they were themselves capable of acting as agents of change (Standing, 2004). This is not the case. Structures of gender inequality within society profoundly condition attitudes towards the rights-based discourse and initiatives related to it (Unterhalter, 2003; Standing, 2004). Health sectors are one of the main sites where this sort of inequality is expressed and experienced (Doyal, 1995). In Latin America, changes in health care organisational policy and implementation are particularly influenced by human-rights based language (Corrêa, 2010). However, the widespread use of human-rights based language to HSRs does not necessarily lead to better health outcomes. In this sense, using Foucault's theory on discourse praxis orients the analysis of social policy by understanding the importance of positionality for social justice. That is, it demonstrates that there is no such thing as 'truth' but rather various political positions that struggle with one another for power and the right to claim 'truthfulness'.

Human rights as a political project for social justice, and more specifically the human right to health as a political movement for structural reforms, aim to defend a particular political position based on ethical values of justice, equality and democracy. It is not static or even faultless. It is, nevertheless, useful for expanding the wider project for gender and social

equality. However, gender equity in health policy may only be achieved when the ethical values of human rights as a political project are respected and abided by in policy making and implementation. Therefore, inconsistencies between rhetoric and reality, i.e. between the use of human rights-based discourses and their implementation must be analysed in the face of the context in which they are inserted, such as international neoliberal models of prevention and promotion of health. Correspondingly, looking at networks and processes, the role of ideas and exclusions and exclusionary effects in policy making and implementation is very important for the deconstruction of the disconnect between discourses and their effects. The literature on policy legacies and epistemic communities fleshes out the nuances in formal and informal fluxes of information and influence, nationally and internationally. Policy networks led by international actors create blueprints based on constructs such as decentralisation in order to shape HSRs issues in Latin America and as a way to progress with a specific neoliberal agenda (such as neoconservative population control agenda). However, the appropriation, re-appropriation and noncritical stance of human rights-based language challenges the advances and undermines the philosophical importance of human rights as a social justice project. For example, as demonstrated in the following chapters, the use of the term decentralisation led to the depoliticisation of the women's rights movement and at the same time incurred the total disfranchisement of the role of the State in the provision of holistic maternal health services under a human rights framework.

The next chapter complements this chapter by explaining the methodological tools that were used to test the aforementioned research hypothesis. It explains that a case-based study was the method chosen for collecting empirical data that provides the empirically-grounded explanation for the marginalisation of reproductive rights from health sector reforms designs. It also notes that feminist standpoint epistemology and interdisciplinary feminist research (or feminist theories of intersectionality) is used for the analysis of the data collected.

Chapter III - Methodology: Building Case Studies as a Way to Track Social Policy Processes and Ideas

Introduction

Although there is no such thing as one type of feminist research, feminist theory as a field is the one that has been dedicated to understanding complex social relations and systemic inequalities particularly from the point of view of gender (Harding , 1993; McCall, 2005). It denotes the significance of gender within society and gives a critical approach to the research process (Letherby, 2011). More importantly, feminist methodology gives continuous and reflexive attention to the significance of gender as an aspect of all social life and its influence in the production of knowledge (Blacklock and Crosby, 2004). Feminist epistemology may involve qualitative or quantitative approaches or both in their research designs (Fonseca, 1998). The use of qualitative methods, in particular in-depth interviews and a life-history approach has been historically recognised as a useful way of diluting the power imbalance between the researcher and the researched (Letherby, 2011). According to Letherby (2011), feminist methodologies focus on the reflection of the researched and the relationship between knowledge and power. Letherby (2011) understands that the researched cannot be separated from the research process and its outcomes. The researcher must acknowledge his/her subjectivities as the producer of non-objective or not value free knowledge (Blacklock and Crosby, 2004).

Therefore, this research will draw on feminist epistemology and intersectionality's use of in-depth interviews as a way to explore the effects of health sector reform on activists' understandings of reproductive rights and women's rights activists' strategies geared towards promoting these rights. This thesis reflects the findings of empirical work conducted in Brazil. It uses a case study of Brazil to examine women's rights discourses around maternal mortality reduction strategies in public policy making and implementation. More specifically, it relies on a larger case study constructed out of a series of individual case studies. As discussed below, this is a reflection of methodological saturation, i.e. results arising out of individual interviews re-asserted one another as if constitutive of a

series of individual case studies (Small, 2009). Furthermore, when the interviews alone were not sufficient to explain a particular policy process, the literature discussed in Chapter II was used to respond to some of the questions raised by individual case studies; the same happened in reverse. In this sense, my selection of questions for interviews, as well the choice of key literature, were essential to the format of the wider case study. In fact, my selection of questions for and during each interview, as well as my analysis, reflects my experience and my perception as a feminist activist and a researcher. In this sense, I do not claim to be presenting objective data (and I hardly think it is ever possible to be apolitical and objective). What I attempt is to present accounts that have otherwise been silenced by mainstream accounts on maternal mortality reduction and activism (Blacklock and Crosby, 2004). The data was collected and analysed as a way to look at the gendered constructions and practices supporting and replicating health inequalities in Brazil (Doyal, 1995). However, the analysis of the data also lent itself to the discussion of deeply racist²⁷ perceptions related to health and illness (Boesten, 2007).

Constructing a Foucauldian Discourse Analysing

Considering the relevance of Haraway's (1991) work on rhetoric, I expand on her arguments by proposing that a Foucauldian discourse analysis is a necessary feminist approach. In her paper 'Simians, Cyborgs, and Women: The Reinvention of Nature', Haraway (1991:1) contends that it is necessary to, in her words, be "attuned to specific historical and political positionings and permanent partialities without abandoning the search for potent connections". That is, she argues it is crucial to trace down discursive processes in order to understand the modes of production, the meanings of, and the control of knowledge (Haraway, 1991: 1). This method of analysis of discourse not only requests us to distinguish between the different positionalities, but also to adopt a clear and specific positioning as a way to improve feminist scientific and political knowledge. In sum, to adopt a feminist Foucauldian approach means to reject all 'truth' claims, including

²⁷ By rejecting the myth of a 'racial democracy', I take the stand that race and class are intertwined, almost inseparable, in Brazil, (Da Matta 1990; 1991a; 1991b; Stolke, 1993; Htun, 2004). This relationship will become clearer throughout the analysis.

ours as researchers, and understand that all academic work is also a type of discourse that departs from a particular political standpoint, in this case a feminist standpoint. In this sense, by looking at ideas and exclusions and exclusionary effects, one is capable of thoroughly analysing the role of networks and processes influencing social policies. This in itself is capable of expanding the feminist agenda for more transparent and inclusive knowledge production which is necessary for advancing feminist claims for social justice.

There are various definitions of discourse that range from a post-structuralist attachment to meaning and limits of the ensemble of representations, to a purely linguistic sense of change in meanings while using the same language, then to the combination of both in order to establish it as an “extended discussion within a particular framework” (Gasper and Apthorpe, 1996: 3). It considers all policy positions and interventions as they effectively change the approach to a particular issue (Waylen, 2002; Hoppe, 1999). For this purpose of this analysis, I look at some of the policy positions and interventions implementing maternal mortality reduction strategies as part of the wider project for HSRs. The policy positions and interventions were selected in terms of their relevance in the change, resistance or maintenance of a particular paradigm. For example, interventionist and market-oriented approaches can both be presented as the need to intervene in the public sphere, either by advocating the importance of the State or the force of the market (Bakker, 1994). At times, research into public health policy-making fails to address the use of language, arguments and discourse by formal and informal networks and their inter-relationship (van Olmen et al., 2012). However, the use of rhetorical language is an essential part of how policy is constructed and enacted (Ollila, 2011). That is, all is discourse and, therefore, rhetoric. In this sense, the use of rhetoric is not always negative or harmful but all knowledge is about discourse and power, but the real difference lies in determining their transparency and capacity to deliver on the outcomes argued for through the use of positive or negative (or empty) rhetoric. That is, the epistemic view of rhetoric defines it as responsible for transmitting and also for generating knowledge (Scott, 1985). Discourse can be used to empower or disenfranchise previously marginalised groups or linking them with others to make a stronger or weaker force for arguing for their interests – (rights which are in themselves a discourse).

The Importance of a Case Study Approach

Qualitative researchers studying social inequality currently face growing pressures to produce results that can be used by other qualitative scholars, quantitative academics, policy makers and activists alike (Small, 2009). As a result, there is an expectation that all research looking into social inequality will produce some sort of empirical finding that is capable of being applied to other contexts sharing similar characteristics, i.e. generalizable (Mitchell, 2006). However, representativeness is not always desirable, or in fact possible in the case of qualitative studies (Mitchell, 2006). The real problem lies in conceiving a design that is appropriate to the social reality being studied (Geertz, 1973). That is, one must not seek representativeness in research, but validity in its analysis (Mitchell, 2006).

Qualitative research has a long standing tradition of relying on case studies for validity (Fonseca, 1998). Case studies are hypothesis testing mechanisms that serve as a tool and as a catalyser for the production of new data, possibly constitutive of ontological statements (those producing new knowledge). Indeed, case studies are used to analyse a particular social situation by comprehensively gathering data on the internal and external circumstances influencing it (Gluckman, 1961). Case-based methods depart from different perspectives of analysis that range from those that look at the external forces generating particular practices to those that focus on uncovering mechanisms and processes related to a particular chain of events (Small, 2009). The latter is particularly relevant to this thesis. This type of extended case method tracks sequential events over a period of time and establishes the significant connections in between them (Gluckman, 1961). By emphasising the links of chains of events, this method provides the basis for an analysis that is able to answer why and how these links were created in the first place (Gluckman, 1961).

Case-based research relies on in-depth interviews to understand the nuances of complex relationships which would not be able to be captured, for instance, by the use of a survey or through the collection of secondary data (Small, 2009). Studies using in-depth

interviews may rely on case study logic in order to construct multiple case-studies instead of small samples orienting one single case study (Small, 2009; Yin, 2002). In brief, the multiple case-study method classifies each interview as a case study and, therefore, dictates that every cluster of interviews (or interview sample) needs to be viewed and organised sequentially (Yin, 2002). Under this model, each interview is conceptualised as a unit that orients and completes the other units (Yin, 2002). In this sense, a new questionnaire is produced for each interview with the aim to test the findings arising out of previous interviews and with the ultimate goal of achieving saturation (Yin, 2002). The interview process will then cease once saturation is achieved (Yin, 2002). That is, giving continuity to the interview process would be irrelevant as it would not be capable of producing new data. At this point, all interviews have already served as a means to reaffirm over and over again statements made previously.

Although extremely important, saturation in the interview process is not enough to establish validity. Any case study or sequence of case studies is not valuable if isolated from its historical context (Fonseca, 1998). That is because a case study-based method is only useful if presented in combination with the body of academic and non-academic work available in the same field (Geertz, 1973). The use of existing empirical and theoretical analyses not only informs the construction of the case study (by orienting the formulation of questionnaires for example) but also challenges and/or validates the ground where a case study stands, and its hypothesis (Mitchell, 2006). This accumulation of experience and knowledge facilitates the insertion of the study into contemporary scholarly conversation as well as promoting its use as part of the corpus of knowledge acquired in the field. Ultimately, a valid case study is one that can become useful to other academic research conducted in the field.

As will be demonstrated, the wider case study used in this thesis is relevant as it serves to inform social policy making and implementation in Brazil. Additionally it is suggested that, with some minor adjustments, it can be extrapolated to other studies analysing themes related to social policy in the country, even those moving beyond women's rights and health sector reforms. Nonetheless, its empirical findings might not necessarily be applicable to every analysis looking at social policy making and implementation or even health sector reform processes and policies. Logical inference is possible when, and only when, similar characteristics exist (Mitchell, 2006). In this sense, it is expected that

neighbouring countries in Latin America might share some of the characteristics illustrated by this case study. Authors such as Weyland (1995; 1996a; 2007) have indeed shown how policy ideas 'diffuse' across neighbouring countries yet we still need to understand the specificities of each country context. However, the construction of such arguments needs to be adapted to each model and specific socio-political and historical context.

The Wider Case Study and its Purpose

According to Mitchell (2006), the purpose of theory is to evaluate the implications of general models against relevant empirical evidence-based conclusions drawn from a particular case study. Here I complement Mitchell's (2006) argument by contending that theory must not only be used to evaluate, prove or disprove research hypotheses. Theory, in my opinion, must be complemented by empirical evidence as much as it complements evidence. What are the practical implications of this assertion? Well, this implies that case-based methods are not linear ontological tools but rather non-linear dialectic processes that integrate theory and evidence as if to obliterate or blur the imaginary line that separates them. For example, in Chapter V, I discuss the portrayal of maternal health as a non-issue in order to link it to existing maternalistic health policies. One might read this as an academic construction or even the imposition of an already existing academic construction. However, the fact is that this chapter was built out of the combination of field work findings with Agamben's (1995) theory on the political economy of discourse and the depoliticisation of discourse. Instead of discovering Agamben's (1995) scheme and then trying to fit the results of interviews into it, I identified recurring issues and then matched these with Agamben's (1995) theory. Or, for instance, in Chapter VI, I trace the institutionalisation of the social movement for health reform in order to show that the movement's language was not incorporated into the democratic constitution of 1988. This observation was made possible by mapping incisive and repetitive remarks denoting the importance of the use of collective health language during interviews (see Chapter I for the comparison of collective health and public health). But also, I was able to understand the reason behind the dissociation between discourses (on collective health and global health and their internalised versions) by re-reading Haraway's (1991) *Cyborg Manifesto*. The

Manifesto, as noted in the second section of this chapter, adopts a feminist reading of Foucault (1980) and highlights the importance of tracing discourse appropriation. By turning my focus to discourse appropriation, I was able to unveil the processes by which progressive language (such as in the case of collective health principles like decentralisation) gets appropriated by conservative policy networks aimed at advancing a neoliberal agenda. Similar to the previous example, under this methodological scheme, theory became more robust when combined with the systematic analysis of evidence.

In this sense, to address the questions raised by this research proposal, and to address the methodological issues exposed above, I conducted a historical mapping of policies related to women's right to health, maternal mortality reduction initiatives and decentralisation in Brazil. I later combined the results of this mapping with my literature review and, when necessary, I sought out new literature in order to comprehensively analyse these results. The interviews were carried out with key actors that work or had worked on women's rights policies and/or maternal mortality reduction political strategies in the country. The wider case study resulting from this series of interviews is intended to provide a general critique of maternal mortality reduction strategies in Brazil (Gluckman, 1961). However, the policy implications of decentralisation and health sector reforms in the last three decades are measured through the use of semi-structured and in-depth interviews. The analytical conclusions were reached as a result of the combination of these interviews with the matching literature.

The fieldwork lasted from September 2011 to December 2012 with additional data being collected between January 2013 and June 2013. An initial mapping took place during the first months of field work in order to identify archival material, academic material and policy documents. Thereafter, there was a period of semi-structured and in-depth interviews with key actors at the national, state and municipal levels. All interviews were conducted as a way of testing the hypothesis of the research. They addressed all or key processes related to the creation and implementation of policies on maternal mortality reduction in Brazil. This process-tracking technique is directly related to Shiffman and Smith's (2007) theoretical framework. All interviews, at some point or another, were directed at discussions related to the four Shiffman and Smith (2007) aspects: (i) actor power; (ii) ideas; (iii) political context; and (iv) issue characteristics. More specifically, interviews were also conducted as a way of addressing some, if not all in some cases, of the categories of

analysis pertaining to the other theories sustaining Shiffman and Smith's (2007) framework, i.e. social policy making and analysis; health sector reforms and policy networks; and Foucauldian power and discourse analysis. The results arising out of the interviews will be presented in specific chapters addressing each of the aspects discussed by Shiffman and Smith (2007). In short, interviews were carried out as a way to track the different discourses created by the different policy legacies and epistemic communities dealing with maternal mortality. The discourses were then classified in terms of the value attached to each approach, as mere rhetoric or reality in their commitment to social justice as a project capable of effectively promoting change.

The field work therefore consisted of two stages. The initial stage was devoted to targeted and institutional mapping of the decentralisation policies and programmes un the period 1980 to 2010 and predominantly relied quite on primary and secondary data from Brazil. The second stage was aimed at testing the research hypothesis, drawn from the earlier mapping exercise, by interviewing key actors. As stated in Chapter I, this stage considerably challenged the initial hypothesis created before the beginning of field work and, at the same time, confirmed the second hypothesis created in the early stages of field work. This exercise was useful in reshaping the methodology and research objectives (Mitchell, 2006). This was particularly necessary given the changes in the research hypothesis.

Research Design

The first stage of the fieldwork was a fieldvisit to both the city and State of Rio de Janeiro, the State of Rio de Janeiro and to the capital of Brazil, Brasília, for targeted and institutional mapping of the decentralisation policies and programmes implemented since the mid-1980s. This was followed by a second trip to the State of Rio de Janeiro aimed at testing the theoretical paradigms drawn from the earlier mapping exercise. This helped to refute many of the assumptions I had before starting field work. Furthermore, it supported some of the findings arising out of the first stage field work (Mitchell 2006). Moreover, the second stage served to gather secondary data as well as primary data in the format of in-depth interviews with key actors. This particular set of interviews or individual case studies (see above), share similar and relevant characteristics with each other and are part of the

same sequential interviewing system (Yin, 2002). These similarities enable inferences and propositions about the particularities of the social, cultural and political phenomena being studied (Mitchell, 2006). This supports final conclusions in regards to policy legacies and epistemic communities as well as the discourses used in decentralisation of health services and maternal mortality reduction strategies in Brazil.

Appropriateness of Design

Brazil was chosen given its leading position in the global economic and political agenda as well as for its paradoxical under-developed public health sector. The initial phase of research was justified by the need to access the Brazilian literature on health sector reform and to have access to the Ministry of Health and the Special Secretariat for Women's Rights as well as documents on health sector reforms and maternal mortality policies. And, finally, the choice of the state of Rio de Janeiro as the base for carrying out interviews is due to the historical importance in health sector reforms' processes (Paim, 2003). Moreover, it is also justified by the expressive number of key actors that are based in the Southeast region that led and/or lead crucial movements informing or pushing for social equality demands and shaping public health policies at the municipal, state and national levels (Paim, 2003).

Interviews

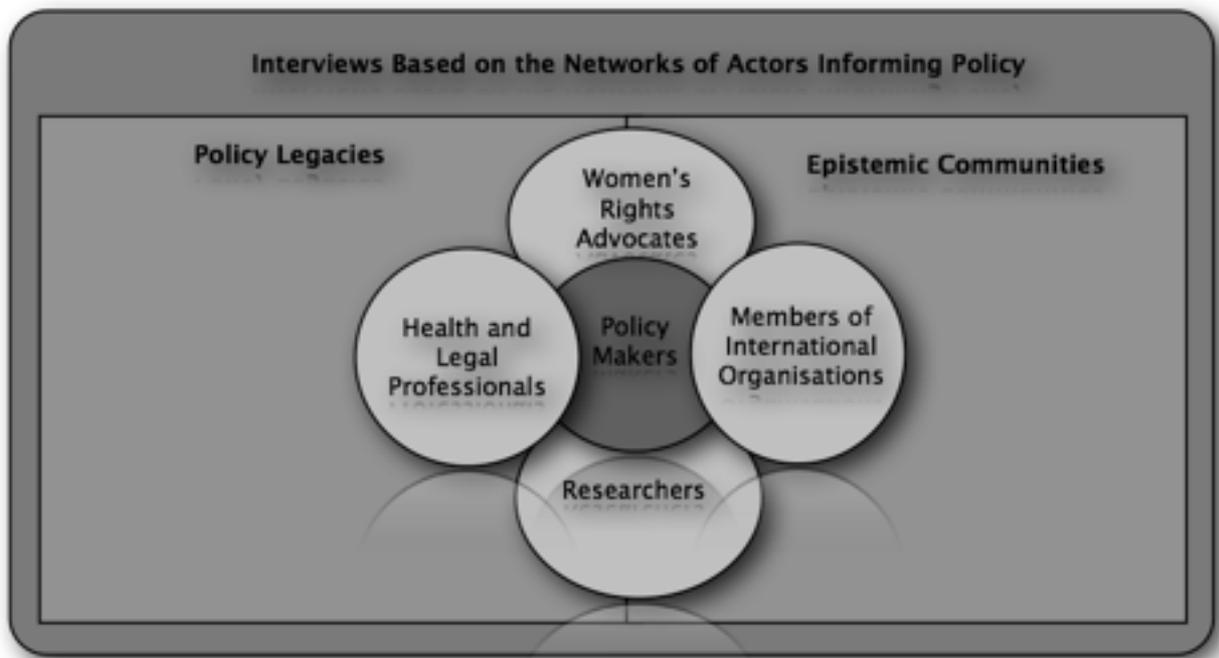
The study is oriented by semi-structured in-depth interviews conducted with forty seven actors. The pool was therefore divided and analysed through the division of key policy players in five separate policy groups:

- (i) policy makers participating in the government's bureaucracy;
- (ii) health and legal professionals in charge of implementing health policy;
- (iii) women's rights advocates (feminists and non-feminists);
- (iv) academic policy researchers; and

(v) members of international organisations (UN agencies and non-governmental organisations working at the global level).

This division stresses the different discourses used by each group and the influences these discourses may have had intra-groups and externally. It considers the internal divisions within each group and the extent of its importance to the wide dissemination of the main discourse promoted by each group. Taking into account Ewig's (2010) framework dividing policy networks into policy legacies and epistemic communities, the relationships represented during interviews can be visually represented in Figure 5:

Figure 4 - Interviews based on Main Characteristics of Policy Networks



From this visual representation it is possible to notice that policy makers, women's rights advocates and researchers operate simultaneously as policy legacies and epistemic communities and/or requesting information or informing policy legacies and epistemic communities. All of the groups intersect with one another in virtue of the work carried out as part of the scope of the networks they operate in; the dependency of each network on one another; and depending on the issue being dealt with. The Figure attempts to demonstrate the intersecting areas of construction of discourses around maternal mortality reduction initiatives. It was based on the most common relationships debated or

represented during interviews. In this sense, it is important to note that there are links that are not represented in this figure.

Informed Consent

During the collection of data with the above mentioned informers, the researcher made clear at the beginning of each interview: (i) the research topic; (ii) the purpose of the interview; (iii) the intention of recording the interview; (iv) the content and purpose of the consent form; and (v) that the interview could be cancelled, stopped, questions could be skipped or left unanswered and that data could be withdrawn or retracted if the interviewee preferred to do so. In sequence, I asked each informer to fill and sign two written consent forms, one to be kept with the informer and one to be kept with the researcher. However, and in spite of the use of the same protocol for all interviews, not all interviewees signed a consent form. All have received and read a copy of the consent form but some have decided to give their consent orally which has been recorded and stored as part of the archive of interviews. This was done in order to accommodate interviewees' requests as well as to guarantee a good flow of conversation during each interview. The sample informed consent form used in the semi-structured interviews can be found at the end of this document.

Sampling Frame

The list of semi-structured interviews with key actors was to a great extent created out of an initial pool of participants recommended by two professors from the Institute of Social Medicine at the University of the State of Rio de Janeiro - UERJ (Instituto de Medicina Social da Universidade do Estado do Rio de Janeiro - UERJ). Both professors, as well as the department they work for at UERJ, are highly regarded among the experts working on

public health in Brazil. Their generosity and reputation were no doubt quite important for the development of a well-regarded group of participants who were willing to take part in interviews, and also willing to share what I consider quite a rich set of accounts and experiences in public policy making, implementation and advocacy. No notices or advertisements were used for this research. After the initial pool of participants was established, then other participants were included on a 'snow-ball sampling' basis (Small, 2009).

It is important to note that I am Brazilian and I have worked for a feminist organisation and published from a feminist standpoint. This served both as a catalyst and inhibitor in the interview-seeking process. As I could easily be identified and matched with a particular policy network, i.e. feminist, I could easily get interviews with people who self-identified as aligned with the left wing, but had considerable difficulty getting any replies from people self-identifying with the right-wing. For example, I was able to get an interview from a moderate centre-left religious advocate, but none with extremely conservative religious advocates. Moreover, my fieldwork overlapped with the 2012 municipal election period (electing representatives for city hall and city council) and the Rio +20 (the 20 year follow-up to the 1992 United Nations Conference on Sustainable Development) period. This also served as an obstacle to interviewing, especially when I tried to interview policy makers. Most of the time, I would not even manage to schedule a preliminary meeting. There were times when I would manage to schedule an interview and then the person would either cancel it at the last minute or disappear altogether. It seemed as if most people involved with the elections were either too busy to take any more commitments on board or too cautious to risk having any sensitive declaration/information leached to the press. In this sense, my political position was not only relevant during interviews but also quite important in the shaping of the research pool.

Confidentiality

As stated above, the institutional support acquired at UERJ was responsible for a fairly friendly and open group of interviewees. Interviewees usually associated me with the professors or the institution I was associated with. This served to incite a certain level of

trust that would not have been possible otherwise. As experts, little or no explanation was necessary in terms of the main subject of the research. However, in order to abide by ethical protocols, before the beginning of each interview, I answered any questions the interviewees had about the research and about my background which was shortly followed by a standard statement affirming that the interviews could be conducted totally or partially in confidentiality and that arrangements could be made for any variations that they preferred. The informers were always in full control of the interview process and the data it generated. None of them asked not to be involved after the initial statements and questions. Three informers asked for transcripts of their interview out of which one asked that a considerable part of the interview were to be kept under strict confidentiality. All these requirements were promptly attended. Moreover, all interviewees have demonstrated an interest in receiving the final version of the thesis as published in the British Library repository. I have committed to sharing this version with all interviewees as soon as it is made available in the official repository.

The sample questionnaires used in the semi-structured interviews can be found at the end of this document. I used a digital recorder which was taken to interviews, conferences and other networking events. Interviews were transcribed by me and classified by using codes and colours according to subject matter, location and interviewee's status. This was done as a way to guarantee proper analysis of the data through the identification of groups of actors. Moreover, notes were taken at all times in order to guarantee that thoughts and perceptions that could not be captured by the recorder were also kept on file. All data collected - including notes, interviews and transcripts - were stored at a personal and secure online server called 'dropbox'.

Instrumentation

As already mentioned, the first month of the study was dedicated to formalising an institutional link with the University of the State of Rio de Janeiro. This institutional link afforded the researcher the status of visiting academic at the University of the State of Rio de Janeiro - UERJ. It also provided the researcher with access to libraries and databases as well as an array of contacts for interviews with policy makers, feminists and

researchers. The researcher then used the initial months to perform a full review of the literature available in Brazil on health sector reform, decentralisation and maternal health. This improved my understanding of the overall status of health in the country as well as the technicalities and politics involved in it. It also allowed for the appropriation of the discourse used by health sector reform specialists in Brazil which in turn improved the chances of scheduling interviews and acquiring the data that could inform the research's main question.

As mentioned above, I was working at the three different levels of government, i. e. Brasília gave me national overview and Rio de Janeiro gave me an understanding of both state and city level. The interviews started at the city of Rio de Janeiro but then were relocated to the national level, i.e. Brasília, for access to the Ministries of Health and Special Secretariat of Women's Rights. Afterwards, aiming at exploring the state and city level policies and implementation, I travelled to the city of Rio de Janeiro in order to interview state level policy-makers, feminists and other women's rights activists. However, interviews were also conducted with actors that resided in São Paulo, Belo Horizonte, Curitiba, Porto Alegre, Salvador, Recife, Bogotá, Montevideo and Geneva. This reflected the level of mobility of women's rights advocates and researchers as well as the high turnover of women's agencies, organisations and departments. This fact stands as one important point to be explored in the analysis of the data acquired. For logistical reasons, not all interviews were carried out in person in which case I relied on video Skype calls. As previously discussed, the initial pool of informants was provided by the high profile professors at UERJ which then served as the key to developing the main pool of interviews. More specifically, the initial pool of interviewees recommended the researcher to other informants. These recommendations allowed the researcher to contact other actors in the area of public health such as women's rights advocates, politicians and medical and legal professionals. This 'snowball' process continued throughout the research.

Data Collection

A semi-structured questionnaire (see appendix) was used to guide in-depth interviews. The majority of questions were developed during the interview allowing flexibility for the interviewer and interviewee. This was done with the aim of capturing the perspective the interviewees had themselves of the state of maternal mortality initiatives in Brazil and their evolution since the 1980s. Along with interviews, it was also possible to collect secondary data and literature in Portuguese available in public and/or academic archives such as policy documents, minutes of meetings and empirical research material on the history of health sector reforms and women's rights initiatives in Brazil. While I intended to use all materials that best represented the main discussions the I identified, in the pool of interviews and secondary literature, this was not feasible given the constraints of the thesis word count. While the inclusion of additional material may have enriched the thesis, I do not believe the key arguments have been compromised. However, I intend to publish more excerpts from interviews in future work, in order to ensure these live on beyond the thesis.

Reflecting on the Role of Researcher in the Production of Knowledge

As argued in Chapter I, this research aims to explore strategies that silenced political strategies as well as forms of political strategies of resistance developed out of the need to make visible the issues impinging upon women's rights and/or as a result of conservative backlashes against women's rights. As a result, it is important to take into account my position as a researcher as an insider and/or outsider (Geertz, 1973), and, as often pointed by feminist standpoint epistemology, it is crucial to understand my role in knowledge production in terms of its: (i) generation; (ii) ownership; and (iii) use and access (Blacklock and Crosby, 2004). This is because social research has the potential of generating the sort of privileged 'truth' that can either challenge the status quo, contribute

to replicating existing systems of oppression or even generate new ones (Blacklock and Crosby, 2004).

This assertion is part of a large body of theory that affirms that social scientists (and in fact all scientists) are never independent or neutral (Geertz, 1973; Fonseca, 1998; Blacklock and Crosby, 2004). Researchers produce and affect the production of data just as much as the researched subjects do (Fonseca, 1998). In this sense, postmodernist analysis of epistemology and feminist standpoint methodology require a constant reflexive exercise to guarantee: transparency; mutuality; and accountability (Blacklock and Crosby, 2004). More specifically, by attempting to understand what is being said by interviewees about the specific subject, one must use the same language to create a bridge inbetween the symbolic universes of the interviewer and interviewees (Fonseca, 1998). Therefore, it is the role of the researcher to facilitate the establishment of common grounds of communication as well as create questions and propose new hypotheses to the research subjects (Fonseca, 1998). In doing so, the researcher must consciously understand the expectations of the interviewees (of being well-regarded, for example) and his/her own expectations (of producing data that validates the research hypothesis, for instance) (Fonseca, 1998). So, while searching for empathy, confidence and/or respect, the researcher is actively shaping the research results. Critically analysing the data in the face of these constraints and benefits is crucial to the production of transparent, reliable and accountable data (Geertz, 1973).

As previously stated, I conducted semi-structured interviews that were loosely based on a previously developed questionnaire approved by the Birkbeck College Ethics Committee. Interviews were also partially based on notes developed by the interviewer before each interview and based on each interviewee's publicly known-role in health sector reforms and/or women's rights activism. This flexibility was crucial for acquisition of the nuance in the material that is necessary for this type of research devoted towards the exploration of ideas and perceptions around the issue of maternal mortality activism. The interviewer used this room for manoeuvre to explore particular aspects of the questionnaire that seemed to be of greater interest to a particular interviewee and/or capable (at least in principle) of generating more interesting responses. All the questions were necessarily linked to a particular part of the questionnaire and therefore were capable of being compared against the material produced through other interviews. This, of course, means

that the researcher played an active role in getting specific answers that are extensively used throughout the analysis. It is important to note at the same time, that I attempted to not force my episteme and standpoint upon interviewees and to leave them with a lot of freedom in terms of response, response-time and follow-up to previous points of discussion.

As mentioned above, another issue that played a particular part in determining the pool of interviews as well as the production of data was the fact that I had self-identified as a feminist. Even if that was not the case, I have previously published academic material from a feminist standpoint. This facilitated setting up interviews as well as gaining trust from feminist activists. I think, however, that being and self-identifying as a feminist may have impaired access to members of religious organisations which remained in their totality completely silent to the researcher's requests for interviews. It is not possible to assess if this can be taken as a straightforward rejection or as something else due to access or communication channels.

Finally, the questionnaire as well as the new questions developed for each interviewee made use of politically charged terms such as decentralisation (instead of policy space) and abortion (instead of contraception). This was done merely because I was unaware of the political scenario and political tensions present in the health sector and health sector discussions in Brazil. In retrospective, the researcher feels that a different type of material could have been collected if it were not for respondents' absolute rejection of the researcher's use of such terms and/or attempt to challenge the terms that are perceived to be sufficiently established by activists or political myths that ought not to be addressed so openly.

Data Analysis: Using Feminist Standpoint Epistemology for Action Research

The analysis entails the examination of policy texts relating to reproductive health programmes over the last three decades, secondary related to Latin American health

sector reforms, and semi-structured interviews with: key actors at national, district and municipal levels. For this purpose, I will rely on feminist standpoint epistemology.

This is, however, a significant debate among researchers. Carby (1982) and Mohanty (1988), for example, demonstrate that feminist research does not perpetuate positivist ideals of truth or its dominance. In the words of Mohanty (1988), western feminist discourse and praxis is not singular or homogeneous. Feminism (or feminisms as a matter of fact) is not conformed to 'objective' knowledge over one subject; it amplifies along a wide spectrum of goals, approaches and interests (Mohanty, 1988). It is nonetheless always political and its discursive practice purposeful and ideological (Mohanty, 1988). It is a political praxis that resists a hegemonic discourse that portrays the scholarship as apolitical by challenging existing power relations (Mohanty, 1988). Carby (1982), on the other hand, denotes that western or mainstream feminism advocates from an 'imperialist' standpoint that fails to acknowledge the interconnections of class, gender and race and the experiences derived from them. Carby (1982) argues that there are multiple sources of oppression and multiple types of lived oppression (struggle). This sort of oppression created and reinforced by hegemonic Western feminism has been the subject of many studies (Fraser, 1995; 2013).

This methodology is not limited to or initiated by 'traditional feminist methodology'. Neither will it be dedicated to the discussion of the different theories within feminist research. This dissertation will only make use of the framework of the feminist standpoint epistemology and interdisciplinary feminist research (or feminist theories of intersectionality) (Martin, 1987; Haraway, 1991; Harding, 1993; Letherby, 2002; McCall, 2005; Hesse-Biber, 2007). Nevertheless, Chapter IV and Chapter V will particularly discuss the many feminist agendas and the marginalisation of non-hegemonic feminist agendas such as those represented by black feminists (Fraser, 2013).

Feminist Standpoint Epistemology: Rejecting Neutrality

Haraway (1991) argues that feminist knowledge making and research is necessarily a political endeavour. She argues that feminist standpoint epistemology is committed to

feminist struggles over the modes of producing knowledge about, and the meanings of, behaviour and the use of discourse in social lives (Haraway, 1991). She contests that discourse is politics in the sense that it has the power to determine stories about 'nature' and 'experience' (Haraway, 1991: 3). Haraway (1991) uses the analogy of the cyborg to defend that a researcher should be committed to partiality. She demonstrates that rhetorical strategies of appropriation and incorporation that serve to erase or police difference are more acute in research that claims impartiality because it obliterates the authority of any other political speech and action (Haraway, 1991).

Llewelyn argues that there is no neutral observer and that researcher neutrality in feminist fieldwork is neither possible nor desirable (2007). Llewelyn (2007) also argues that researchers keep imposing their epistemic, or theoretical, framework on interviewees, but in fact need to direct critical attention to both their perspectives as well as the interviewees' perspectives. Social positions and personal identities shape our understanding of a particular event, process, or thing (Llewelyn, 2007). This postmodernist vision that rejects single truth is endorsed by Hesse-Biber (2007) who in contrast says that the social researcher often deals simultaneously with a multitude of different standpoints and negotiations of multiple identities. This series of negotiations can be better accommodated if seen from a feminist standpoint episteme (Hesse-Biber, 2007).

In the same sense, Harding (1993) affirms that feminist standpoint epistemology provides arguments claiming that scientific analysis of social situations are better observed from the point of view of the marginalised. Feminist standpoint epistemology would in this sense provide more objectivity by providing methods for situating knowledge in a systematic way, with respect to history and context, clearly politically oriented but at the same time transparent to its tools and impartiality (Harding, 1993).

Intersectionality: Understanding Factors that Inform Gender Experiences

As mentioned about, all interviews were oriented by intersectionality theory. Intersectionality is a theoretical paradigm that gained emphasis in third wave feminist research through the work of Crenshaw (1991). Intersectionality is a social sciences

methodological theory that rejects the separation of categories of analysis and identity (McCall, 2005). It is understood as the acknowledgement of the existence of multiple social dimensions and subjectivities (McCall, 2005). McCall understands that intersectionality requires scholars to adopt analytical categories to trace relationships of inequality among social groups and configurations of inequality along multiple dimensions (McCall, 2005). She calls this the 'inter-categorical complexity approach' (McCall, 2005: 1772). This entails the analysis of race, gender and other identity categories for the inclusion of research voices that are normally marginalised from the mainstream and departs from the standpoint of feminist and racial liberation movements, i.e. it looks at promoting social power and reconstruction through deconstruction (McCall, 2005).

In this sense, intersecting patterns of analytical categories and identity politics, i.e. being a black woman who suffers domestic violence, define particular experiences and how these experiences are presented within different discourses (Crenshaw, 1991). This paradigm attempts to supersede traditional boundaries by taking into account the complexities of dimensions such as gender, race and sexuality, among others (Crenshaw, 1991; McCall, 2005). Intersectionality is broadly useful in delineating and understanding health sector reforms in terms of group politics (Boesten, 2007; 2010).

Conclusion

By acknowledging current methodological discussions on qualitative research representativeness, this chapter indicates that, instead of seeking generalizable conclusions, this thesis seeks to assess validity of its analysis. As explained above, the methodology is built on sequential case studies or individual in-depth interviews for asserting validity. The chapter demonstrated that sequential case studies (and therefore the wider case study composed by them) are important in understanding processes related to the influence exerted by the different discourses used by policy legacies and epistemic communities. This case-base method is then combined with the ongoing academic discussion on health sector reform's designs, implementation and social policy making.

This chapter also notes that all data gathered during fieldwork - i.e. interviews and secondary data in regards to the ongoing academic discussion, as well as other information on the context in which these interviews are inserted in - is analysed against the backdrop of feminist standpoint epistemology and intersectionality. As argued, this will allow transparency, accountability and mutuality in the generation, ownership, use and access of the information produced during interviews. Establishing this set of combined methods from a feminist standpoint is also particularly useful in understanding political discourses and their links to women's rights activism and their overall relation to reproductive health and rights in Brazil. This is because it rejects the idea of a neutral observer and of apolitical research. By allowing and even demanding a clear and transparent reflection of my position as a feminist researcher, it transfers to the reader the ultimate responsibility of confirming the validity of the analysis. In sum, this method means that my political position and personal judgements are made clear so as not to cloud the analysis with their interference. This methodology will be crucial to operationalise the theoretical framework.

The following chapters look at the implementation of decentralisation in the health sector in Brazil and attempts to establish if the health sector reform rhetoric was translated into real and improved health policy making and implementation. It relies on a series of case studies to build a wider case study on maternal mortality reduction strategies in Brazil. It uses data collected from the literature and from in-depth interviews performed with key actors. The chapters address the four aspects affecting maternal mortality policy making created by Shiffman and Smith's (2007): actor power; ideas; political contexts; and issue characteristics. The next chapter makes a historical analysis of the global community that was built around maternal mortality reduction initiatives. This not only addresses actor power as an aspect but also as an entry point for the discussion of its sub-factors as pointed out by Shiffman and Smith (2007), i.e. policy community cohesion; leadership; guiding institutions; and civil society mobilisation.

Chapter IV - Back to the Basics: The Advancement of Women's Right to Health at the Global and National Levels

Introduction

Shiffman and Smith's (2007) framework is particularly concerned with understanding collective action and its capacity or incapacity to subvert existing power structures. The first aspect in the scholar's framework points to the power of actors connected to maternal health as a political issue (Shiffman and Smith, 2007). In their opinion, the strength or weakness of actors involved in maternal health is crucial to inhibit and/or enhance political change (Shiffman and Smith, 2007). This aspect is divided into four factors: policy networks' cohesion; leadership; guiding institutions; and civil society mobilisation (Shiffman and Smith, 2007). This chapter aims to respond to this framework by addressing the first aspect and the four factors shaping it. More specifically, it will describe the actors involved in shaping maternal mortality as an issue globally and nationally as well as all factors influencing the effectiveness of their actions.

National maternal health strategies have been widely framed in terms of global strategies on maternal mortality, such as the 1987 Safe Motherhood Initiative. Regardless of its limitations, global human rights instruments have the capacity to substantially influence policy change at national levels. The global framework has considerably changed over time moving from a widening approach to sexual and reproductive rights towards narrowing them to maternal health and mortality. This article deconstructs these strategies and places them in terms of the discussion on restrictive and comprehensive approaches to reproductive health and rights. Indeed, the recent history of health sector reforms in Brazil is inextricably linked to the wider global human rights project.

In order to provide a better understanding of this overreaching and complex exchange, the first section outlines the global context and the efforts towards maternal mortality reduction, mainly the key United Nations conferences and strategies and the new

approach created with the Millennium Development Goals. The second section discusses the Brazilian context, the current status of women, its demographic transition, the national programmes and feminist's political strategies. It argues that the resistance to progressive approaches to sexual and reproductive rights has led to the reinforcement of a restrictive concept of maternal health. The historical analysis of maternal mortality reduction initiatives demonstrated that global hegemonic discourses essentialise women, placing sexual and reproductive rights at the margins.

Actor Power: Measuring Impact in Global Maternal Mortality Strategies

Global maternal health strategies have been at the core of development practice since the 1970s, in particular during the United Nations Decade for Women (UN, 1993). Since 1990, there have been improvements in indicators on maternal mortality (UN, 2013a). However, progress in promoting maternal health as part of the wider women's rights framework has been far from perfect (Amaral et al., 2011; Berry, 2010). For this reason, the framework created by global strategies has been subjected to several revisions and alternative strategies for implementation. For instance, global reports acknowledge that the Millennium Development Goal 5 - aimed at reducing maternal deaths by 3/4 from 1990 and 2015 - will not be met (World Bank, 2013; UN, 2013a). This calls for an analysis of the historical evolution of global maternal health strategies in order to determine how these have affected the concepts and discourses on maternal health as an issue as well as the issues included in the sexual and reproductive rights framework that were left out of the agenda.

The strengthening of health services for the delivery of basic health care to address the high levels of maternal mortality was first recognised internationally by the World Conference of the International Women's Year held in 1975 in Mexico City, and later the World Conference of the United Nations Decade for Women: Quality, Development and Peace that took place in Copenhagen 1980, and the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace convened in Nairobi in 1985 (UN, 1993). Corrêa, Alves and

Jannuzzi (2006) argue that these international conferences emphasised the instrumental value of maternal health linked with demographic and economic concerns, while associating it with child health and neo-Malthusian values. These population policies were therefore restrictive, and divorced from premises for social justice (Corrêa, Alves and Jannuzzi, 2006).

This reflected the fact that the different population policies of the time were basically divided into neo-Malthusian imperialism of developed countries and the pro-natalist rhetoric of developing countries (Alves, 2002). Developed countries urged for population control strategies, blaming the rise of a poor population on the depletion of world resources, linked with the belief that population control would lead to development, while developing countries argued that economic development depended on an increasing population (Alves, 2002). The latter was adopted as the official United Nations discourse at the 1974 UN Conference for Population and Development of Budapest (UN, 1974).

Policy Community Cohesion: The Emergence of Global Epistemic Communities

The International Meeting on Women and Health held in 1984 in Amsterdam is one of global maternal health reduction strategies' cornerstones (Mattar, 2008). It was one of the turning points in the history of the evolution of population and development discourses and its shift from population control measures to reproductive health approaches (not always in this order though) (Berquó, 1998). This evolution started with the 1954 United Nations World Population Conference held in Rome and reached its most progressive stage with the 1994 United Nations International Conference of Population and Development held in Cairo (Berquó, 1998). The presence of Third World feminists became salient from 1974 at the United Nations World Population Conference held in Bucharest, but was more influential from 1984 at the conference held in Amsterdam (Berquó, 1998). The Amsterdam Conference was not a United Nations conference (Mattar, 2008). This conference is particularly significant as it was organised and led by feminists from the "north" and the "south" and was responsible for building up consensus around the term "reproductive

rights" and creating the Women's Global Network for Reproductive Rights –WGNRR (Mattar, 2008).

In the mid-1980s, during the UN Decade for Women and following important conferences held in 1984, 1985 and 1986, the WHO funded a study that produced the first maternal mortality estimative (WHO, 1996). This research found that at the time, half a million maternal deaths occurred every year globally (WHO, 1996). The results raised international concern over the issue by identifying it as one of main obstacles to the fulfilment of women's rights and led to a series of research critiquing the 1970s–80s focus on antenatal risk screening and traditional birth attendants' training, because under WHO's perception the solution to reducing the risks of maternal mortality should be mostly focused on promoting skilled birth attendants and universal primary health care coverage (WHO, 2012). As will be discussed below, although this WHO approach has had significant effects on local health systems (certainly more positive than any of the World Bank blueprints), its shift away from structural investments is problematic.

Leadership: Analysing the Absence of a Clear Global Leader

In 1987, the V International Women and Health Conference launched the Campaign for the Reduction of Maternal Mortality in San José, Costa Rica (Araújo, 2002). The campaign was developed by women's health organisations of 80 countries and was influenced by feminists that participated actively in subsequent international women's rights events (Araújo, 2002). It was organised by the WGNRR with support of the Latin America and Caribbean Women's Health Network, and eventually led to the launch of a campaign declaring 28 May as the International Day of Action for Women's Health (AbouZahr, 2003). AbouZahr (2003) claims the creation of the international day of action was instrumental to raising the political profile of maternal health as a priority issue in Latin America.

On that same year, the WHO, UNFPA and the World Bank organised an international conference for health experts, development professionals and policy makers in Nairobi for the inauguration of the Safe Motherhood Initiative (Araújo, 2002). The Safe Motherhood

was created by WHO, UNFPA and the World Bank with an appealing title to be used in advocacy and to attract the attention of heads of States and other high level officials (Berry, 2010). This conference resulted from the lobbying of World Bank experts since 1985, who were conscious of the United States administration's conservative views on family planning and decided to use a concept that was easy to defend both politically and economically (Shiffman and Smith, 2007). The conference looked at expanding the agenda on women's health and development without touching upon contentious issues such as abortion and sexuality (Amaral et al., 2011).

Although managing to engage United States' officials and UN agencies, it failed to acquire adherence from feminists because of its failure to address the demand for contraceptives and abortions and its use of a language that reinforces socially constructed gendered roles (AbouZahr, 2003). One could rightly argue that the Safe Motherhood was not targeted at feminists but instead, as in any other international conference, it was directed to policy makers and experts. Nonetheless, given the scope of the issue dealt with, a minimum engagement with feminists is expected. However, the initiative not only failed to engage but also lacked in feminist sensibility. As a result, it did not receive wide support from progressive women's rights groups and this considerably impacted the construction of policy discourses implementing the strategy thereafter (Shiffman and Smith, 2007). This was a reflection of the power that fundamentalist and conservative forces have in these issues (Corrêa, 1997).

This initiative was based on three pillars: (a) prenatal care - guaranteeing access to primary health care; (b) appropriate childbirth - ensuring skilled attendance at all births; and (c) postpartum care - reducing fifty percent of all maternal deaths by the year 2000 (WHO, 1986). However, as already affirmed above in terms of MDG5, global progress in reducing maternal deaths failed to reach this goal by the deadline in 2000 and it is unlikely it will be able to reach the goal of reducing it by 3/4 by 2015 (UN, 2013a). An Inter-Agency Group for Safe Motherhood was formed to increase financial resources and gather political momentum by bringing UNICEF, UNDP, WHO, World Bank, International Planned Parenthood Federation, The Population Council, International Federation of Gynaecology and Obstetrics, International Confederation of Midwives, Safe Motherhood Network of Nepal, Regional Prevention of Maternal Mortality Programme (Africa) and Family Care International, among others, to prioritise maternal mortality reduction (WHO et al., 1999).

The II World Conference on Human Rights of Vienna held in 1993 changed human rights principles by providing a better tool to advocate for women's rights (Mattar, 2008). In Vienna, States agreed to define human rights as universal, interdependent and indivisible and recognised that they exist in all spheres of life, public and private advocacy (UN, 1993). The Conference's declaration calls on States to eliminate gender-based violence and protect sexual rights (UN, 1993). Vienna was important because not only did it introduce the idea of using a human rights based framework to global advocacy but it also established that culture must not be invoked to prevent the full enjoyment of women's rights (Mattar, 2008). It links to previous initiatives as it recognises the need to create a legal basis for the advancement of women's human rights, but in a sense it recognises more clearly the tensions that exist between religious and traditional cultures and feminist networks (Corrêa, 1997).

In 1994, the Third International Conference for Population and Development of Cairo, organised principally by the UNFPA and the Population Division of the UN Department for Economic and Social Information and Policy Analysis, also established the reduction of 50% of maternal mortality rates as one of its goals (UN, 1994). Cairo built on previous international conferences consensuses such as Bucharest's and Mexico's that consider the interrelationship between population and development and placed sexual and reproductive health at the centre of primary health care (UN, 1994). It also expanded Nairobi's and Vienna's definitions of women's right to health and human rights-based approaches by creating a framework that specified the scope of each legal framework under its mandate and demanding specific targeted action for their achievement (UN, 1994). (For example by creating a very clear definition of reproductive health and rights) (UN, 1994).

Among other things, the Cairo platform reaffirms the right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so (UN, 1994). According to Corrêa, Alves and Jannuzzi (2006), Cairo led to a change in paradigm. The language dealing with maternal health and rights shifted from a framework that saw women's rights as an instrument to economic development (i.e. reducing overpopulation of the 'poor' or producing the offspring of the new generation), to one that recognised the intrinsic value of women's rights (i.e. from population control to sexual and reproductive rights) (Corrêa, Alves and Jannuzzi, 2006). ICPD's sexual and reproductive rights definitions have been catalysts for

change and expansion of framework used in the human rights based approach (Cook, Dickens and Fathalla, 2003).

In March 1995, the United Nations World Summit for Social Development, convened in Copenhagen, reaffirmed that sustainable development needed to be people-centred and geared towards social development (UN, 1995a). The Copenhagen Declaration invokes in its Commitment 6 (item m) an integrated and inter-sectorial approach according to the Health for All strategies already established in Alma Ata's Declaration (UN, 1995a). This approach continued to insist on plans of action and investments at country levels focused on access to basic health services (UN, 1995a).

The Cairo declaration was used in the drafting of the Programme for Action of the Fourth World Conference on Women that took place in Beijing in September 1995 (UN, 1995b). Beijing recognised the right to the enjoyment of the highest attainable standard of physical and mental health and linked it to women's wellbeing and empowerment (UN, 1995b). It expanded the human rights principles from Cairo and consolidated the policy space of the sexual and reproductive rights movement (Cook, Dickens and Fathalla, 2003). Corrêa, Alves and Jannuzzi (2006) argue that - from this point on - maternal health stopped being dealt with from a purely economic and ideological perspective in order to be included in a broad human rights agenda. As mentioned before, both Cairo and Beijing reaffirmed the commitment to the Alma Ata and promoted countries' targeted investments to provide universal access to basic health services and emergency obstetric care as a way of reducing maternal mortality and morbidity (UN, 1994; UN, 1995b). Despite its achievements, they did not include a clear road map of how to integrate and coordinate services in health systems and how to put in place budgetary and administrative arrangements (Petchesky, 2003).

The initiatives that came shortly after Beijing and Cairo did little to improve the legal framework and/or the strategies of implementation put in place in 1994. This is to a certain extent related to the resistance of conservative sectors to even reaffirm Beijing and Cairo, as it was difficult to reverse the achievements enacted by their programmes of action (Galli, 2012). For example, in 1997, Nairobi +10 was held in Colombo, Sri Lanka, commemorating the tenth anniversary of the Safe Motherhood Initiative (Berer and Ravindran, 2000). Nairobi +10 confirmed Beijing's and Cairo's strategies that determined the need for the presence of skilled birth attendants assisting midwives backed by a

system of access to emergency care (Berer and Ravindran, 2000). Something similar happened in 1999 when new maternal mortality programmes were launched in the United States financed by the Gates Foundation (Shiffman and Smith, 2007), and when in that same year, an international political movement was formed under the name of the White Ribbon Alliance with the aim of promoting cross-national advocacy for safe motherhood, linking civil society institutions with donor and other organisations (Shiffman and Smith, 2007).

It is clear that the historical evolution of global maternal health policies map out the non-linear shift from a population control discourse using maternal health and rights as instrumental value to a sexual and reproductive rights discourse reframing maternal health as an intrinsic value, and then backwards. It is possible to note that the 1994 Cairo Conference is up until today the legal landmark for sexual and reproductive rights recognition and advancement (see table at the end of next section). The next section will discuss the Millennium Development Goals in light of this evolution in order to establish that the use of discourse has not always been linear and that maternal health strategies were marked by progress and retrogress and, therefore, did not follow the logic of gradual improvement.

Guiding Institutions: The Millennium Development Goals and Its Silencing of Reproductive Rights

The 1990s was a period of considerable achievement for feminist movements. During the next decade women's rights suffered from the same shifts of agendas and leadership that affect the development of the framework of the human right to health (Meier, 2010). The human right to health, for instance, was considerably reduced when WHO's global policy making leadership was replaced by the World Bank's (Meier, 2010). The replacement of WHO - as an inherently technical organisation based on epidemiological tradition - for the World Bank - as a financial institution - marked the ascent of a politically driven discourse. The rise of the World Bank and the global health policy agenda and its push for structural adjustment programmes (SAPs) notably shaped a new wave of policy studies and

recommendations. These political changes had an effect on subsequent international meetings and the documents produced, the most important being the Millennium Declaration and the even more restrictive Millennium Development Goals (Corrêa and Alves, 2005).

The Cairo follow-up meetings, Cairo +5 and subsequent reviews (Cairo +10 and +15), provided a foundation for Millennium Development Goals (UN, 1999). The language in the final document of Cairo +5 settled for key actions that placed sexual and reproductive health within the broader context of health sector reform (UN, 1999). This represented a major shift in the politics of global health (Berer and Ravindran, 2000). Whereas the WHO's 1970s Health for All discourse placed sexual and reproductive health within primary health, the World Bank's 1993 Investing in Health report restricted the issue to health sector reforms, promoting cost-effectiveness and targeting based on the burden of disease (World Bank, 1993).

The language of Cairo + 5 resulted in a series of policies targeted at health sector reforms linked to structural adjustment programmes (Petchesky, 2003). These policies fostered a discourse that, while aiming for legitimacy through the use of human rights language, in fact favoured market interests (Petchesky, 2003). Gideon (2012) notes that the use by the World Bank of rhetoric in Cairo + 5 removed the right to health from the political realm and rendered it a purely technical affair, for example in the use of concepts such as equity instead of equality. The discourse replaced terms promoting social justice - such as equality of outcomes - with terms recognising and replicating some types of inequalities - such as equity of opportunity (Gideon, 2012; Diniz, d'Oliveira and Lansky, 2012).

In this sense, due to fundamental conceptual and philosophical grounds, the World Bank's SAPs' discourse was dissociated from the human rights project (Mattos, 2006). The SAPs were responsible for promoting organisational reforms that were unrecognisable within a human rights framework (Mills, 2006). It promoted efficiency and cost-effectiveness, and was unable to deal with qualitative concepts and measures seen as non-technical (van Olmen et al., 2012). However, the human rights project pushes for social justice and is based on a global framework that aims at challenging unequal power structures (Petchesky, 2003). SAPs were responsible for changing human rights principles such as universal access to health care and decentralisation of services so as to fit into neoliberal values and reforms (van Olmen et al., 2012). The World Bank was particularly eager to

argue objectivity and neutrality of its managerial models to shield it from any attempts to reveal a 'deeply entrenched ideology' and challenge free market economics (Petchesky, 2003: 153).

In 2000, the UN announced the Millennium Development Goals (MDGs) as a group of eight targets to build political momentum and action for the prioritisation of some development issues (UN, 2000). Along the list of goals, MDG 5 aims for the reduction of global maternal mortality ratio by 75% over 1990 by the year 2015 (UN, 2000). This target was based on a review done by the WHO, UNESCO, CEDAW and other international bodies (UN, 2000). Geopolitics played an important role in the reframing of the right to health in the MDGs (Corrêa and Alves, 2005). The influence of conservative governments such as that of the United States under George W. Bush was in part responsible for the reduction of sexual and reproductive rights to only one goal (Corrêa and Alves, 2005). This was part of a political strategy drafted by conservative caucuses supported by the Bush government (Family Care International, 2007). For example, in 2002, the United States government attempted to reject the women's reproductive rights agenda by equating safe motherhood with abortion (Family Care International, 2007). As a result, and giving the power of the United States' influence over the global agenda, fundamentalist forces in member countries succeeded in reverting the achievements of the human rights and women activists of the 1990s enshrined in Cairo and Beijing (Mills, 2006). Furthermore, the MDGs Road Map was advocated as parameter against which everything else regarding development policy had to be measured against and compared to (UN, 2000). Although this might not completely be the case, as the previous human rights framework is still operating, inevitably the MDGs trickle down a reductionist effect of reproductive health policies globally (Mills, 2006).

Similarly to the Safe Motherhood Initiative, although the MDGs were able to gather funds for programmes for the reduction of maternal deaths, it failed to properly engage feminists as it reduced women's health to maternal health and focused on access to skilled health workers as an indicator of women's wellbeing (van Olmen et al., 2012, Barot, 2011). This is in part due to the absence and/or marginalisation of women's movements and human rights progressive networks from the processes involving the MDGs negotiations (Corrêa and Alves, 2006). And in part due to the MDGs silence in regards to key causes of maternal mortality such as abortion that have been fought for long and hard by feminists (Barot, 2011).

The MDGs failed to deal with abortion as part of the global health agenda and implied a shift to a maternal-child framework that is explicit in global strategies for women's and children's health such as those presented throughout the 2000s by the UN Secretary-General and other UN agencies (Mills, 2006). Also, the marginalisation of feminists from maternal health global policy in the making Millennium Declaration and the MDGs led to the strengthening of neo-Malthusian policy networks that in short made it possible for a shift away from the paradigm in the family planning mainstream discourse (Corrêa and Alves, 2006). Thus, maternal mortality reduction was in fact used to encourage lower fertility rates, completely abandoning the radical politics of the dichotomy between family planning versus population control while rejecting to address politically contended issues such as sexual freedom and abortion (Barot, 2011).

At this point it was clear that the strategies implemented so far did very little to the reduction of maternal mortality rates, maternal deaths did fall yet despite this, the MDGs, are still behind. UNICEF, UNFPA, WHO, and the UNDP (under the MDGs) developed safe motherhood activities which were often run independently of one another (Berer and Ravindran, 2000). At some points, the agencies were antagonistic, differing on intervention approach and competing for scarce safe motherhood resources (Shiffman and Smith, 2007). At the same time, although WHO was seen as a natural leader to the initiative, no agency took ownership of the leadership of safe motherhood as a homogeneous strategy (Berer and Ravindran, 2000). UNICEF, for example, has been at the forefront of maternal mortality initiatives but while promoting decentralisation and district health systems, it has relied on hard quantitative methods for setting up targets for vertical health programmes (Atkinson, 1996). Atkinson argues that decentralised approaches only include self-help activities and are small-scale operations that do not address the power and economic structures which are causing inequalities in the first place (Atkinson, 1996). Moreover, these schemes were used by national governments to excuse local elites from responsibilities arising from using a human rights-based approach to public health reforms (Atkinson, 1996). This generated a new series of targeted approaches to the right to health which, as explored below, failed to address the underlying social determinants of illness which persist in the MDG 5.

Indeed, between 2002 and 2005, a broader international strategy was formed for maternal, newborn, and child health replacing separate maternal survival programmes that were run independently by agencies (Family Care International, 2007). A 2006 Lancet series on

maternal survival reaffirmed the Safe Motherhood Initiative goals by pushing for a public policy consensus calling for deliveries to be attended by midwives in health centres, with other health professionals present and higher levels of care available if needed (Shiffman and Smith, 2007). This had the predicted impact (Graham et al., 2008). However, some developing countries expressed strong concern over resource scarcity and the difficulty that poor countries faced in expanding care (Graham et al., 2008). This resulted in weak guiding policy toolkits and loosely oriented national strategies (Béhague and Storeng, 2013).

In 2005/2006, given a growing recognition from women's movements of the retrogression in terms of the recognition of sexual and reproductive rights, several initiatives were created as a way to challenge the restrictive approach adopted by the MDGs in 2000 (Family Care International, 2007). For example, a civil society movement was formed in 2006 by the Latin American and Caribbean Committee for the Defence of Women's Rights (CLADEM) advocating for the creation of an InterAmerican Convention on Sexual and Reproductive Rights expanding Cairo (Pandjarijian, 2003). This initiative has not moved forward thus far. Much resistance to it coming from governments derives from an erroneous strategy that binds sexual and reproductive rights together (Lapa and Gonçalves, 2011).

This strategy has been subject to many heated discussions amongst experts and advocates. For example, Corrêa, Alves and Jannuzzi (2006) argue that this resistance to the creation of independent international sexual rights legislation can be explained by the resistance created by fundamentalists and the fact that sexual rights have been used by feminists since Cairo in order to increase their bargaining power when it came to defining and expanding reproductive rights. In spite of the successes of Cairo and Beijing, Lapa and Gonçalves (2011) say that the lack of a specific international convention creating a clear framework for the implementation of reproductive rights limits their interpretation, applicability and the recognition of their violations nationally. Also, the authors say that the absence of a binding legislation on women's human rights (particularly sexual and reproductive rights) serves to ratify a maternalistic rhetoric surrounding motherhood and reproduction (Lapa and Gonçalves, 2011).

In 2005, the Partnership for Maternal, Newborn, & Child Health was launched under the leadership of the WHO with UNICEF, UNFPA and the World Bank as a larger and broader

successor to the Safe Motherhood Inter-Agency Group aimed towards the achievement of the MDGs (WHO, 2005). And, in October 2007, the first Women Deliver conference was held in London to commemorate the Safe Motherhood Initiative's 20th anniversary (Women Deliver, 2012). This was the beginning of a series of conferences that had the objective of creating an inter-sectorial approach to global maternal health initiatives and to establish and maintain political momentum for putting maternal mortality as a priority of national public policy agendas (Shiffman and Smith, 2007).

Women Deliver conferences (now also a global advocacy organisation) served to confirm that although many of the events organised internationally upheld the language used in previous UN Conferences, real commitment to the complete implementation of sexual and reproductive rights has been at best inconsistent (Women Deliver, 2012). For example, Women Deliver issued a declaration with World Watch Institute and Nourishing the Planet to denounce the fact that the final declaration of the United Nations Conference on Sustainable Development - Rio +20 - failed to address the sexual and reproductive rights' achievements of the 1990s affirmed in Cairo's and Beijing's documents (Women Deliver, 2012). Galli from IPAS Brazil argues that the Brazilian government (chairing the negotiations) only used the term reproductive health (instead of reproductive rights) because of political pressure coming from the Holy See (Galli, 2012). And even reproductive health was only used as a way to guarantee access to family planning methods excluding other public health interventions such as abortion (Galli, 2012). Galli says that this was one of the many signs showing that although the Brazilian government uses women's rights rhetoric to acquire legitimacy, it has recently been shown to be a supporter of maternalistic views which impair the fulfilment of women's reproductive rights (Galli, 2012).

In fact, Shiffman and Smith (2007) identify three characteristics that in their opinion impede the success of international maternal mortality initiatives: (i) maternal deaths are not as common as other high-burden disorders such as HIV/AIDS and malaria; (ii) accurate measurement of maternal mortality is technically difficult; and (iii) the interventions to avert maternal death are not as simple and cheap as other health-related problems such as diseases preventable by vaccines (2007). There is however a crucial point that is not included in this list, which relates to the inability of the international community to afford real value to health initiatives that benefit women only without dealing with women as an instrumental value to something else such as childbirth or childrearing. This section served

to demonstrate this last point. Although considerable progress in terms of women’s rights was observed at the global level during the 1990s, the inverse happened in the following decade. In fact, the 2000s was the ‘lost decade’ for reproductive rights. It is interesting to see that although all these initiatives have considerably increased the quality of data available, they did little to actually transfer decision making powers and/or to challenge patriarchal structures. Indeed, a sort of ‘power cycle’ seems to exist in which conservative/ progressive epistemic communities appear to alternate in. Tracking the build-up to conservatism is therefore crucial to understanding policy change and policy spaces. There might be an argument from progressive communities against the disclosure of such information (as it could arguably increase the negative impact of these ‘conservative cycles’) (Hawkes and Buse, 2013). However, non-disclosure can lead to unethical behaviour, which can potentially replicate jargon and exclusive knowledge that serves to maintain existing power inequalities. Table 3 briefly illustrates this argument by pointing to the reproductive rights’ achievements of Cairo and Beijing and their retrogression expressed through the MDGs:

Table 3 - Global Conferences on Sexual and Reproductive Rights

UN Initiative	Year	Outcomes	Main Actor	Key Actions	Feminist Support
Cairo	1994	Expanded framework for women’s right to health.	UNFPA	Demanded for sexual and reproductive health to be placed at the centre of primary health care strategies.	Yes
Beijing	1995	Expanded Cairo’s definition of sexual and reproductive right.	UN Commission on the Status of Women	Requested guarantees to basic right to family planning and highest attainable standard of health.	Yes
Cairo + 5	1999	Reduced scope of sexual and reproductive rights in health.	UNFPA	Placed sexual and reproductive health within broader context of health sector reform.	Yes
MDGs	2000	Reduced reproductive health to maternal mortality - MDG5. Silent in regards to reproductive rights.	UN General Assembly	Pushed for concerted efforts towards the reduction of maternal mortality by 3/4 until 2015.	No

The next section will attempt to demonstrate through the analysis of civil society mobilisation the importance of this non-linear development in global initiatives at the national level. It is possible to notice that the change in feminist discourse had complex roots in radical politics, but was to a certain extent affected by global development discourse. For this reason, the analysis of national policies reflects the connection between the national and global development initiatives. While engaging with discourse challenging maternal mortality as a women's rights issue, national policies fail to challenge deeply entrenched power imbalances. This shaping and re-shaping of supposedly feminist-friendly discourses affected maternal health policies.

Civil Society Mobilisation: Policy Legacies and The Context of Maternal Mortality

Social, cultural and political contexts define and determine power dimensions in health and health care (Mackintosh, 2002). An extremely unequal context will necessarily produce an unequal health care system (Atkinson, 1996). That is, public health policies geared towards health equity will have no effect if not inserted into a wider package of political measures for positive change (Standing, 1997). This patriarchal ubiquity is felt across sector-specific structures such as legislative and judicial systems (Doyal, 1995). The gendered character of the context in which women's rights have to advocate into makes it particularly difficult for activists (Finley, 1989).

Mesquita (2011) explains that feminists' strategies towards integral women's health care were and are perceived differently by different policy networks. The different readings of their engagement with different theories of development and their approach to the issue of maternal mortality determines that feminist engagement with public policy does not always help to foster a better environment for the achievement of women's right to health to its fullest (Mesquita, 2011). As established by Shiffman and Smith's (2007) framework, feminists' demands for women's rights compete with other health-related problems and strategies. Feminist articulation and/or rejection of particular policy networks sensibly shaped the implementation of women's rights discourse in health sector reforms in Brazil and this was particularly visible during periods of transition (Álvarez, 1990).

Most places in Brazil have already gone through demographic transition (Alves, 2002). The Brazilian transition - the state from being high fertility and high mortality to one where both fertility and mortality are low - happened in the same pattern as in all other countries in the world (Alves, 2002). Generally speaking, the demographic transition occurs as any linear process: mortality falls (voluntarily through family planning or involuntarily through forced sterilisation, for example) while birth rates remain high then fertility rates drop and the population stops expanding (Berquó, 1998). Low mortality rates, often associated with eugenics discourse,²⁸ mean the fulfilment of the ideal size of family before the end of the reproductive cycle, which in turn leads to an increase in the demand for contraceptives (Stepan, 1991). The intergenerational wealth cycle is reversed from parents to children, meaning that parents spend more on their children than the other way around, as previously occurred (Alves, 2002). This increases the rate of reduction of fertility rates (Alves, 2002). However, in Brazil, as in most countries, this pattern does not occur equally across social divides such as class, region and ethnic group (Buss and Gadelha, 1996). Poverty, rural settings and low levels of education are amongst some of the factors that reduce the downwards curve of fertility (Galli, 2002).

The demand for contraceptives generates the rise of several contraceptive methods (including abortion) as a means of controlling fertility, generating a drop in fertility rates (Berquó, 1998). In the face of conservative social values (that only afford real value to women as mothers) and legislation (that prohibit certain contraceptive methods), women are left with no option but to resort to unsafe practices in order to be able to effectively regulate and control their family planning choices (Caldwell, 2010). Unsafe abortions rise, contributing to the increase in hospital admissions caused by abortion complications when these are referred, and to the underreporting of maternal deaths in the case of complications that are not referred to hospitals (Valongueiro, 2000). Women start being exposed to and exposing discriminatory practices of post-abortion care and denouncing essentialised notions of femininity that see abortion as negative and birth as positive (Corrêa, 2010).

²⁸ Stepan (1991) argues that throughout Latin America eugenics - the 1881 pseudoscience promoting the 'wellborn' and the 'purity' in reproduction - have been widely used in public policy discourses associating fertility reduction to family planning when in fact secretly (or not so secretly) pursuing a population control agenda. Eugenics discourses are not only dissociated from the real social justice values in family planning but, most importantly, they seek to reduce the fertility rates among the poor population (seen 'unfit' to reproduce) while promoting higher fertility rates amongst the upper classes (seen 'fit' and appropriate to bear the fruit of the future of the nation) (Stepan, 1991).

Brazil's demographic transition and all the changes that came with it triggered an ideological battle between the feminist and the religious organisations that led to the stigmatising of activists trying to advance a progressive human rights agenda (Mesquita, 2011). Women's movements, not only feminist, were responsible for bringing about public discussions related to public-private life divide in which women - confined to the private - are invisible and therefore did not enjoy the privilege of having their issues (such as domestic violence, sexuality and women's health) dealt with by public policy (Galli, 2002). Nonetheless it was the activism of feminists that led to collaborating with leftist movements and to gender being included in the public agenda (Mesquita, 2011).

Human rights advocacy for family planning was particularly complex under the Brazilian military government. Up until 1977, the authoritative government had no official programme or position yet it implicitly supported population control practices internally while advancing a progressive family planning discourse externally (Costa, 2004). Costa (2004) flags up as particularly curious the government's rejection of neo-Malthusianism at the 1974 Bucharest Conference, and the simultaneous permissive attitude (and therefore without any control or regulating) towards international foundations and non-governmental organisations (such as the International Planned Parenthood Federation, PathFinder, BEMFAM and others) providing family planning services (see subsequent chapter for a more detailed discussion).

In Brazil, this led to two positions in two different points in time. Before 1979, albeit countering neo-Malthusianism for very different reasons, the military, the Catholic Church, socialists and feminists all represented, at least publicly, a discourse against population control defended by developed countries (Alves, 2002). This position created a space for a dialogue focused on population policies but at the same time it gave rise to a series of public policy gaps silent to the right to freedom of family planning (Álvarez, 1990). This is all because, at the time that preceded the Brazilian democratic transition, health problems could not be discussed separately from the political system (Mesquita, 2011).

After 1979, the Catholic Church, socialists and feminists assumed a stronger opposition to the military government without being vocal about the differences in values among their discourses against population control (Costa, 2004). With the passing of a law conceding amnesty to political actors in exile and with the crisis of the military government, there was the formation of an environment for expansion of social movements and discussion on

several fronts longing inclusion of social demands, such as the one for health reform (Buss and Gadelha, 1996). During the whole process, the participation in the wider movement of opposition to the dictatorship had to be done through politically organised groups (Osis, 1998). As discussed in the preceding chapter, out of all the social movements, the movement for health sector reform (the sanitary movement) was the one that managed to gain greater visibility and therefore served as a catalyst to the demands coming from other movements (Mesquita, 2011). At this time, and it is quite a crucial one, feminists were accused by socialists of fragmenting the democratic movement with parallel demands involving women's social roles and essentialised ideals of motherhood (Osis, 1998).

With the results of the UN Decade for Women and the 1984 Mexico Conference and a new push for international cooperation in adopting family planning policies, the military government feels obliged to respond to some of the demands arising out of the women's movements but only does so under a maternal and child framework (Álvarez, 1990). As will be discussed in next chapter, in 1982, State Governors are elected in the first democratic election since the coup which gave rise to a historical defeat of the party of the military by its main oppositon (Corrêa, 1993). This election then gives leverage to democracy activists and opens up space for the advocacy of the recently created PAISM (Programa de Atenção Integral à Saúde da Mulher), loosely translated as the Women's Integral Health Programme (Corrêa, 1993). This marks a shift in the maternal-child paradigm, whereby contraceptive methods stop being treated as a population control mechanism and become one which affords freedom in family planning (for rhetorical purposes, at least).

Population Control and Women's Right to Health in Brazil

As mentioned above, Brazil's government did not have a history of adopting official positions in regards to population policies, but at the same time clearly pro-natalist practices were put in place by private organisations (Costa, 2004). From the 1960s, the government replaced, at least publicly, pro-natalist incentives to a population control practice (Scott, 2001). This reflected a change of politics from the expansionist programme of populating the Amazon region to the rise of neoliberal interests in family planning services (Alves, 2009). Essentially, this meant that families were put at the centre of

reproductive health strategies and that maternal health was seen as an instrument to the successful maintenance of family wellbeing and economic development (Scott, 2001).

Also, at this particular point in time, targeting occurred as part of a rhetoric that rejected welfare state theory and instead gave preference to vertical and fragmented policies and interventions characteristic of a minimalist and non-interventionist State (Alves, 2009). New programmes were formed giving focus to phytosanitary measures (looking at bacterial and virus contamination as well as other forms of infection that may need inspection), based on traditional tropical medicine concepts of disease, while also giving preference to the identification of specific segments of society that would be subjected to special programmes and treatment such as women, teenagers, the elderly and others (Scott, 2001).

From the 1970s, the term 'women's integral health' - a broad concept that defines women's health biologically and socially and takes into account the underlying determinants of illness and health - was introduced as a form of expansion of citizenship rights and specially aimed at linking biological and social reproduction in order to encapsulate and challenge gender inequalities and their differentiated effects on health (Costa, 2004). Women's integral health was a strategy used by the feminist movements to gather public and political support towards strategies that tackle inequalities of power (Corrêa, Alves and Jannuzzi, 2006). This strategy aimed to institutionalise the feminist movement for the recognition of human rights such as family planning and gender equality (Osis, 1998). Although the term women's integral health embodied feminist ideals of holistic care integrated across sectors, it was in fact a proposal created by the federal government based on the principles defended by the movement for health reform of equity, universality and integrality (comprehensive or holistic care) (Osis, 1998).

The process of creation of the programme institutionalising women's integral health into bureaucracy (Women's Integral Health Care Program - PAISM) occurred in the late 1970s and early 1980s, putting Brazil at the forefront of the global health and rights debate (Osis, 1998). The participation of feminists in the sanitary movement for health reform was the embryo for the creation of PAISM (Interviewee 8, 21.11.12). As discussed in Chapter I, the sanitary movement for health reform challenged the crisis of the preventive and curative health care model by proposing a social justice model as an alternative (Interviewee 23,

19.09.12). The political positioning of the sanitary movement allowed for discussions about public policy focused on women (Costa, 2004). This policy space created by the reformists was used by feminists as an entry point to mainstream political discourse which eventually influenced the outline of PAISM (Osis, 1998). Thereafter, PAISM, as well as the strategy used to advance it, would serve as a reference for future programmes on women's health (Mesquita, 2011).

The Legal Human Rights Framework versus its Implementation

The government of Brazil has signed almost all relevant international human rights treaties but there is a large gap between the applicable legislation and the actual policy outcomes (Htun and Power, 2006). Controversial gender issues, such as abortion and access to emergency contraception, benefit from a very small and often unreliable political clout (Htun and Power, 2006). This can be partly explained by the history of construction of human rights as a public policy issue in Brazil. Human rights in Brazil originated from fundamental rights and for this reason have quite a different historical origin from those of European countries (Santos and Gonzales, 2011). The language of basic rights was a political project of the political and economic elite with 'top down' implementation, dating back to the Imperial Constitution of 1824 and therefore is yet to deliver on its promise of extrapolation beyond its mere legal connotation (Santos and Gonzales, 2011).

In this sense, as Fleury (1986) noted at the VIII National Health Conference, it is also important to note that the issue of women's rights gained strength quite recently through the rise of social rights during the period of transition to democracy as demanded by organised social movements, not necessarily feminists, such as rural workers, unions, churches, academic groups and others. Women's claims gained space and scope, creating a growing interest in gender equality as human rights in society as a whole, because feminists' strategies were capable of re-politicising the issue (Costa, 2009). This whole scenario of rich and diverse social participation where the labour movement, the Catholic Church, the academic radicalism and feminists stood side by side in support for

improved health standards culminated in the creation of PAISM by the Ministry of Health with the political and technical support of feminists (Mesquita, 2011).

The change of paradigm came with the making of a document entitled 'Integral Care to Women's Health: a basis for programmatic action' (Brasil, 1984). This document was a product of a parliamentary investigation initiated by the Senate and a result of the discussions coming out of a technical group created by the Ministry of Health and formed by four experts: Ana Maria Costa, Anibal Faúndes, Maria da Graça Ohana and Osvaldo Grassioto (Osis, 1998). This group benefited from a clearly feminist orientation with the participation of Ana Maria Costa allowing space for the creation of health programmes such as the Adolescent Health Programme - PROSAD, Community Health Agents Program - PACS, Family Health Programme - PSF and Women's Integral Health Care Programme - PAISM, as seen in chapter V (Scott, 2001).

Corrêa, Alves and Jannuzzi (2006) say that PAISM was the first programme to fully address the issue of women's integral health as postulated by feminists. Scott (2001) on the other hand argues that a national programme such as PAISM promotes a social perception that privileges individuals and that is not context-specific. That is, Scott (2001) promotes individual rights based on generalist assumptions about health and about women as a homogeneous group. A former bureaucrat from the Ministry of Health argues that the real limitations of PAISM was that it was conceptualised as a programme and not a public policy, and that this limits to a great extent its ability to acknowledge and promote cross-sector action (Interviewee 17, 19.11.12). However, a feminist academic says that PAISM was and is in fact a policy that manages to encapsulate the entire scope of the concept of women's rights, and that the only challenge lies in PAISM's implementation (Interviewee 2, 30.10.12).

In spite of the different perceptions of PAISM's real capacities, it is nonetheless undisputed that PAISM created more space for the reproductive rights agenda nationally which eventually combined with and/or replaced the use of women's integral health terminology (Corrêa, Alves and Jannuzzi, 2006). Whereas reproductive rights focus on legal entitlements and abstract definitions that create a framework for activism, women's integral health promotes integral and comprehensive care that enables action across sectors (Cook, Dickens and Fathalla, 2003; Costa, 2004). PAISM relied on the adoption of reproductive health language used by the WHO and was influenced by activists'

international experiences with second wave feminism instigated by the period of political exile in France and in the United States (Corrêa, Alves and Jannuzzi, 2006). Therefore, the change in feminist discourse had complex roots in development discourse and radical politics and for this reason reflected a connection with global development initiatives, while at the same time engaging with discourse challenging deeply entrenched power imbalances. As discussed below, this shaping and re-shaping of feminist discourse affected maternal health policies.

Maternal Mortality as an Issue from Invisibility to Instrumentality

At the time, there were virtually no specific policies for coping with high rates of maternal mortality (often related to poverty, lack of health care, transport and others) (Costa, Guilhem and Silver, 2006). In 1983, with the creation of PAISM, a new look and a new concept of facing women's health problems came to life (Corrêa, 1993). The process culminating in the approval PAISM was capable of building up consensus around basic principles of women's autonomy and the right to health (Costa, Guilhem and Silver, 2006). PAISM was seen not only in the academic milieu but in society as a whole, as a milestone in the history of conceptualisation of women's health care (Osis, 1998).

In an interview, a health scholar argues that PAISM is a product of dialectics (Interviewee 29, 22.11.12). It came to replace the 1975 maternal-child health paradigm and several unsuccessful short-lived programmes (i.e. high risk pregnancy programme and maternal-child programme) and was the result of the accommodation of political demands coming internally - from the feminist movements that demanded family planning - and externally - from developed countries that wanted population control (Interviewee 29, 22.11.12). Another respondent affirms that the degree of involvement between the feminist movement, the sanitary movement and also the Catholic Church during the preparation of PAISM had close relationships with the context of democratisation in Brazil, where, more than a commitment to women's health, there was a commitment to democracy (Interviewee 7, 01.12.12). It was perceived in this sense by the wider movement for

democracy that the approval of PAISM would rely on cutting corners, giving up more radical proposals - such as abortion - and discussing more conservative proposals – such as natural methods of contraception, to reach a consensus that would enable a proposed policy that would include contraception, for example (Interviewee 7, 01.12.12).

The need for dialogue with the Catholic Church at that time was due to the recognition of its position as one of the leaders of the democratisation process in the country (Interviewee 7, 01.12.12). The power of the Church in society and in politics was extremely strong and important to the success of the democratisation process (Interviewee 7, 01.12.12). The Catholic Church in Brazil was well known for its strong opposition to the dictatorship and its human rights abuses, therefore its role at the forefront of the wider movement for democracy had not only to be recognised, but at the same time rewarded (Interviewee 7, 01.12.12). On account of this particular context, women's movements in general had to adapt their demands to reproductive rights specifically to support the struggle for national political issues (Interviewee 7, 01.12.12).

For collective health academics, the approval of PAISM represented a social and a political gain even if it was not exactly what the federal government believed in at the time (Interviewee 29, 22.11.12). It embodied all the public health principles demanded by the sanitary movement and institutionalised these demands, creating tools for their implementation and development (Interviewee 29, 22.11.12). Moreover, this ability alone (to institutionalise social demands) can be said to be one of the key achievements of the sanitary movement and of feminist movements, as they manage to make use of this policy space as a way of re-politicising women's demands for rights. This, of course, can (and in fact had, as will be discussed below,) impact on feminists' ability to stand against the government at the time of the implementation of programmes such as PAISM.

Oliveira (2003) cites three important developments after the creation of PAISM that occurred in 1986: the VIII National Health Conference (with roots in the 1979 I Health Symposium of the Chamber of Deputies); the National Conference for Women's Health and Rights; and the creation by the Ministry of Health of the Commission for the Study of Reproductive Rights. They aimed to consolidate the results of the 1984 Amsterdam Conference and to initiate a full-blown public health reform institutionalising a new model of health care based on the principles of universality, integrality, hierarchical demand

(favouring preventative care), decentralisation and social control or participation (Oliveira, 2003). See the section above for more about these conferences.

At the time, a process of decentralisation of health was already being put in place with the implementation of an integrated information system – SIS (see chapter VI for more details) (Valongueiro, 2000). From 1987, this was coupled with the creation, with the incentive of the Ministry of Health, of maternal mortality committees in all three spheres of government, federal, state and municipal (Valongueiro, 2000). The maternal mortality committees were created as inter-institutional and multidisciplinary bodies that have the responsibility to investigate maternal deaths and recommend measures for their prevention and reduction (Valongueiro, 2000). A member of a maternal mortality committee explains that these institutions rely on limited federal funding which is distributed unevenly across the regions and municipalities (Interviewee 42, 29.11.12). Both initiatives, the integrated information system and the maternal mortality committees, were part of a wider reform initiated by PAISM (Valongueiro, 2000). It is interesting to see that, although these initiatives have considerably increased the quality of data available, they did little to actually transfer decision making powers or to challenge patriarchal structures.

The Democratic Constitution and the Right to Family Planning

In 1988, the Federal Constitution was approved, creating the unified and decentralised health system and incorporating many of the demands presented at the VIII National Health Conference by all sectors of society from organised social movements, health professionals to bureaucrats (Brazil, 1988). The Constitution recognised family planning as a right and condemned forced contraceptive methods but failed to regulate abortion (Brasil, 1988). According to Alves (2002), this has to do with the allegiance the socialists had made with the Church during the period of democratic transition. Politics then was more than ever the art of advancing possible demands and learning to compromise those that you know that cannot be advanced (See chapter VI for more about the process leading the Constitution on 1988). Nevertheless, public health indicators (high maternal

mortality, infant mortality and others) combined with the new political environment (such as the end of the authoritarian regime, the VIII National Health Conference and the promulgation of the Federal Constitution of 1988) resulted in a consensus for social and political demands arising out of organised movements which helped the creation of an extremely progressive national health and human rights framework of action (Osis, 1998).

The Issue of Marginal Demands for Racial Equality and Reproductive Rights in Brazil

In 1989, a feminist organisation fighting for racial equality called Geledés - Instituto da Mulher Negra - organised a preparatory meeting in Itapeccerica da Serra for the 1994 Cairo Conference which resulted in a landmark declaration (Geledés, 1993). The "Declaration of Itapeccerica da Serra for Black Brazilian Women" presented many issues which were later included in the government's official report to Cairo (Geledés, 1993). Some of the issues presented at the declaration addressed racial inequality in access and quality of health services, comprehensive family planning available for women and men irrespective of their social positioning and the rejection of neo-Malthusian policies and practices that essentialised the 'poor' (Geledés, 1993). A member of the international feminist movement (Interviewee 9, 22.11.12) argues that Itapeccerica da Serra's most important achievement was defining maternal mortality as a political issue that addressed women's individual rights for health care, removing it from a purely epidemiology realm, and more importantly from the maternal-child health binary.

However, women's health demands were set aside during the Fernando Collor/Itamar Franco administration that lasted from March 1990 to January 1995 (Oliveira, 2003). During this period, Zilda Arns, a well-known catholic paediatrician averse to the feminist causes, was appointed coordinator of the Maternal and Child Technical Area of the Ministry of Health which at the time was responsible for overseeing the implementation of PAISM (Oliveira, 2003). Most feminists see Arns' political appointment as a means to undermine the potential of PAISM and limit (if not trump) feminist participation in its

implementation (Interviewee 9, 22.11.12). This was indeed a period where most of feminist activism was concentrated on building up global frameworks and creating international networks for joint action, i.e. Cairo and Beijing.

Nonetheless, some important legal milestones were achieved from 1993 onwards. In 1993, the Inter-sectorial Commission for Women's Health – CISMU was created as part of the National Health Council – CNS (Costa, 2009). In 1996, the law n. 9.263 regulating family planning was passed, regulating contraceptives and providing legal abortion referral services for women victims of rape and those at risk of death if carrying the pregnancy to term (Costa, 2009). Additionally, in 1997, the CNS approved a resolution recognising maternal mortality as a public health priority and making its notification mandatory (Cavenaghi and Alves, 2012). These were quite impressive achievements that certainly were able to reduce the maternal mortality rates by some extent and in this sense contribute to the reduction of inequality between men and women (Cavenaghi and Alves, 2012). However, inequality amongst women of different classes and racial backgrounds remained silent (Interviewee 47, 22.07.13).

The Importance of the Technical Area for Women's Health of the Ministry of Health

Oliveira (2003) argues that the period from 1998 to 2002 was the one that saw the greatest improvement in terms of women's integral health care policies. At that time, PAISM was already being implemented by the Technical Area for Women's Health – Department of Strategic and Programmatic Action, Health Care Secretariat of the Ministry of Health - which was coordinated by Tânia Lago, a feminist doctor, who was appointed after feminist political activism, but who also counted on the support of the Minister José Serra and the fairly progressive President Fernando Henrique Cardoso (Interviewee 28, 26.10.12). Her appointment was responsible for a greater articulation of the Technical Area for Women's Health with other sectors of the Ministry of Health (Interviewee 28, 26.10.12).

Moreover, in adherence to the Safe Motherhood Initiative, and responding to the activism of a prominent feminist organisation behind these processes (the Latin American and

Caribbean Women's Health Network - CLADEM), the Brazilian government created the National Day of the Fight for Women's Health, the Parliamentary Investigation Commission of Maternal Mortality, an Inter-sectorial Commission on Women's Health and Civil Society Committees (Brasil, 2007). Also, the Ministry of Health created the Technical Norm for the Services to Women Victims of Violence, the Technical Norm for Pre-Natal Care Procedures and the Technical Norm for the Provision of Emergency Contraception (Brasil, 2007). This afforded visibility to maternal mortality as a social problem and promoted the creation of partnerships between the women's movement, specialised police units, and public hospitals (Interviewee 4, 18.08.12). Notwithstanding, in the words of an interviewee, PAISM was not a guideline of the unified health system (SUS) (Interviewee 28, 26.10.12). PAISM as well as the subsequent technical norms were only implemented partially (Interviewee 28, 26.10.12).

The Advances and Difficulties in Consolidating the Women's Integral Health Care Programme

From 2003 to 2010, many programmes were implemented alongside PAISM, contributing to the slow reduction of maternal mortality rates in the country. For example, the programme for humanisation of prenatal care and birth of 2000 - SISPRENATAL, the programme for family health of 1991 – PSF and the programme of community health workers of 1994 - PACS (Brasil, 2004). From 1990 to 2010, the number went from 120 to 56 deaths for every 100 thousand born alive (WHO et al., 2012). This is slow in comparison to similar countries such as Chile, which managed to reduce the rates from 56 to 25 (WHO et al., 2012). This is particularly important if considering that higher maternal mortality rates are easier to reduce and that there is a percentage of up to 40 per cent that is used for the adjustment of these numbers due to underreporting and misclassification in Brazil when, in the case of Chile, there are not reports claiming the need for any readjustment (WHO et al., 2012). Furthermore, if the figures are disaggregated by class, region and ethnic group, the socio-economic paradox of Brazil and the differences in quality of health care enjoyed by different groups become even more apparent (Brasil,

2006). Lower classes and historically marginalised social groups are disproportionately affected by higher maternal mortality rates (Brasil, 2006).

In 2003, a national policy called the National Policy for Women's Integral Health Care – PNAISM was created, aimed at broadening out the scope of PAISM, (Brasil, 2004a). In 2004, the resolution was made effective with the creation of the National Pact for the Reduction of Neonatal and Maternal Mortality and the National Pact for Sexual and Reproductive Rights (Brasil, 2004b). In addition, in 2006 there was the National Commission on Social Determinants of Health, in 2007 the National Policy on Family Planning, and the Integrated Plan for Strategies against the Feminization of AIDS and other DST, and in 2008 the National Policy for Natural Births and Against Unnecessary Caesarean Sections (Victora et al., 2010). These milestones advanced sexual and reproductive health but they did not fully deal with important issues such as forced sterilisation, other types of abortion or men's participation in reproductive lives (Victora et al., 2010). These were big advances that were made possible by the presence of feminists in the State bureaucracy and the election of a president from the Labour Party, Luis Inacio Lula da Silva (Victora et al., 2010).

In August 2006, the Law 11.340, also known as Maria da Penha Law, was enacted in order to implement the CEDAW and the Belém do Pará Convention nationally (Lapa and Gonçalves, 2011). It was created as a result of a flagship domestic violence case brought against the government of Brazil before the Inter-American Commission on Human Rights by a woman called Maria da Penha who was paralysed as a result of violence inflicted upon her by her husband and the negligence she experienced while denouncing this violence to the police in several instances before being paralysed (IACHR, 2001). The Inter-American Commission judged in favour of Maria da Penha arguing, in sum, that the State negligence over her security amounted to a serious human rights violation and that the government was, among other things, responsible for establishing legal mechanisms to effectively resolve cases of domestic violence (IACHR, 2001). Lapa and Gonçalves (2011) say that Maria da Penha Law represents a significant achievement for the women's human rights struggle. They however recognise that there is much controversy questioning whether or not this law has been implemented, and if it promoted any changes on the ground (Lapa and Gonçalves, 2011). Health professionals, on the other hand, argue that the law created an extremely useful tool for health professionals working with women as it

provides a framework for legal action and activism and, for this reason, argue that this model should be replicated to other fields such as maternal health and mortality (Interviewee 31, 29.10.12).

Neoconservatism and the Return of Maternalistic Policy Making

Although the two governments of President Lula adopted policies affirming sexual and reproductive rights by using the Cairo framework, the same cannot be said about President Dilma Rousseff, his party colleague or successor (Cavenaghi and Alves, 2012). Although, Dilma Rousseff was a political prisoner tortured during the dictatorship for opposing the regime and therefore for, at least at the time, having very progressive values and politics, she has been strongly criticised by feminist activists (Galli, 2012). In December 2011, the president enacted the Provisional Measure 557 (Medida Provisória 557) which established a mandatory national pregnancy registry for all women of reproductive age (Brasil, 2011b). Far from increasing women's reproductive rights, the registry posed a genuine threat to those rights because it implicitly recognises the rights of the foetus and readopts a maternalistic conceptual framework to women's health which precisely limits one of the main components of reproductive rights, freedom (Cavenaghi and Alves, 2012).

For a bureaucrat of the Secretariat for Special Policies on Women (an institution with a similar status as a Ministry but directly linked to the Presidency), the major problem of MP 557 was the lack of dialogue and discussion during the policy making proceedings, particularly within the State apparatus and with social movements (Interviewee 26, 30.08.12). In the end, the national congress decided not to approve MP 557's transformation into law allowing the provisional measure to cease effect on 31 May 2012 (Galli, 2012). According to Galli (2012), this occurred in response to an intense feminist campaign aimed at guaranteeing the reproductive rights enshrined at Cairo and Beijing. This process is particularly representative of the progresses and retrogresses of women's

health policies in the country and the limits that exist to the advancement of a feminist political agenda.

The Provisional Measure 557 was part of a wider plan to tackle maternal mortality rates called Rede Cegonha (Brasil, 2011a; Cook, Dickens and Fathalla, 2003). Lapa and Gonçalves (2011) say that this plan partially recognises reproductive rights by affording limited (i.e. maternalistic) protection by a new network of family planning and humanised care to pregnant women and their newborn children, but it fails to address the need of women that are not pregnant. This is clearly another confirmation of a step backwards towards a new maternalistic rhetoric and an instrumental use of the human rights language for political purposes. Academics argue that the approval of Rede Cegonha does indeed represent a step backwards and a re-institutionalisation of the maternal-child approach (Interviewee 1, 14.11.12). However, health professionals see it as positive as it provides an entry point for more comprehensive maternal health care by complimenting a previous prenatal care programme – SISPRENATAL (Interviewee 31, 29.10.12). Interestingly, Rede Cegonha establishes as one of its principles the respect, protection and fulfilment of human rights (Brasil, 2011a). Nonetheless, from a legal point of view, Rede Cegonha is conflicting with other norms created by the Ministry of Health that recognised reproductive rights and therefore did not leave space for interpretation that could lead to readings in favour of the foetus and not the pregnant woman.

Costa, Guilhem and Silver (2006) found, even before the creation of Rede Cegonha, in a study about women's access to contraceptive methods that inconsistencies still exist in the practice of services and routines of family planning, expressed in the different quantitative and qualitative access to contraceptive methods and insufficient care for infertility across the country. The authors concluded that the State still provides contraceptives associated with neoliberal Malthusian values responding to international demands for the control of the Brazilian population while limiting women's freedom of choice (Costa, Guilhem and Dee Silver, 2006). As will be explored in the next section, this controversy permeates all corners of the feminist and sanitary movements and can be traced to strategies beyond Rede Cegonha, such as the overall process of implementing women's integral health care strategies, programmes and policies. See a summary of key policies in the table 4 below:

Table 4 – Women’s Right Movements and HSRs in Brazil

Year	Type of Participation	Main Actor	Outcomes	Key Actions	Feminist Support
1974/1975	UN International Women’s Year conference in Mexico City – national participation and preparation	ECLAC	Catalyser of institutionalisation of gender perspectives and machineries and professionalisation of feminist movements as well as use of right-based discourse	Full gender equality and the elimination of gender discrimination	Yes but minimal
1975	PSMI	Ministry of Health under the military government	Vertical programme focused on the rendering of pre-natal, birth and post-partum care controlled and run by federal executive	Implementation of population control electing sterilisation as preferred contraceptive method	No
1977	Prevention of High-Risk Pregnancy Programme	Ministry of Health under the military government	Neo-Malthusian family-planning project substitutes pro-natalist regime in Brazil	Implementation of population control electing sterilisation as preferred contraceptive method	No
1979	Return of men and women in political exile	Presidency under the military government	Political scenario strong against authoritarian regime but weak on international reproductive rights which were set aside in favour of population control discourses	Build-up of movement for sanitary reform	Yes
1984	PAISM	Interdisciplinary group formed by Division for Maternal-Child Health, Ministry of Health, after a Parliamentary Inquiry - CPMI	Appropriation of reproductive rights discourse defended by women’s feminist movement as a mask to population control motives	Implementation of concept of women’s right to integral health care	Yes
1985	CNDM	Ministry of Justice	Increase in family planning programme’s budgets and greater participation of women’s movements in political transition	Implement women’s human rights and guarantee end of discrimination against women	Yes
1986	National Conference on Health and Women’s Rights	National Secretariat for Special Health Programmes, Ministry of Health	Alliances formed during the authoritarian government with the Catholic Church and reinforced by the Sanitary Movement were still too strong to permit the rise of feminist issues such as reproductive rights to the mainstream health sector reform	Approved strategy to streamline position on women’s right to integral health care, reproductive rights, abortion and sexuality	Yes
1993	National Seminar on Black Women’s Reproductive Rights and Policies – created Declaration of Brazilian Black Women	Geledés in name of black feminist movement	Strengthened the movement’s policy work and affected the national feminist movement participation in the subsequent UN Conferences	Declaration of Itapeperica da Serra which focused on the social determinants of unequal health and illness	Yes but limited
1996	New Family Planning Law	Presidency	Questioned ability to afford women access to unbiased information and freedom of choice	Recognised the right to family planning and creates standards for its enjoyment	Yes

2003	PNAISM	Department for Strategic Programme Action, Ministry of Health	Seen as highly technical and suffering from lack of political support and financial resources	Expanded the scope of PAISM across all sectors of the bureaucracy	Yes
2011	Rede Cegonha (Stork Network) and MP 557/11 (Provisory Measure 557)	Presidency	Highly criticised by feminists for its return to maternalistic values and instrumental value added to women's maternal health	Gathered resources for initiatives aimed at the reduction of maternal mortality rates	No

The above sections analysed the historical trajectory of maternal mortality reduction strategies by discussing the national programmes and institutions created for the promotion of maternal health. They noted that feminists strategically articulated with the leftist movement for health reform in order to establish consensus around a new conceptualisation of women's health care. This strategy was capable of institutionalising this discourse through the creation of PAISM and the subsequent policies. However, a brief reading of the history of the institutionalisation of the discourse for women's integral health care demonstrated that this strategy was not capable to build a bridge between policy making and implementation. The following section engages with the feminist perception of the institutional discourse and its association or dissociation with effective implementation strategies, as well as with the different strategies to maternal health advances by different sectors of the women's movement.

Conclusion

In light of Shiffman and Smith's (2007) framework, this chapter pointed to the strength/weakness and political cohesion observed in the strategies and discourses used by actors involved in pushing the agenda for reduction of maternal mortality forward. It analysed policy cohesion, leadership, guiding institutions and civil society mobilisation in global and national maternal mortality reduction initiatives. It demonstrated that international organisations have shown interest in promoting maternal mortality reduction and have attempted to work as a cohesive group by, for example, creating the Safe Motherhood Inter-Agency Group. This has been capable of bringing attention to the issue but was

problematic in securing the legal reproductive rights achievements of the mid-1990s. Also, problems in promoting a successful model for investing in leadership or demonstrating any sort of leadership (embodied in one organisation for instance) has resulted in non-homogeneous approaches to the implementation of the global maternal health framework. Moreover, this lack of cohesive policy implementation and leadership facilitated the creation of a restrictive human rights agenda - i.e. the MDGs - which represented a serious retrogress in terms of sexual and reproductive rights. Lastly, the global maternal health framework has been effective in promoting a number of new initiatives addressing maternal health and mortality. Unfortunately, some of these initiatives still persist in approaching the issue from a maternalistic perspective which rejects principle and even, in some cases, the existence of an international legal framework for sexual and reproductive rights.

In brief, this chapter traced the history of global maternal mortality initiatives to demonstrate that women's rights achievements are always susceptible to retrogress. It particularly demonstrated that the legal benchmarks for sexual and reproductive rights achieved at Cairo and Beijing were ignored (if not trumped) by the new development framework presented by the MDGs. It also drew a parallel between the comeback of conservative policy making at the global level and the national level. In this sense, it discussed the Brazilian demographic transition and its relation to higher demand for sexual and reproductive rights. It noted that the conservative-progressive-conservative policy influxes occurred alongside the democratic transition, which invariably affected women's rights activism. It noted that feminists had to adapt their strategies in terms of the complexities arising out of a non-official population policy during the military government, and then to the social articulation necessary for the strengthening of the movement for democracy. In spite of what was logically expected, the later period of democratic consolidation has marked the comeback of maternalistic policies, just as observed at the global level.

The next chapter will discuss the effects of these transitions on national and feminist strategies for maternal health by relying on secondary literature and primary data acquired through semi-structured interviews with key actors. As discussed in Chapter I, all interviews have been classified in terms of the policy networks (epistemic communities or policy legacies) and then coded as to afford confidentiality to interviewees. The interviews are presented in a way as to accurately represent the different voices coming out of each

policy network and the differences observed within these same networks. The following chapter specifically uses these accounts to discuss the national maternal health strategies in order to understand the institutional discourse used in policy making across time and its association or dissociation with implementation strategies.

Chapter V - Idealising and Ideologies: Feminists Understanding and Portrayal of Maternal Health as a 'Non-Issue'

Introduction

Shiffman and Smith (2007) are concerned with how political behaviour can be modified by the different interpretations of maternal health initiatives. That is, policy change depends on the way maternal health is understood by activists and portrayed publicly (Shiffman and Smith, 2007). The second aspect presented by their framework is related to the role of ideas. This aspect is then divided into two factors: internal frame; and external frame. This chapter traces the history of national maternal mortality strategies by looking at key programmes that argue to promote women's right to health in Brazil. It also looks at internal perceptions of the role played by these national initiatives.

More specifically, this chapter compares the processes behind the creation and implementation of new formal rules and programmes institutionalising the new health system. It particularly focuses on the processes of the creation of different political agendas advancing women's rights discourses, the actors behind them and the real motivation triggering each strategy. It analyses the different political strategies implemented by the different political networks aimed at institutionalising women's integral health care principles and practices in Brazil. The chapter compares Brazil's public policy agenda and discourse versus the real effects it has on overall public health, and more importantly, on maternal mortality rates. Differing from what has been said in the earlier chapters, it approaches the discussion from the perspective of feminists' engagement (and disengagement) with maternal mortality strategies and maternal mortality as an issue. The final section concludes that, despite formal legal measures put in place, maternal mortality rates reduce at an incredibly slow pace. It argues that Brazilian feminists' late engagement with the issue of maternal health has allowed for a considerable political space that became populated by conservative religious caucuses, which in turn led to public health measures that essentialise women and therefore fail to tackle the real problems behind health inequality.

By focusing on women's movements, it discusses the results gathered from interviews with key actors participating in public health sector reforms. It argues that in spite of their best endeavours, feminists' late engagement with maternal mortality discourse and policy making allowed space for expansion of conservative politics and a step back in the health and human rights agenda, which in itself led to a slow reduction of maternal deaths. That is, the health sector reforms created new policy spaces for the shaping of women's health from a political standpoint. The disengagement with maternal health policy spaces meant that feminists were not only marginalised from the mainstream agenda but also served (unconsciously and non-intentionally) as facilitators of the inclusion of conservative and instrumentalist women's rights politics to that realm.

The Role of Ideas: Feminists Perceptions and the Public Policy Agenda

Two main issues arise in the context of health policies in Brazil: the challenge posed by the different demands from unequal social groups and segments; and the influence that political transitions have over these policies and their implementation (Scott, 2001). Health policies have changed back and forth depending on the ruling party and the politicians in charge (Htun and Power, 2006). Progressive or conservative politics and policy making is highly dependent on party membership (Htun and Power, 2006). Left parties have been found consistent in their support to gender issues and social equality (Htun and Power, 2006). The same is not observed in centre and right parties. Centre and right parties tend to use gender politics, in special controversial gender issues, as bargaining chips ultimately leading to discrepancy in gender-related policy making and implementation (Htun and Power, 2006).

In fact, along the years, politics either focused on maternalistic rhetoric or women's rights discourse (Scott, 2001). Unfortunately, these changes have not followed a logical and upward progress. This inconsistency can also be observed in other traditionally marginal issues such as racial equality (Htun, 2004). For example, a quota system for higher education was implemented in 2001 rejecting long-standing myths of a 'racial democracy' in Brazil (Htun, 2004). Official discourse demonstrates that, rather than treating racial

equality as an important issue in itself,²⁹ the implementation of affirmative action was influenced by ideas coming from policy networks (in this case an epistemic community pushing for the implementation of the results of the World Conference on Racism held in Durban in 2001). These political contexts put these issue as well as the policy agendas accompanying them in transient and vulnerable positions.

Internal Frame: Feminists' Political Perceptions and Maternal Mortality Strategies

Multiple actors inside and outside the state attempt to influence the policy making process, in such cases the strength of political parties, institutions and civil society determines the opportunities for policy change (Haas, 2010). HSRs are normally conducted as a technical and managerial activity aimed at improving quality and efficiency (Bloom and Standing 2001). Policy reform is highly political and controversial. For this reason, good governance rules, monitoring and accountability are essential to civil society. This explains why social movements in the form of non-governmental organisations and other political networks and movements have become increasingly important (Bloom and Standing 2001). Local organisations, social movements and political networks may help improve the overall status of health or may perpetuate inequalities by, for example, not challenging unequal power relations. Indeed, civil society “has taken on new meaning and importance, for example trade unions and political parties are replaced by voluntary associations and non-governmental organisations, few of whom are democratically accountable or representative” (Gideon 2006: 1280). The ‘NGOisation’ of civil society and in particular the women’s movements may influence the orientation of policy strategies and its outcomes (Alvarez 1998).

The policy process includes or excludes various groups which in turn shape policy itself, as well as the expectations of those looking for future engagement with the state (Haas,

²⁹ So far, the quota system has produced some positive outcomes (Cicalo, 2012). However, it also stratifies and organises each racial group (such as black, mixed race, white) in a way that maintains a sort of racial hierarchy (Htun, 2004). This demonstrates the lack of sensibility to racial issues and critical issues on racialising attitudes.

2010). The feminist community, as a part of the wider women's movement, is devoted to transformation of the unequal gender relations and power through radical and/or moderate strategies (Alvarez, 2000; Letherby, 2011). It seeks through a plurality of 'feminisms' and feminist movements to eliminate power inequalities and, in so doing, seeks full and equitable incorporation of all individuals citizens, and in this sense becomes a critical force for policy change (Haas, 2010). When it comes to advancing women's human rights through HSR civil society, women's movements have been particularly important (Mesquita, 2011).

In Latin America, the women's movements gained particular visibility in the 1970s and the 1980s during the moment of democratic transition (Blacklock and Crosby, 2004). Feminists argued for the return to democracy and a respect for human rights (Almeida, 2002). Through alignment with opposition political parties, women's movements had an active and influential participation in pro-democracy movements and post-transition governments and managed to exert influence (public opinion, political discourse and politicisation) in the areas of domestic violence, political participation, the family and civil rights (Mesquita, 2011).

This political clout led by feminists has not been successfully translated into sustained political influence and gender sensitive policymaking (Htun and Power, 2006). Since the consolidation of democracy, there was a reduction in visibility of feminism as a source of political pressure for policy reform, either due to the fragmentation of the movement, the resistance of political parties to incorporate a feminist policy agenda or to co-opting of its key members by the new institutional political structure (Haas, 2010). In some cases, feminists strategies have become too narrowly focused and cut off from the base serving as a 'vehicle of choice' for non-radical government gender policies and undermining feminist participation in wider issues such as HSRs (Fraser, 2013). This happens because "[a]lthough the political Left tends to be the most supportive of women's rights, participation in a coalition government will force the Left to temper its agenda in negotiating with its governing partners (...) as the coalition parties distribute their members throughout the government ministries, policy in a particular area often reflects the ideological position of whatever party the relevant ministry" (Haas, 2010: 49).

The Construction of the 'Women's Experience' and the Plurality of Feminism

As Haraway describes, international women's movements have constructed 'women's experience' and used this collective objective as one of the most strategic political 'facts' of modern history (1998). Although this political construct served to advance women's demands, it also had internal political fragmentation as its non-adverted collateral damage (Fraser, 2013). In Haraway's (1998) opinion, divisions among women, in particular among feminists, generated a crisis of political identity whereby the construct of 'women's experience' became elusive, serving most of the time as a justification for the creation and/or maintenance of a system where women dominate one another.

Haraway (1998) also uses an analogy to support her arguments, the cyborg. The cyborg is a concept that binds imagination and material reality arranging a strategy where possibilities of historical transformation form new identities that are contradictory, partial and strategic. Haraway's (1998) cyborg is a son of militarism and patriarchal capitalism. This type of false discourse is embodied in early feminist strategies and in PAISM. This chapter applies the arguments present in Haraway's analogy of the cyborg to the strategies put in place in Brazil for the reduction of maternal mortality and divides the issue into three problems: (i) the limited attention given to maternal mortality by feminists; (ii) the political volatility of the Technical Area for Women's Health; and (iii) the internal divisions created within the women's movements.

As often explained by academics, in spite of a largely feminist participation in the development of PAISM and its elements, most feminist movements³⁰ decided to emphasise other components of sexual and reproductive rights such as sexual violence and legal abortion instead of prioritising maternal mortality (Interviewee 29, 22.11.12). This is also recognised by many sectors of the women's movement which argue that this meant the 'ghettoisation' of maternal health as if reproductive rights were only applicable to cases of non-reproduction (Interviewee 10, 28.09.12).

³⁰ There are many different ways to express and represent ideals and this is flagrant in the divisions that exist within feminists in Brazil. Grupo Curumim of Pernambuco is cited by Valongueiro (2012) as an exception to the mainstream feminist approach to maternal health. Curumim has been working with maternal health since its creation in 1989 and particularly with humanization of birth from 2000.

Academics argue that for feminists it was extremely important to oppose everything that represented the maternal-child paradigm, and at the time safe motherhood was almost placed outside of the realm of the sexual and reproductive rights discourse (Interviewee 29, 22.11.12). Some members of the judiciary dispute that maternal mortality became a 'non-issue', completely invisible and de-politicised (Interviewee 21, 09.11.12). It is possible to note that, in the opinions of academics and those often in charge of implementing human rights law such as judges, this feminist strategy of disengagement was a failure to balance political activism (Interviewee 21, 09.11.12; Interviewee 29, 22.11.12).

Some health professionals that participated in the creation of the Technical Norm for the Humanisation of Legal Abortion Care by the Ministry of Health, explain(s) that feminist activism in Brazil has an intricate relationship with each activist's personal experiences and opportunities (Interviewee 19, 22.11.12). The interviewee says that many women's rights strategies were built through the exposure to new ideas and models of political organisation (Interviewee 19, 22.11.12). In this sense, not only was maternal mortality subject to strategic scrutiny, but so was abortion, for example (Interviewee 19, 22.11.12). The interviewee cites the case of articulation between Colombian and Brazilian feminists supported by the Women's Health Coalition to demonstrate how personal experiences have affected the feminist advocacy model in Brazil (Interviewee 19, 22.11.12). In that case, as opposed to the model in Colombia, feminists in Brazil consciously decided not to engage with the provision of abortion services as it was thought that abortion advocacy was more adequate to the context and more capable of producing results (Interviewee 19, 22.11.12).

The Institutionalisation of Feminist Demands and Importance of the Technical Area for Women's Health

As cited above, Oliveira (2003) argues that the activism surrounding women's integral health care is also related to the work developed by the institutionalisation of feminist demands through the participation of feminists in the State bureaucracy. In the opinion of abortion activists, during the period of 1998 to 2002, Tânia Lago was able to use her role

as coordinator of the Technical Area for Women's Health to politically articulate feminist demands with other areas of the Ministry of Health, local bureaucrats as well as organised groups of health professionals (Interviewee 19, 22.11.12). This perception seemed to strengthen the movement for women's rights and provide an incentive for strong feminist strategising during that particular period.

However, in the views of abortion activists, from 2002, with the replacement of Tânia Lago by Maria José Araújo, women's integral health was progressively de-politicised becoming only a locus of thematic public policy making (Interviewee 19, 22.11.12). This change was related to a strategic decision made by Maria José Araújo, and also to a political position maintained by the Ministry of Health (and intensified during Lula's second administration) that the Technical Area for Women's Health is only responsible for the vertical implementation of PAISM and therefore not entitled to think and re-think its politics (Interviewee 19, 22.11.12). In principle, the division should be able to have political and programmatic powers to horizontally influence other areas of the Ministry of Health (partially achieved by Lago), but in practice it is still seen as a women only affair (Interviewee 19, 22.11.12). It is possible to note at this instance that the division's practices depend a lot on its head manager and in the political links it holds with top officials, and this in turn results in a lack of uniformity across time and across sector of the bureaucracy and volatile political will.

Some academics argue however that other areas of the Ministry of Health that have expanded, such as Health Surveillance Secretariat, have absorbed some of the responsibilities of the Technical Area for Women's Health after its de-politicisation (Maia, Guilhem and Lucchese, 2010). Nevertheless, Maia, Guilhem and Lucchese (2010) have found that since 2002 (precisely during the period of depoliticisation noted above) there is little articulation between the Health Surveillance and Women's Health areas due to the fact that women's health issues are still perceived as not being part of surveillance priorities, and in this sense, only subject to collaboration through health inspections and thematic seminars.

A policy maker notes that from 1996 the budget for Women's Health was increased considerably following the strengthening of the political compromise to implement PAISM (Interviewee 8, 21.11.12). The interviewee observes that this represented the

institutionalisation of some of PAISM's principles through the decentralisation of the programme and the transformation of the normative powers of the Ministry of Health (Interviewee 8, 21.11.12). Despite its successes, and due to unknown political decisions, the Technical Areas had its team and budget reduced in 2007/2008 (Interviewee 8, 21.11.12).

Bureaucrats at the Ministry of Health argue/maintain that the work carried out by Health Surveillance and Women's Health is completely different (Interviewee 8, 21.11.12). Currently, Health Surveillance develops and monitors impact indicators while Women's Health is responsible for process indicators (Interviewee 8, 21.11.12). This means that Health Surveillance deals with the analysis and diagnosis of quantitative data that serves as a basis of specific actions, while Women's Health works with strategic proposals geared at promoting change in the paradigm at all levels of the federation given the political proposals delineated in PAISM (Interviewee 8, 21.11.12).

It is nonetheless important to note that, as defended by academics, the Technical Area for Women's Health, the Health Surveillance Secretariat along with the Department of Science and Technology are crucial to continuation of PAISM (Interviewee 2, 30.10.12). The articulation among these areas has afforded particular visibility to the issue of maternal mortality and the importance of the investigative work developed by maternal mortality committees (Interviewee 2). Feminist activists also stress the importance of the Special Secretariats directly linked to the Presidency, for example the Special Policies on Women and for Human Rights (Interviewee 33, 06.11.12). Subsequently, there is some sort of agreement and recognition of the role played by the bureaucracy, but at the same time there is clear the frustration with the lack of articulation within the State apparatus.

Implementing Women's Right to Integral Health Care and the Production of Knowledge

A former bureaucrat argues that since 2004 the Ministry of Health has been responsible for developing and supporting the development of research in the area of gender and health (Interviewee 38, 01.11.12). The interviewee points out however that process of

accepting research proposals and of using their findings was not only technical but also political (Interviewee 38, 01.11.12). The Evaluation of Health Technologies (ATS), one of most relevant tasks assigned to Science and Technology, often fails to give proper attention to important issues such as female condoms and syphilis because the lobbying exerted by pharmaceuticals avoid themes that do not lead to profit or a rise in the demand for new products (Interviewee 38, 01.11.12). These limitations in the use and production of knowledge contribute to Brazil's unfinished reproductive health agenda.

A coordinator of a maternal mortality committee agrees that feminists focused too much on abortion, leaving the problem of unresolved maternal mortality aside (Interviewee 42, 29.11.12). However the interviewee explains that feminists' engagement with maternal death was also linked to external forces not necessarily linked to a strategy per se (Interviewee 42, 29.11.12). In the opinion of the interviewee, maternal mortality became a hot issue in the beginning of the 1990s responding to the results coming from UN conferences, but soon after that its political momentum faded (Interviewee 42, 29.11.12). International funding directed to NGOs was withdrawn making the issue only a matter of public policy – an ethereal and unreachable arena for many (Interviewee 42, 29.11.12). Moreover, previously large donors such as the MacArthur and the Ford Foundation cancelled several projects, arguing that Brazil had finished its demographic transition (Interviewee 10). Thus, a lot of international cooperation and projects were redirected to new issues such as teenage pregnancy and HIV/AIDS (Interviewee 42, 29.11.12). This obviously ignores the slow reduction of maternal deaths and that the country's regional inequalities might mean that the demographic transition is not a reality in poorer regions. This impairs maternal health efforts that are integrated in a continuum and particularly harm non-governmental organisations that rely on the availability of external funds for their activism before and/or against the State.

As pointed out above, this focus was changed from 2004 with the MDGs. Although the MDGs were able to gather funds for programmes for the reduction of maternal deaths, it failed to properly engage feminists in Brazil as it reduced women's health to maternal health and focused on access to skilled health workers as an indicator (Interviewee 42, 29.11.12). This not only excluded abortion from the global agenda, but also returned to a maternal-child framework rejected by PAISM (Interviewee 42, 29.11.12). However, as defended by members of maternal mortality committees, there were some positive and

unexpected results arising out of the MDGs process: the review of maternal mortality estimates; and the acknowledgement by the government of Brazil that the millennium goals will not be met under the MDGs framework (Interviewee 42, 29.11.12),

Lastly, perhaps already evident in the above account, another problem that limits women's rights activism is the divisions created within the women's movements and their perceptions related to the implementation of PAISM. This problem can be analysed from two angles: the theoretical perception of PAISM; and the segmented political claims arising out of the broader movement of women's integral health care. Even though PAISM is seen as highly positive and avant-garde, some controversies in regards to its terminology and theoretical scope exist.

The Problems in the Construction and Implementation of the Programme for Women's Integral Health Care

Feminists that headline the abortion debate do not agree with PAISM's terminology because they think it is not adequate to SUS's more progressive model of integrated and comprehensive care as it fragments the delivery of services (Interviewee 19, 22.11.12). In the interviewee's opinion, a programme presumably deals with a vertical model of care creating thematic areas that are artificially separated and encapsulated (Interviewee 19, 22.11.12). Arguably, if there is no holistic practice at the national level then integral care becomes impossible at the local level (Interviewee 19, 22.11.12). Furthermore, if policies are forced upon local levels without dialogue or partnership, little political commitment will be created at these levels (Interviewee 19, 22.11.12). In a sense, this critique indicates PAISM's failure to acknowledge the importance of 'street level bureaucracy', which to a great extent is responsible for either ensuring and/or avoiding the implementation of State programmes (Lipsky, 1980).

By contrast, a public health academic argues that the initial material and implementation strategy of PAISM demonstrate that it was conceived as a horizontal policy and not a vertical programme (Interviewee 2, 30.10.12). Vertical decentralisation is perceived to only benefit federal entities that already have a well-developed and well-funded bureaucracy

favouring monopolies (Lobo, 1992). More importantly, PAISM strategically uses an essentialised notion of women (by re-affirming socially constructed gender roles to expand the capacity to gather political support) in order to afford visibility to the issue of women's integral health care (Interviewee 2, 30.10.12; Interviewee 32, 22.09.12). In addition, feminists elucidate that the terminology was designed to engage and attract the conservative wings of religious organisations that thought that integral care would implicate the provision of abortion services (Interviewee 27, 03.08.12).

Academics also make clear that, despite the influence exerted by academics and feminists that were part of the State bureaucracy, at first social movements rejected PAISM due to the political compromises that were needed at the time to create a political strategy capable of replacing the old maternal-child paradigm (Interviewee 2, 30.10.12). Soon after, social support converged around PAISM acknowledging that it did indeed provide a new perspective, and that it traced important family planning obligations on the part of the State (Interviewee 2, 30.10.12). In the interviewee's opinion, PAISM suffers the same obstacles faced by other policies which have to do with the implementation under a complicated Brazilian model of decentralisation specifically: (i) a series of contradictions in the process of implementation; (ii) different levels of participation and funding; and (iii) the diversity of managerial capacity at local levels (Interviewee 2, 30.10.12).

Some social scientists affirm that the women's health political project lost momentum once it was institutionalised (Interviewee 13, 14.11.12). One respondent states that political projects of social reform often navigate through processes to define subjectivities (public values and common claims), incorporate them into the Constitution and institutionalise demands that may be synergetic or not (Interviewee 13, 14.11.12). For example, the Brazilian Constitution instituted the right to family planning in recognition of feminists' demands, but at the same noted the importance of the family (the socially constructed patriarchal view of what constitutes a family) in recognition of the demands arising from religious caucuses (Brasil, 1988). Arguably, in the case of the movement for women's integral health care, these processes were not synergetic because the creation of PAISM culminated at a point when movements and subjects were still being constructed (Interviewee 13, 14.11.12).

Although there is consensus in terms of the importance of PAISM to women's rights, the same cannot be said of PNAISM. Many respondents mention PNAISM as capable of scaling up interventions prescribed by PAISM, while some do not believe in PNAISM's force as a radical social justice marker. These divisions in terms of the internal understandings and external portrayals of PAISM and PNAISM affected their political credibility and weakened the women's rights movement as well as feminists' capacity within the State bureaucracy.

For a former bureaucrat of the Ministry of Health, neither PAISM nor PNAISM are examples of public policies targeted at women, they are in fact fragmented programmes that attempted but failed to effectively create a framework of action across sectors. In her opinion a public policy presupposes comprehensive and complex knowledge of a thematic area (Interviewee 17, 19.11.12). The interviewee presents two obstacles to public policy making in Brazil: lack of experience in making public policy with a broad approach; and an extremely dependent political scenario that revolves around elections and vote-seeking practices, limiting political commitments to two year timeframes (Interviewee 13, 14.11.12).

Contradictorily, a policy maker at municipal level affirms that PAISM had its scope expanded with the creation of PNAISM, which the interviewee states to be the first Brazilian public policy representing the interests of women and that was based on Alma-Ata principles (Interviewee 35, 15.11.12). A former bureaucrat of the Ministry of Health says that from a programmatic perspective, PNAISM was considerably superior to PAISM (Interviewee 4, 18.08.12). Yet current members of the bureaucracy say that the State institutions have been orchestrated to afford invisibility to women's issues and to women in all areas, giving little institutional power to promote change (Interviewee 35, 15.11.12). Regardless of the way one accommodates these differing views, it seems clear that the different perceptions of the capacity of PAISM and PNAISM to deliver on their policy promises were in themselves capable of fragmenting the women's movement. This fragmentation weakened women's rights activism and the gaps in the movement by the conservative opposition as arguments in favour of alternative policies.

Feminists point out that there are a series of misperceptions within and outside the State bureaucracy of women's integral health care strategies (Interviewee 27, 03.08.12). PAISM evolves in parallel to other health programmes and projects (Interviewee 27, 03.08.12).

For academics, PNAISM and all the technical norms and pacts arising from it are used as reference to health professionals but are not implemented locally (Interviewee 24, 20.08.12). Furthermore PAISM does not interact with other similar programmes such as PSF (Interviewee 37, 27.09.12). Although PSF could in theory mean a territorial expansion of the reach of PAISM, feminists criticised it for its focus on basic health care only and for its failure to reject the maternal-child discourse (Interviewee 19, 22.11.12; Interviewee 37, 27.09.12). A connection with men's health was also dismissed by feminists who thought it risked redirecting attention to men's problems instead of women's (Interviewee 37, 27.09.12). All of these mishaps mean that PAISM remains in the theoretical dimension (Interviewee 27, 03.08.12).

Women's Health as a Fragmented Social Movement

Some activists from the black women's movement say that because the field of women's integral health care incorporates so many emerging issues, it is inevitable for there to be divisions within the movement itself (Interviewee 22, 17.09.12). The segmented political claims arising out of the broader movement are embodied roughly in the separation of: (i) freedom of choice and legal abortion advocacy; (ii) activism for the humanisation of birth; and (iii) demands for the visibility of issues of widespread violence – domestic, sexual and/or institutional. Feminists are usually positioned politically in terms of the first (although might also work with the second) and do so by demanding for the full recognition of sexual and reproductive rights and the availability of services that guarantee their enjoyment.

Public health scholars emphasise that the political and strategic divisions within the feminist movement weaken the sanitary reform project and limits its scope of action (Interviewee 37, 27.09.12). For instance, the separation between claims of violence and humanisation fail to explore their commonalities (Interviewee 37, 27.09.12). Maternal mortality definition remains therefore limited to an epidemiological frame of action, when in fact it holds a much more political standpoint (Interviewee 37, 27.09.12). In this scenario, issues such as the rise of violent acts during pregnancy by women's intimate partners are given double invisibility (Interviewee 37, 27.09.12).

An activist for the humanisation of birth explains that the movement started as an extremely politicised criticism of medicalisation of birth and the absence of a medical practice based on evidence (Interviewee 10, 28.09.12). A health professional elucidates that the movement for humanisation has many actors and many different approaches that can range from educational activities to complete reorganisation of health services and articulation (Interviewee 18, 01.11.12). The feminist sector of the movement fights against the 'perinatal paradox' (o paradoxo perinatal), the high medicalisation of birth being associated with higher maternal mortality (Interviewee 18, 01.11.12).

An activist explains that the National Network for Humanisation of Birth – REHUNA – is not exclusively feminist; it includes several social groups such as religious organisations (Interviewee 44, 07.11.12). Claims are heterogeneous but mostly demand for the return to the model where midwives and traditional birth attendants are the majority of health professionals dealing with births (Interviewee 44, 07.11.12). Obviously, this strategy faces serious resistance from private sector companies and in particular from doctors (Interviewee 44, 07.11.12).

An obstetrician alerts that the dichotomy created between technocratic and humanistic model of care is a fallacy (Interviewee 20, 05.11.12). In the interviewee's view, excessive technocracy may increase the risks or the number of maternal mortality, but at the same time humanistic care without proper referral in cases of emergency or complication can be deadly (Interviewee 20, 05.11.12). It is claimed by health professionals and academics that a balance must be struck with the combined use of both models (Interviewee 28, 26.10.12). This is where the problem lies in terms of women's rights advocacy (Interviewee 28, 26.10.12). In the midst of these discussions, feminists are perceived to be polarising the discussions in terms of the extremes (Interviewee 20, 05.11.12; Interviewee, 28, 26.10.12). The perception that feminists have created for themselves of being extremists does not help them to create political alliances or alternatives in the face of a more conservative environment.

Another health professional elucidates that his involvement with the movement for the humanisation of birth started after his exposure to midwifery practice and birth houses outside the country (Interviewee 16, 19.11.12). Just as noted by feminists (Interviewee 19, 22.11.12), this type of activism was also oriented by personal experience and opportunity.

His activism nonetheless resulted in a very strategic and structured medical practice based on evidences and on a discourse that relies on the law to avoid possible moral or religious resistance (Interviewee 16, 19.11.12). This not only helped him to create strong links with the movement for humanisation of birth, but also some connections with feminists (Interviewee 16, 19.11.12). This bridge-building is unfortunately not the rule.

According to an activist and birth attendant, the movement for humanisation of birth is a political construct created by the federal government aimed at gaining wider political support (Interviewee 12, 28.11.12). The activist is the founder of one of the many groups that fight for better birth conditions and choice but denominate themselves as a network of users and/or consumers who are activists (Interviewee 12, 28.11.12). Their goal is to draw attention to high rates of caesarean sections and provide information to those women who are looking at alternative options (Interviewee 12, 28.11.12). It is a digital social movement articulated by middle class white women who primarily use private health services (Interviewee 12, 28.11.12). It is clear that the use of 'consumer', i.e. neoliberal, language is highly linked to the discourse used by upper classes in Brazil. This demonstrates how diverse women's rights activism may be across the country, movements and classes.

Many of the activists in the movement for humanisation of birth state that the main obstacles faced in this area have to do with the profit-seeking capitalist system (Interviewee 12, 28.11.12). Private health plans, doctors and women themselves are some of the actors who oppose demands for different birth conditions (Interviewee 12, 28.11.12). Activists explain that, although subject to great visibility from the media, there is little dialogue with feminist movements which, in the interviewee's opinion, is too focused on working with violence against women and abortion (Interviewee 12, 28.11.12). Feminists on the other hand argue that the movement for humanisation of birth was co-opted by conservative networks (Interviewee 9, 22.11.12). This movement, in feminists' opinion, is part of a political strategy to exclude extremists and to co-opt moderates (Interviewee 9, 22.11.12).

In brief, the above sections applied the arguments present in Haraway's analogy of the cyborg in order to demonstrate that the strategies put in place in Brazil for the reduction of maternal mortality faced three problems: (i) the limited attention given to maternal mortality by feminists; (ii) the political volatility of the Technical Area for Women's Health; and (iii) the

internal divisions created within *women's movements*. It particularly drew on interviews from members of different sectors of the women's movements in order to understand the importance of these problems in relation to the progress of maternal health strategies. It observed that feminists' late engagement with the issue of maternal health, alongside the sophistication of conservative policy networks, allowed space for conservative politics and policy making. The next sections will discuss the public policy agenda and the structural obstacles that constrain the full implementation of women's rights.

External Frame: Public Policy Agenda, Public Data and Maternal Health in Brazil

Public health in Brazil is not a priority (Interviewee 29, 22.11.12). There is investment but it occurs in an odd-like manner with bits and pieces being allocated to different programmes in an inconsistent and unreliable way. The government transfers responsibility undermining its governance role through the transfer of financial resources linked to the investment in specific and fashionable programmes (Interviewee 29, 22.11.12). Therefore, HIV/AIDS might, for example, receive more attention than maternal health at a specific time and so forth and so on (Interviewee 29, 22.11.12). The network of services is therefore artificially compartmentalised and no structure or protocol is put in place to allow a synergetic interface (Interviewee 26, 20.08.12). These compartments are replicated in other levels of government challenging the bureaucracy's capacity to delivery on an integrated model that is effectively capable of changing the neoliberal paradigm (Interviewee 26, 30.08.12). This creates a wave-like political engagement by different social movements; feminists in particular are left at the mercy of unstable funding and unable to politically populate spaces disputed with conservatives (Interviewee 42, 29.11.12).

A congressman affirms that even though the last three Workers Party's (Partido dos Trabalhadores - PT) governments (initiated by Lula and continued by Dilma) perpetuate a populist rhetoric claiming the promotion of human rights, insufficient commitment is shown for the actual implementation of health as a right (Interviewee 30, 09.11.12). Public health, and more acutely women's health, continues to be treated as a political bargaining tool (Interviewee 30, 09.11.12; Interviewee 21, 09.11.12). The federal government resists changing the rules to effectively improve health financing, while at the same time insists on

the transfer of responsibility to the local levels unaware or unwilling to recognise the lack of conditions of implementation of programmes at the bottom of the system (Interviewee 30, 09.11.12).

At the same time, there are no resources or transfer of resources allocated to the wide monitoring and evaluation of the implementation of these programmes (Interviewee 29, 22.11.12). Therefore, data collection is not systematic and when collected its use is limited (Interviewee 29, 22.11.12). Maternal mortality committees are created as a space for social participation and control but these spaces have only evaluation powers and are still formed in its majority by organised women (Interviewee 42, 29.11.12). This fragmented institutionalisation becomes an expression of a widespread perception that maternal death is still a women's only interest and, more importantly, a less politically important issue (Interviewee 42, 29.11.12). The data collected by maternal mortality committees is not taken seriously by other – male-dominated – public health institutions (Interviewee 42, 29.11.12).

In an academic's opinion, an authoritative patriarchal culture and tradition of vertical programmes and citizenship leads to a practice that is not based on evidence (Interviewee 29, 22.11.12). The State does not feel bound by social demands and society stops making use of their citizenship rights (Interviewee 29). In one interviewee's opinion, the overall population is still politically immature and therefore does not perceive social control as part of a process of politics for the exercise of citizenship rights (Interviewee 29, 22.11.12). Moreover, education is just as under financed as health leaving great parts of the population uninformed or misinformed of the rights-based framework of action (Interviewee 29, 22.11.12).

Accessing Political Spaces and Democratizing Health Decisions: To Decentralise or not Decentralise?

Brazil's health system is decentralised but members of maternal mortality committees explain that the decentralisation of health in Brazil does create more space for political participation, but these spaces are not accessible to the overall population (Interviewee 42, 29.11.12). Maternal mortality committees, for example, are often formed by members

from NGOs or other recognised institutions (Interviewee 42, 29.11.12). When a community is not politically organised, it is not even able to reach institutionalised political places such as the committees (Interviewee 42, 29.11.12). With the exception of cases when they are able to do so, the discussions are limited to the mere analysis of deaths not making the leap to a more politically driven reflection and discussion (Interviewee 42, 29.11.12). This is a form of mediated citizenship that, although positive, may in effect create an interface that distorts demands coming from the population and information from the State. It is nonetheless one of the compromises that are necessary to the existence of an established democracy and in particular of a federal and decentralised political system.

In spite of the above mentioned initiatives, progress is far from desirable. The real impact of central proposals hardly ever promotes real change at the local level, which are basic local health establishments (Interviewee 4, 18.08.12). As a former policy maker clarifies, the demand of basic local health establishments is usually completely ignored or disregarded (Interviewee 4, 18.08.12). For example, the Ministry of Health may order, in spite of the reported demand, 30% of the contraceptives needed leaving 70% of users unattended (Interviewee 4, 18.08.12). It is as if the State actively relies on the private sector to fill the gaps in demand. Consequently, the ones suffering from reproductive rights violations such as maternal mortality are those who are outside the formal market and who therefore have no access to quality of services and products that can be easily accessed through the private sector (Interviewee 4, 18.08.12).

PAISM formally ruptured with the maternal-child paradigm in 1983 but this paradigm keeps on coming back either formally or informally (Interviewee 42, 29.11.12). Additionally PAISM used the principles of the sanitary reform (discussed in Chapter VI) to challenge the biomedical model of care but neoliberal biomedical ideals and interests were maintained (Interviewee 2, 30.10.12). One think tank researcher notes that this has serious implications for social participation and control (Interviewee 13, 14.11.12). The unified health system is built on an intricate decentralised model that divides regions and municipalities while transferring responsibilities, but none of it can be effective if public-private partnerships become more and more widespread (Interviewee 13, 14.11.12). In the interviewee's opinion, the problem is that there are more spaces for the participation of different interest groups (including the private national and private international sectors) and few or no rules binding public-private contracts and services to social accountability

standards (Interviewee 13, 14.11.12). In fact, the tools provided by the programme promoted little change to the already existing inequalities (Interviewee 2, 30.10.12).

Deconstructing Strategies for the Implementation of the Programme for Women's Integral Health Care

As noted above, the Brazilian health system fails to reflect upon and provide for a practice based on evidences which in turn makes it difficult to pinpoint the real problem in the gaps between policy making and implementation (Interviewee 2, 30.10.12; Interviewee 40, 16.11.12). A feminist activist affirms that the Ministry of Health resists endorsing reports and research that present findings that contest the mainstream maternal mortality reduction practices already put in place (Interviewee 14, 23.10.12). The system fails for example, to acknowledge the importance of chronic disease and of emerging issues such as maternal morbidity which have become important issues universal to health care and maternal mortality as they tend to represent how health inequalities affect women across their lifetimes (Interviewee 2, 30.10.12; Interviewee 40, 16.11.12).

A member of parliament argues that the problems with innovation and implementation are linked to: (i) insufficient financing of public health; (ii) managerial problems at the municipal level; and (iii) under appreciation of human capital (Interviewee 30, 09.11.12). A nurse working at a public health establishment counters that the reason why programmes are not implemented strategically is the absence of protocols binding health professionals to a discrimination-free, non-moral and/or religious practice (Interviewee 22, 17.09.12). An obstetrician affirms that philanthropic hospitals (such as Perola Byington and Sofia Feldman) that have put in place specific protocols have been able to guarantee rigorous care and a considerable reduction in maternal mortality rates (Interviewee 11, 07.11.12).

Although there is not necessarily a consensus around the strategies adopted to implement PAISM or, more specifically, to reduce maternal mortality, there seems to be consensus in the fact that the creation of PAISM was indeed positive to the improvement of women's health indicators. Professionals at the very tip of the system agree that there is considerable progress, particularly in terms of the inclusion of issues such as family

planning, pregnancy, childbirth and postpartum, prevention of breast cancer and cervical cancer, sexually transmitted diseases, menopause, sexuality and adolescence (Interviewee 31, 29.10.12). New practices such as curriculum reform at university level have helped to reduce striking differences in a country with continental proportions (Interviewee 31, 29.10.12). Most importantly, PAISM along with all the programmes implemented within SUS, have improved access, leading to an outstanding coverage rate (Interviewee 31, 29.10.12).

Indeed the context changed but up to this date the very concept of PAISM and comprehensive health care (*integralidade*) continues to face constant obstacles to its fulfilment (Interviewee 7, 01.12.12). Academics argues that in spite of wide resistance from feminists there is a necessity for better articulation of feminist demands through the dialogue with other organised social movements, and possibly with the progressive sector of the Catholic Church (Interviewee 7, 01.12.12). This is not to say that the reduction in maternal mortality and the outstanding coverage rate were in spite of the feminists (initial) opposition to PAISM. On the contrary, feminist activism was crucial to advancing the women's integral health care agenda. However, the institutionalisation of the movement, the depoliticisation of women's rights and the lack of articulation with other social movements are among the causes of the limited implementation of PAISM in the country.

Religious Backlashes, Neoconservatism and the Women's Human Rights Agenda

An activist explains that the role the progressive wing of the Catholic Church plays in the promotion of human rights cannot be undermined (Interviewee 34, 04.10.12). Initially, the Catholic Church rejected human rights altogether because the Church thought it led to individualism (Interviewee 34, 04.10.12). However with the progress of the human-rights based movements and discourses, the Church revised its position in order to adopt human rights as part of the Catholic 'ideal' (Interviewee 34, 04.10.12). In the interviewee's assessment, the new discourse adopted by the Church influenced its political strengthening that can be particularly traced to the period of the democratic transition (Interviewee 34, 04.10.12).

Academics believe that the influence the religious bench has in the Legislature today is not reflective of the Catholic Church's role in politics in the 1970s and 1980s, but of the overall cultural importance Catholics and Evangelicals have in Brazil (Interviewee 7, 01.12.12). For members of parliament, the presidency is currently far too committed to maintaining electoral promises given by President Dilma to the religious caucuses (Interviewee 30, 09.11.12). Frequently elections are determined by votes directed to candidates who raise 'flags' of religious morality and promise to extend this morality to his/her public life and its exercise (Interviewee 7, 01.12.12). This goes to say that women's rights in Brazil is not only an issue of conflicting interests (such as feminists vs. conservatives and left vs. right) but it is in fact a matter of morals. Women's rights, just as human rights, have been appropriated by the mainstream moralistic discourse that claims to advance ethical values, when in fact it attempts to decide (based on stereotypical and moralistic views) who gets the best quality of services and who does not.

In a sense, this discussion has to do with the capacity of human rights actually promoting a profound change to unequal power structures in Brazil. Judges dispute that the expansion of the human right to health should be done through the use of the justice system (Interviewee 21, 09.11.12). According to this position, legal hypotheses could be explored as a way to expand the terminology currently used in order for it to embody the principles of the sanitary reform (Interviewee 21, 09.11.12). Legal professionals explain that although legal cases are usually used to advance claims supported by pharmaceuticals and/or other profit-seeking interests, not enough has been done to bring social rights and politics to the realm of law enforcement professionals (Interviewee 21, 09.11.12). Today, the language of rights is almost inexistent at the local level (Interviewee 22, 17.09.12). Even in exceptional cases, health professionals commonly rely only on the Maria da Penha Law (on domestic violence) and the discourse coming out of the movement for the elimination of all forms of violence against women which frame the lack of effective and efficient reproductive services as a matter of violence (Interviewee 22, 17.09.12). This framework has proven very successful in cases brought before international courts but it has a clear limitation, which is framing reproductive rights violations as something else and not as specific reproductive rights norms.

In practice, this signifies an institutional and instrumental use of the rhetoric of human rights completely dissociated from its ethical value (Interviewee 37, 27.09.12). Academics

studying public health note that health professionals tend to understand the full exercise of human rights as a privilege and only qualify health care as social benefits highlighting social constructs that apply to women, men and functions (Interviewee 37, 27.09.12). This represents a persistence of the needs-based rhetoric at the local level whereby morally, practices can be accepted as a matter of necessity and not of human rights and/or citizenship (Interviewee 34, 04.10.12). This ubiquity of a patriarchal moral discourse divides perceptions of the social value of the law in two: the law with a legal perspective; and with an ethical perspective (Interviewee 37, 27.09.12).

Maternal Mortality and its Moral Judgements and Dilemmas

Maternal mortality is an issue that is filled with moral judgments and dilemmas (Interviewee 41, 24.10.12). To die from complications arising out of a pregnancy is seen as the most noble and natural way a woman can pass away by society in general (Interviewee 41, 24.10.12). For a public health specialist, maternal mortality is neither seen as a matter of human rights nor as a public health problem by society in general (Interviewee 41, 24.10.12). A specialist on preventive health, he/she affirms that maternal health is given priority in basic health services, but under a reductionist approach (Interviewee 28, 26.10.12). This 'marianismo' has made maternal mortality seem less viable for feminists rallying given the call for the Church (Interviewee 9, 22.11.12).

A step towards judicialisation of sexual and reproductive rights was taken through the Alyne da Silva Pimentel Case presented against the government of Brazil before the CEDAW (Interviewee 3, 28.09.12; Interviewee 5, 20.10.12; Interviewee 14, 23.10.12). The case was filed in 2007 by a local NGO, Advocaci, and, an international organisation, the Center for Reproductive Rights, and called for the recognition of the right of women to receive timely, non-discriminatory, and appropriate maternal health services (Interviewee 3, 28.09.12). The case was decided in 2011 by CEDAW which then found Brazil to be responsible of grossly negligent care (Interviewee 3, 28.09.12). The Alyne Case is emblematic because it recognises the systemic problems in the management of public health and of privately-contracted public health services (Interviewee 5, Interviewee, 20.10.12).

As of January 2013, the specifics of the implementation of this decision have yet to be decided by negotiations between the government and the organisations in charge of overseeing the case, the Center for Reproductive Rights (Interviewee 3, 28.09.12). A member from the Center for Reproductive Rights clarifies that initially the government resisted engaging with the case by denying any responsibility (Interviewee 3, 28.09.12). The interviewee explains that acceptance only came after the CEDAW delivered its decision, and even then the government only seemed to give a rhetorical recognition of maternal mortality as a problem (Interviewee 3, 28.09.12).

Another exceptional example of the judicial expansion of reproductive rights definitions through social activism can be seen in the landmark case of abortion in the case of diagnosis of foetal anencephaly (Interviewee 24, 20.08.12). The case was decided in 2012 by the Federal Supreme Tribunal and declared all legal interpretations of the Penal Code limiting abortion in the cases of foetal anencephaly to be unconstitutional (Brasil, 2012). The decision recognised the right to access legal abortion services without the need for any type of authorisation and classified the procedure as the therapeutic anticipation of delivery based on the human right to health and dignity (Brasil, 2012). Feminist activists saw this decision as a demonstration of a reaffirmation of a framework for services for legal abortion and favourable legal interpretations that classify previously non-codified cases of abortion as being legal and not the other way around (Interviewee 24, 20.08.12).

Notwithstanding, feminists argue that the de-politicisation of women's integral health movement resulted in the systematic and institutional failure to prioritise and protect women's health rights (Interviewee 14, 23.10.12). The current government resists accepting the perspective that maternal health is a human right, therefore treating it as an instrument for development and not an entitlement (Interviewee 14, 23.10.12). This creates a dichotomy whereby internationally, Brazil defends a reputation of a human rights defender, but internally fails to transfer this rhetoric to reality (Interviewee 3, 28.09.12; Interviewee 32, 06.06.12).

These last sections concluded that feminists strategies based on the institutionalisation of the women's integral health care discourse were very successful at engaging different policy networks and influencing policy making during the time of transitions - demographic

and democratic - but were not as successful in terms of the implementation of these policies. Feminist human rights discourses were subjected to appropriation by other policy networks which then transformed them to fit their own political interests. Although this led to the use of women's rights discourses, it did little to effectively reduce maternal deaths and even more importantly, did nothing to challenge patriarchal conceptions of womanhood and motherhood.

Conclusion

We live in a patchwork reality, full of different strategies, feminists and feminisms. The plethora of demands and political spaces create division within the different feminist movements which undermined their own epistemological strategies which is crucial for determining possible articulations. PAISM, as part of feminists' initiative within the wider movement for sanitary reform, is a political process that needs to be constantly reshaped and reflected upon. It is still difficult to analyse whether feminists' epistemologies will manage to build effective affinities to properly implement PAISM and tackle maternal mortality. It is nonetheless clear that thus far, the failure to timely afford visibility and priority to maternal mortality has allowed for the creation of political spaces that have been populated and dominated by conservative religious movements. This not only negatively influenced the provision on reproductive health services, but also the delivery of public health under a framework that allows for space for practices enclosing the social determinants of health and illness.

In sum, this chapter contributed to a better understanding of the complexities attached to women's rights activism in public health sector reforms in Brazil. It highlighted the importance of understanding the role of new policy spaces in the creation, appropriation, transformation and re-appropriation of political discourses. It stressed that the competition for the participation of public policy making and implementation becomes more acute when delivery and evaluation of services are decentralised. It concluded that in the Brazilian context the advancement of women's rights as intrinsic value is limited by backlashes and setbacks characteristic of not only decentralisation itself, but of the multiple policy spaces it creates.

Moreover, this chapter pointed out that feminists are not involved in the making of the policy spaces themselves and therefore have limited understanding of their dimensions, compositions and limitations. This drastically reduces feminists' ability to fully advance their agendas within those spaces because they are often unable to act in a strategically sound manner. This happens not only, as stated before, because health sectors are inherently gendered, but also because politics has been historically constructed as a male dominated cluster of spaces that replicate and are built by male-oriented discourses.

It is therefore possible to conclude that women's rights experiences in political activism, particularly feminist activism, were in fact political experiments. This finding is important in the sense that it calls for a constant and critical reassessment of the drawbacks and backlashes of these experiments in order to delineate better ways to move forward. It flags up that women's rights' advancement not only depends on the success of progressive activism but also of conservative agendas. Obviously, it is safe to say that other progressive policy networks that are not necessarily aligned with feminists (i.e. indigenous people's rights, children's rights and others) can have positive and/or negative effects on the achievement of a policy framework for the achievement of women's rights as an intrinsic value. However, regardless of other external and competing forces, the data analysed here suggests that feminists' strategic distancing from conservative discourses has not always produced the best policy outcomes, and in this way may not always be a good political tactic for the diffusion of women's rights.

The next chapter will discuss the importance of market-led policy networks in maternal health policy making and implementation. It will explore the definitions of policy space, development discourse and depoliticisation in order to understand the implications of private policy networks in maternal mortality reduction strategies. It situates the discussion in terms of transition politics and does so in light of the previous chapter on the pre-1980s and the 1980s and 1990s public health reforms and the period of re-democratisation in Brazil.

It highlights that health sector reform politics are considerably shaped by political transition as well as by the political spaces created by them. When several policy spaces are created, politics are changed as to require resources and sophistication for the appropriation and instrumentalisation of political discourses that, in the current state of

affairs, can only be attained either by the State itself or by wealthy policy network with large and/or strong political basis, i.e. conservative networks. In this case, it is/will become visible that the private sector policy networks (along with religious caucuses) are better equipped and more aware of the implications of the development of women's rights policy discourse and therefore better able to influence the discourse used for the implementation of these same policies.

Chapter VI - Turning Left and Leading Right? Health Sector Reforms and Movements and the Political Context for Women's Rights Political Activism

Introduction

Shiffman and Smith (2007) affirm that the political and social context inhibit or enhance support for maternal health initiatives at the time. The historical moment in which political actors operate in determines the limits and opportunities of their strategies and acknowledging this is important for the design of successful frameworks of action (Shiffman and Smith, 2007). This aspect is therefore divided into two factors: political moments; and platform for collective action. The focus here is put on discussing the influx of new social justice discourses in the pre-1980s, 1980s and 1990s in order to establish if the design of health sector reforms in Brazil contributed to the marginalisation of reproductive health and rights. This chapter then denounces health sector reforms' political manoeuvres by uncovering at all specific thematic sections the political moments in which policy changes were created from and the governance structure available for the creation and continuity of a social justice platform for collective action.

The reform of public health systems differs considerably from country to country. A myriad of approaches have been used in different settings. These range from sweeping reforms to narrower changes and can be grouped into fiscal changes, organisational changes or policy changes. However, it can be said that most Latin American countries implemented, at some point throughout the 1980s and the 1990, some sort of sweeping public health reform strategy based on organisational changes (Mesa-Lago, 2007). This type of reform can promote greater flexibility, efficiency, accountability in resource use and community participation and involvement (Mesa-Lago, 2007; 2008; Cornwall and Shankland, 2008). Nevertheless, it can also lead to sector fragmentation, loss of policy leadership, confusion of responsibilities and deterioration of services (Yamin, 2000, Homedes and Ugalde, 2005; Pribble, 2010).

As explained in the methodology chapter, this thesis does not have the purpose of analysing neoliberalisation and health reforms in Latin America. However, it must engage with scholarly materials written on the subject as a way of situating the current research within a wider context. For this reason, this chapter will attempt to deconstruct neoliberalism and its different phases of implementation as a way of understanding how market-driven forces and projects such as the Washington consensus and post-Washington consensus, as well as emerging pro-poor economic policies, have influenced new neoliberal policies and health sector reforms in Latin America. This chapter will therefore also discuss and position these issues in terms of the pre-1980s, 1980s and 1990s Brazilian context and the first wave and second wave neoliberal health sector reforms.

Political Contexts: Deconstructing Neoliberalism

We live in capitalist times. All capitalist projects make use of a political rhetoric that uses cultural images that rely on fear as one of the many instruments used to support a particular discourse and practice that increase economic dependency and the poverty gap (Ewig, 2010). Modern capitalist projects are mostly known and classified in the form of the cluster loosely named neoliberalism (Hall, Massey and Rustin, 2013). The neoliberal project represents the continuity of an exclusive way of policy making and implementation, run by an elite that is alienated and disconnected from reality (Harvey, 2005). This policy praxis results in a lack of commitment to people's experiences and needs and in a discriminatory and delusional perception of the reasons and the purpose of programmatic targeting and retrenchment (Boesten, 2007).

Neoliberalism uses discourse (as mere rhetoric) for the promotion of cuts, privatisation and widespread contempt for the poor (Saad, 2004). It means shifting the mainstream political discussion from the ethical dimensions of austerity measures to moralistic values of socially constructed roles (Ewig, 2010). It purposefully exposes individuals to criticism in order to protect the corporate determinism embodied in the shift of paradigm performed by policies under neoliberal governments (Harvey, 2005). This does not usually occur in a visible and transparent manner (and this is perhaps one of the main problems of its rhetorical appropriation) (Hall, Massey and Rustin, 2013).

For example, poor black mothers can be demonised as ‘bad mothers’ while no critique is presented against those conditions that might have put that woman in a poor and marginal condition in the first place (De Benedictis, 2012). Simultaneously, attempts to criticise the interests that uphold neoliberal governments in power are forcefully blocked. The deconstruction of the symbolic meanings of neoliberalism reveals the discriminatory nature of capitalism. It subjugates the feminine and feminist aspirations and choices and it fails to view power as gendered (De Benedictis, 2012). Motherhood is used, in this sense, in authoritative terms as a form of representation of women’s predominant and conforming roles and their bounded devotion to a heterosexual male-dominated family (Berry, 2010). This re-emphasises the male/female relationship in terms of the nature/culture binary by oversimplifying a spectrum of gendered experiences, disregarding other social categories that impact over women’s and men’s lives and creating artificial groups that are incapable of translating highly transient definitions such as womanhood and motherhood (Ortner, 1972; 1996).

It depoliticises political and economic discourses sustaining and/or rejecting neoliberalism while instrumentalising the image of mothers, in particular poor and marginal mothers (De Benedictis, 2012; Galli, 2002). In sum, it fails to expose the political rhetoric sustaining neoliberal policies which undermines any democratic attempts to openly deconstruct and challenge these same policies as well as the symbolic meanings associated with them (Harvey, 2006; Davis, 2007). In this sense, the following sections will attempt to further explore the implications of having women’s rights policies implemented under such an environment. It will enquire whether or not the discourses around women’s interests and health needs are used in policy for permissive, individualistic and discriminatory economic policies that only serve to advance profit-seeking behaviour and a pathological ideal of a heterosexual and male-dominated nuclear family.

Washington Consensus and Post-Washington Consensus

In the late 1970s, western countries were suffering from the effects of the 1972 oil crisis and the 1973-4 stock market crash and the threat coming from the Cold War communist bloc seemed more imminent than ever (Fine, Lapavitsas and Pincus, 2001; Harvey, 2006; Meier, 2010). The economic liberal crisis of the 1970s created rising unemployment and

inflation (Harvey, 2006). At this point, as a way of reviving 'capital accumulation', the United States and the United Kingdom supported by the World Bank and the IMF, institutionalised the political doctrine widely known as neoliberalism (Fine, Lapavitsas and Pincus, 2001; Harvey, 2006). Although dominating in the 1980s and 1990s and reinforced in 1998 as the formalised Washington consensus and the World Trade Organization (WTO) rules, neoliberalism's 'project' can be traced back to the 1920s (Fine, Lapavitsas and Pincus, 2001; Harvey 2006). Peck, Theodore and Brenner (2009) understand it as a political economy theory that proposes the achievement of individual wellbeing through the increase of entrepreneurial freedoms and correlated institutional framework pushing for free markets and free trade.

After the introduction of neoliberalism as an ideology, the role of the welfare state as a promoter of well-being to its population was replaced by an enabling, rather directive government in search of good business (Dean, 2002; Harvey, 2006). In this sense, neoliberal purists may argue that the role of the state is to create and preserve an institutional framework appropriate to such practices (Harvey, 2006). Limited government intervention and the diffusion of independent regulatory agencies with the purpose of liberalising and privatising utilities and trade are inherent to neoliberalism (Hall, Massey and Rustin, 2013).

Regulatory agencies foment increased technical regulation leading to the formation of new political networks and alliances (Dean, 2002). In this environment, political power is diffuse and new political spaces foster strong policy networks (i.e. anti-democratic forces, historical traditions, structural institutional arrangements, etc.) (Simon 1983; Haas, 1992; Ewig, 2010). Consequently, as the neoliberal ideals become more and more embedded in most modern societies as if 'naturalised' to institutional planning, the influence of strong networks become higher and higher in public policy making (Harvey 2006).

Arguably, the exploitable contradictions within the neoliberal agenda, that is "the gap between rhetoric (for the benefit of all) and realisation (for the benefit of a small ruling class), increase over space and time" (Harvey, 2006: 169). As we move away from a neoliberalisation transitional period and closer to monopolisation, centralisation and internationalization of corporate and financial power, the neoliberal emphasis upon individual rights and the increasingly authoritarian use of state power to sustain the system

will become a flashpoint of contentiousness (Hall, Massey and Rustin, 2013). In Latin America, the spread of the neoliberal ideal in the 1970s and 1980s escalated with creation of neoliberal policy networks (either in the form of policy legacies or epistemic communities) during military governments supported by the United States, which was certainly true in the case of Brazil (Weyland, 1996b; 2010; Harvey 2006).

Pro-Poor Policies

By the second half of the 1990s, neoliberalism as promoted by the World Bank and the IMF was proving to be disappointing (Saad, 2004). Poverty reduction was unsatisfactory, uncontrolled international capital flow was once more on the brink of a crisis and growth was at a steady pace (Saad, 2007). This resulted in the rise of a post-Washington consensus which, as opposed to the previous framework, took market failure and institutions to the core of its rules (Fine, Lapavitsas and Pincus, 2001). The novelty in the model was the description of types of positive government interventions justified by market and institutional failure (Mackintosh, 1992).

But, still, in spite of the inclusion of the concept of social capital, social factors were not properly recognised as decisive to development (Harriss, 2002). Social capital, as described in the 1997 World Development Report, was defined as informal rules and norms created by social relations that influence economic outcomes (Fine, Lapavitsas and Pincus, 2001). Social capital theory shifted the model towards more participatory language and approaches, but this was underpinned by utilitarian values and depoliticised version terminology valued primarily for their contribution to the main goal of economic growth (Mawdsley and Rigg, 2003). That is, in spite of an inclusive rhetoric, the use of the social capital economic metaphor mostly served the World Bank's new neoliberal agenda and was therefore decisive to the creation of a movement against the Post-Washington Consensus (Harriss, 2002).

It was only with the third generation reforms, i.e. post post-Washington consensus of pro-poor policies, that mixed markets and social democratic policies were introduced (Grugel, Roggirozzi and Thirkell-White, 2008). This was an extension (or perhaps a rejection) of the

1998 post-Washington consensus development alternative (Fine, Lapavitsas and Pincus, 2001). Thus, the moment beyond the post-Washington consensus is characterised by a variety of pro-poor policies and pro-poor development strategies based on Post-Keynesian, Institutionalist, Evolutionary, Kaleckian and Marxist schools (Saad Filho, 2007). Pro-poor (or poverty alleviation) economic theory challenges the discourse on the origins and mechanisms of reproduction of poverty presented by the mainstream embodied by the first and second generation Washington consensus (Saad Filho, 2004; 2007).

This wave of pro-poor theory directly aims for the achievement of distributive economic outcomes and defends the introduction of economic policies that not only take into account but purposefully focus on the needs of the poor by democratically distributing income, wealth and power (Saad Filho 2007). In contrast to previous economic scholarly studies, it argues for an increase in the public sector size and spending as a way to regain welfare state practices (Saad Filho 2007). Some scholars identify Brazil as a middle income country that has moved away from Washington consensus' and post-Washington consensus' strategies in order to favour pro-poor reforms (Kakwani et al., 2006; Saad Filho, 2004; 2007). Current Brazilian social policies are perceived to value equity rather than growth with improvements in distribution and social welfare (Kakwani et al., 2006). Social programmes dependent on targeted conditional cash-transfers such as Education Allowance (Bolsa Escola) and Family Allowance (Bolsa Família) are identified as examples of pro-poor strategies (Molyneux, 2007; Macaulay, 2002).

However, contradictory mainstream policies associated with these programmes (and with most macroeconomic strategies) transform 'poverty elimination' into 'poverty management' by implementing monetary hand-outs rather than investing in public goods (Castiñeira et al., 2009; Bresser-Pereira and Nakano, 2003; Saad Filho, 2004; 2007). Indeed, pro-poor policies and development initiatives became fashionable in Brazil as well as throughout the Latin American region, even becoming recognised by profit-driven international organisations such as the IMF (Draibe, 2006; Saad Filho, 2007).

Notwithstanding, Latin American countries are far from actually eliminating poverty. In this sense, one could say that pro-poor approaches have fallen short of achieving the goals envisioned by pro-poor theorists (Castiñeira et al, 2009). Or, perhaps, one could argue that countries such as Brazil have been incapable of abandoning the neoliberal model

pertained to the Washington consensuses; merely using pro-poor reforms as a way to advance a particular political agenda that increases the level of influence neoliberal policies have on social policy making and implementing (Saad Filho, 2007).

Neoliberalism failed miserably in Latin America leaving behind a series of inconsistent policies and gross inequality (Saad Filho, 2004). Latin America experienced the rise and the fall of the two Washington consensuses and it is still struggling to deal with the contradictions created by them (See Castiñeira et al., 2009; Draibe, 2006; Grugel, Roggirozzi and Thirkell-White, 2008). These contradictions are quite clear in the assessment of health care provision. Indeed, the results in terms of health care access within the region have been mixed. In some countries it decreased or stagnated, and in others it increased while segmented (with mixed public/private participation) health systems predominant in the region contributed to the low coverage and the decrease (Mesa-Lago 2010). It is clear that throughout the region social insurance cover is still very unequal across gender, class and race as it is still aimed at affording protection to formal employees in urban zones (Mesa-Lago 2010). Macroeconomic policies also created more inequality and exclusion from which disfavoured women, the poor, low-income rural population and ethnic minorities suffered the most (Macaulay, 2010). For example, conditional cash transfer programmes have used the image and support of poor women to support election-driven political interests (Molyneux, 2007).

In the next section, I will look at how the Washington consensus, post-Washington consensus and pro-poor policies' theoretical frameworks interact with Brazil's federal system, distributive social policies and health system financing. Mainstream discourse of different periods substantially shaped key actors participation, responses and their implications to reproductive health. The periods consisting of health sector reforms are crucial to understanding the context in which women's rights activism around the issue of maternal mortality was inserted into. For the purpose of this systematic analysis, the following sections will be divided into three main time periods: pre-1980s, 1980s and 1990s. This breakdown lends itself to the analysis and contributes to answering the research question.

Policy Windows: The Brazilian Context and Neoliberal Health Sector Reforms

The effects of HSR policies can be analysed in terms of coverage of the labour force and population; sufficiency and quality of benefits; equal treatment and social solidarity; gender equality; efficiency and administrative costs; and, finally, financial sustainability (Mesa-Lago 2010). These following sections are mainly concerned with the efficiency and administrative costs under Brazil's current federal regime and the effects it had or has on the achievement of effective, efficient and universal health care. The next sections acknowledge the intersectionality inherent in Brazil's diverse society and rich political scenario (Galli, 2002; Htun, 2004). As defended by Saad Filho (2007), the perspective taken here is one that assumes the government is the only social institution capable of improving overall health and the underlying social determinants of health such as education, employment, production and distribution of goods and services and distribution of income and assets (Saad Filho, 2007). It does so with a focus on the importance of health institutions, the context and the actors who shape these institutions. Therefore, for the analysis present in the next sections, it will be crucial to establish the reforms of the public health sector and the role of current health strategies to the production, reproduction or reduction of social inequality in Brazil.

Pre-1980s: The Build-up to Political Transition and Health Sector Reforms

The External Governance Structure

From 1880 to 1930, Latin American health care consisted only of social hygiene strategies oriented by eugenics (Stepan, 1991). Most countries had capitalist and clientelistic governments that promoted extremely bureaucratic legal-political structures that afforded little to no value to health services (Fleury, 1992). In these contexts, political elites were given considerable power over the development of medicine (Boesten, 2007). Fleury (1992) suggests that this demonstrates that from the beginning Latin American medicine was conceived as an exclusive instrument for domination.

Progressively, with the participation of international and philanthropic organisations such as the Rockefeller Foundation, Latin American countries started to see the importance of epidemiological control and of the provision of health care for ideological purposes (Santos and Faria, 2003). Health institutions were slowly incorporated into the bureaucracy but the provision was linked to capitalist values and therefore benefited mostly the formal workers (Mesa-Lago, 2007). However, with economic crises and fiscal retrenchment, western capitalist actors became more and more responsible for the definition of social policy in the region (Fleury, 1992). These international pressures are then represented as either externally imposed or as internally proposed (Fleury, 1992). In the case of the latter, the nuance to how internalisation takes place relies heavily on the historical context and the actors participating in it (Htun, 2004).

In 1919, the International Labour Organization (ILO) was founded in order to introduce the concepts of social insurance and selectivity to the global agenda (Mesa-Lago, 2008). The 1944 ILO Declaration of Philadelphia and the 1948 Universal Declaration of Human Rights (United Nations Charter or UNDR) established the human right to social security (Mesa-Lago 2008). Subsequent ILO conferences, conventions and recommendations developed social security principles further with the influence of the World Bank (WB), the International Monetary Fund (IMF) and the Inter-American Development Bank (IADB), particularly in the 1980s and 1990s (Mesa-Lago, 2008).

With the creation of the World Health Organization (WHO) by the World First Health Assembly in 1948 (constitution drafted 1946 but entered into force on 7 April 1948) a rights-based approach informing WHO policies was formed (Koivusalo and Ollila, 1997; Meier 2010). The preamble of the WHO Constitution declares that everyone has the right to the enjoyment of the highest attainable standard of health encompassing “both insurance for medical services and underlying conditions for, inter alia, adequate nutrition, housing, education, and social security” (Meier 2010: 9).

This broad and positive definition of the right to health was confirmed by the International Health Conference and pursued by the WHO from 1948 until 1952 (Yamin, 2008). It also guided the drafting of the International Covenant on Human Rights (ICHR) which later, due to Cold War politics, had to be broken down into two instruments: the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on

Economic, Social, and Cultural Rights (ICESCR) (Galli, 2002). However, a change in leadership caused a dramatic shift to WHO's paradigm from 1953 to 1973. It parted from the rights-based approach in favour of highly technical vertical disease specific programmes (Koivusalo and Ollila, 1997). At this point, the "WHO came to reposition itself in global health governance as a purely technical organisation, focusing on medical intervention and disease eradication to the detriment of rights advancement" (Meier, 2010: 8).

Global health then became infiltrated with biomedical jargon and targets as a result of post-World War science advances (Walt and Gilson, 1994; Crisp, 2010). This conceivably came at a large detriment to the development and implementation of the right to health and its inclusion in HSR policies (Bakker, 1994; Walt and Gilson, 1994; Koivusalo and Ollila, 1997). The first formal Latin American critique to technocratic and over-medicalised approaches to health arose from the Cuenca Conference of 1972 (Fleury, 1992). Cuenca produced the blueprint for political proposals committed to social medicine values, i.e. to social transformation geared towards the marginalised population (Fleury, 1992).

In 1973, the WHO position was reverted back to a rights-based movement materialised in the 1978 Declaration of Alma-Ata (WHO, 1978). The Declaration of Alma-Ata introduced WHO's Health for All Strategy which majorly focused on the achievement of horizontal primary health care goals by the year 2000 (Koivusalo and Ollila, 1997). This marked the introduction of the idea that reforms geared at administration and financial schemes pertinent to national health systems would tackle structural determinants of health (Ollila, 2011). However, a medicalised approach to the right to health was not withdrawn and an inter-sectoral approach to policies still remained rhetoric (Baxi, 2010). Contrary to 1973 Health for All Programme's genuine health-promoting intentions, it re-inserted to WHO policy agenda a new rights-based discourse, which in fact had negative effects on social policy making (Meier, 2010). As a result of the rise of the neoliberal paradigm to the scheme, "developing states reduced health expenditures [retrenchment] and health inequalities widened" and the right to health was reduced to the right to health care (Meier, 2010:47). Effectively ensuring the full enjoyment of health (in its wider meaning) was even more distant (Baxi, 2010).

Since the end of the 1970s, supranational and global actors have been increasingly important in changing policy outcomes (Cohn, 2011). In the case of welfare state and social policy, international institutions such as the ILO, the WHO, the IMF and the World Bank, diverted from their initial objectives in order to engage more in social policy making, redistribution and regulation (Deacon et al., 1997). This influence became particularly acute supra-nationally and nationally through the 1980s and 1990s free market structural adjustment programmes (SAPs) (Abouharb and Cingranelli, 2007).

In Latin America, a series of HSRs were fomented by these international agencies using Lordoño and Frenk's neoliberal models of 'structured pluralism' (Cohn, 2011). These increased the participation of the private sector in public health provision and promoted the rise in the level of targeted social policies, particularly conditional cash transfer programmes (Murray and Elston, 2006). Cost reduction caused by new restrictive policies not only perpetuated structural inequality and assistencialism but also the adoption of primary health care as the new model for health provision (Cohn, 2011). At the forefront of a resistance movement challenging the concept of health as defended by WHO, was the Brazilian Association of Collective Health (ABRASCO – Associação Brasileira de Saúde Coletiva) (Vaitsman, Moreira and Costa, 2009). ABRASCO was created in 1978 to articulate the interdisciplinary use of epidemiology, administration and planning in health and social sciences of health (Paim, 2003). ABRASCO was connected with the Brazilian Centre of Health Studies (CEBES - Centro Brasileiro de Estudos de Saúde) which produces and publishes a very important and influential journal in the field, *Debate on Health (Saúde em Debate)* (Weyland, 1995). These institutions emphasised health promotion, the prevention of its risks and aggravations, prioritisation of the needs of patients and the improvement of quality of life (Weyland, 1995). In spite of the philosophical underpinnings of social movement for health reform, institutional factors such as bureaucratic politics and clientelism prevented the advancement of its wider strategy for health equality (Weyland, 1995).

The Internal Political Moment

Until 1915, public health policies in Brazil were limited to urban areas (Santos and Faria, 2003). The political debates of the first republic surrounding social hygiene started to

problematise health and point towards the need for a national centralised health system (Santos and Faria, 2003). This started a discursive tradition whereby only the direct intervention of the central government was seen as capable to challenge regional and local clientelistic networks to promote an effective programme against rural epidemics (Almeida et al., 2000; Campos, 2006b). In 1920, the National Department of Public Health (DNSP-Departamento Nacional de Saúde Pública) was created for the expansion of epidemic control services to all regions of the country (Santos and Faria, 2003). At this point, two separate doctrines were born, one pushing for a public health reform mirrored in European models, and another arguing for a nationalistic public health reform (Saldanha, 2009). The first was widely supported by the Rockefeller foundation (particularly present from 1917 to 1949) through investments in eugenic prophylaxis and disease control and medical education programmes (Corrêa, Petchesky and Parker, 2008).

However, health sector reforms preceded pension reforms in Brazil (Mesa-Lago 2008). In 1923, the Eloy Chaves Law was enacted as a way of incorporating private medical services by the Social Prevention System and giving access to formal workers to health services (Paim et al., 2011). This opened up a period of 'regulated citizenship' characterised by assistencialism and non-universal access to health care and services (Cohn, 2003:18). This was furthered by President Getúlio Vargas' populist democracy of 1930-1945 (Saldanha, 2009). Getúlio Vargas put poverty into the public policy agenda and determined it would be the target of specific programmes (Paim et al., 2011). In his first decade of government, Getúlio Vargas created the national system of social protection strictly linked to labour policy and law and to the pension system (Cohn, 2011). The poor who did not have a formal place in the economy were then seen subservient to formal workers and were therefore not granted access to the social security and health system (Mesa-Lago, 2008).

In 1936, the first women's rights organisation was created by the feminist Bertha Luz (Macaulay, 2010), but resistance from the populist authoritarian government of Getúlio Vargas and later by the decades of military governments stalled its creation (Macaulay, 2010). Notwithstanding, some important achievements occurred in this period such as the creation of protectionist employment legislation in 1943, guaranteeing maternal leave and other child care rights (Vianna and Lacerda, 2004). However, the women's rights movement has not always been at the forefront of human rights politics. In 1962 a right-

wing women's movement guided by right-wing men conspiring for a military coup was created for the reinstatement of 'morality and order' in Brazil (Álvarez, 1990). This reaction to Joao Goulart's government looked at legitimising the military coup and later served as the foundation of the military government's agenda against communism and social change (Álvarez, 1990). Therefore the use of women's movements and rhetoric claiming the defence of family and morality have been used from early on in Brazil. It created 'sanctified' female symbolism to restructure the political economy dependent on capitalism. This is a common strategy in gender politics in Latin America (Craske, 1999). This was repeated, for example, in Chile in the overthrow of Allende's government (Álvarez, 1990).

In the period of 1966-67, after the military coup of 1964, the pension system was reformed giving greater emphasis to health as a clientelistic bargaining power (Cordeiro, 1991; Cohn, 2003). Social security was unified and centralised to expand coverage to formal workers while simultaneously delegating the expansion of health services coverage to the private sector (Cordeiro, 1991). Until the 1970s Brazil's system was a pinnacle of social inequality; it only consisted of a centralised 'health care of social prevention' system (predominantly curative) rejecting underlying determinants of health, such as housing, clothing, education, food and nutrition and social services. (Weyland, 1995).

During the period of 1964 to 1974, the military government created stronger links with Western capitalist economies and portrayed these capitalists' interests as essential to the country's economic development (Cohn, 2011). The priority of the so-called 'economic miracle' (milagre econômico) was to stimulate economic growth, but in truth there was only a huge increase in the international debt and an increase in all social inequalities (Baptista, 1996). Informal workers had access to public health services but these were limited to social hygiene purposes – i.e. they were treated for any epidemic threatening economic development (Cohn, 2011). At this time, social policy was attributed a secondary role and the issue of poverty remained invisible in the public policy and academic agenda (Cohn, 2011). In fact, in 1968, the same symbolism of 'the family' was used by another women's movement, but this time against the repressive dictatorship (Álvarez, 1990). The dictatorship's economic policies thrust women into the workforce into low-paying and low-status jobs while holding them morally accountable for the family's survival (Álvarez, 1990). Patriarchal ideologies, State violence and repression permeated women's lives

(Costa, 2009). This stimulated adherence to the opposition to the government and the construction of a strong women's movement in the 1970s and the 1980s (Mesquita, 2011).

From 1974, as a reaction to the end of the 'economic miracle' and the political crisis arising from it, a series of new social policies were put in place in several sector bureaucracies, including the health sector (Cordeiro, 1991). President Geisel's government expedited a package of integrated and independent social policies focused at increasing social-institutional control (after a period of heavy economic-institutional control) (Baptista, 1996). These schemes reoriented institutional planning and financing and revealed a tendency towards universal health (Cordeiro, 1991; Baptista, 1996). This was the beginning of the project for community and preventive medicine in Brazil (see Chapter I for more on collective health) (Baptista, 1996). Research grew and there was a momentum for public health policies that were planned, integrated and controlled (Baptista, 1996).

In 1975, with the passing of the Law 6229, public health and medical care responsibilities were divided respectively between the Ministry of Health and the Ministry of Social Security and Welfare (Rodrigues Neto, 1997). The latter was guaranteed a regular flow of financial resources, while the first was only granted a part of the remaining resources (Rodrigues Neto, 1997). In that same year, the national Programme for Maternal-Child Health (PSMI - Programa de Saúde Materno-Infantil) was created by the division of special health programmes of the Ministry of Health (Vianna and Lacerda, 2004). The PSMI was a vertical programme focused on the rendering of pre-natal, birth and post-partum care (Mesquita, 2011). Even though PSMI strategies were rolled-out to states, its control was highly centralised in the hands of the national executive through the Ministry of Health (Victora et al., 2011). It not only blocked any sort of articulation with other health care programmes, but also ignored broader issues related to women's reproductive health that were not related to child birth or child care (Vianna and Lacerda, 2004).

In 1977, the National System of Social Security (SINPAS – Sistema Nacional de Previdência Social) was created and was formed by the National Institute of Medical Care of Social Security (INAMPS - Instituto Nacional de Assistência Médica da Previdência Social), the Institute for the Administration of the of Social Security and Protection (IAPAS – Instituto de Administração da Previdência e Assistência Social) and by the National Institute of Social Security (INPS - Instituto Nacional de Previdência Social) under the

umbrella of the Ministry of Social Security and Welfare (MPAS – Ministério da Previdência e Assistência Social) (Cordeiro, 1992; Collins et al., 2000). Also in 1977, succumbing to international pressure, a State-sponsored limited birth control pill provision called Prevention of High-Risk Pregnancy (Programa Prevenção de Gravidez de Alto Risco), was designed as the first Neo-Malthusian family-planning project to substitute the pro-natalist regime in Brazil (Costa, 2009). This led to the recognition in 1978 by President Ernesto Geisel of the responsibility of the State as the provider of family-planning mechanisms (Álvarez, 1990). The 1977 project was extended in 1980 with the creation by President Figueiredo of a preventive health care programme (Prev-Saúde) (Paim, 2003). Neither programme, however, reached nation-wide provision. This was the beginning of an “overtly neo-Malthusian, racist targeting of low-income and Black population for birth control” (Álvarez, 1990: 183).

Indeed, pressures from international lenders such as the IMF prompted the substitution of a pro-natalist regime for a national family planning programme. Again, the military government appropriated the image of an ally of the women’s movement as a way to gain legitimacy in its transition into democracy (Álvarez, 1990). Only after 1980, feminist groups started pushing political parties for reproductive ‘choice’ policies (Mesquita, 2011). During this period, the government, influenced by international organisations, created some sector specific interventions from which the most relevant was the Programme for the Internalisation of Health and Sanitation Action (PIASS - Programa de Interiorização de Ações de Saúde e Saneamento (Rodrigues Neto, 1997). PIASS focused on building up a network of basic health services at the municipal level (Weyland, 1995). This however only permitted the development and re-design of health services of politically privileged municipalities (Weyland, 1995).

Beginning in 1979, several seats of Parliament were filled with representatives of or aligned with the democratic movement (Rodrigues Neto, 1997). The new representatives expanded the movement’s diffuse tactics by advising the members of the Ministry of Health while also providing privileged information and encouragement to those questioning the Ministry’s policies (Weyland, 1995). At the same time, feminist militants who participated in illegal political parties pushed for the structuring of women’s rights departments at state level and for diffusion of the right to reproductive health (Interviewee 27, 03.08.12). As a whole, the women’s rights movement defined a political agenda

prioritising the creation of a new Civil Code (removing paternalistic social constructions from previous legislation), day care services and family planning (Interviewee 27, 03.08.12).

1980s: The Democratic Transition and The First Wave Neoliberal Reform

The External Governance Structure

By 1980, independent 'think tanks' financed by individuals and corporate donors as well as international organisations such as the World Bank, applied these economic principles to social security and health care in Latin American countries (Harvey, 2006; Homedes and Ugalde, 2005; Mesa-Lago, 2008). In the context of international health policies, the right to health was then restricted to the right to health care and comprehensive primary health care to selective primary health care (Koivusalo and Ollila, 1997). This restriction was supported not only by the international financial institutions but also by foundations and academic institutions, i.e. Ford Foundation, Rockefeller Foundation, Center for Disease and Control and Harvard University (Koivusalo and Ollila, 1997).

Structural reforms (that totally or partially change or replace the structure of a public system) started in Chile in 1981 with the privatisation of its pension system and were shortly followed by reforms (either of pensions or health care) in Uruguay, Argentina, Cuba, Brazil and Costa Rica (Mesa-Lago, 2008). This then gradually influenced the creation of new programmes in the other Latin American countries, these ranging from more market-oriented reforms, mixed methods – consistent but not radical - reforms, and others such as 'solidarity' oriented reforms (Costa, 1996; Gideon, 2006; Ewig 2006, 2010). The general (but artificial) belief advanced by structural reforms is that the *private sector* is more efficient than the public sector and that the way forward is to develop models of reduction of role of governments as regulators (Costa, 1996; Abouharb and Cingranelli, 2007). This anti-welfare state rationale was fostered by the World Bank throughout the decade while new policies would also provide for the expansion of the private sector as providers of medical care (public and private) (Costa, 1996; Abouharb and Cingranelli,

2007). Possibly, as defended by most scholars, this was done in an aim to free government funds to pay for the 1980s public debt acquired as a bailout out of the economic crisis (Armada et al., 2001).

A little too late to this race came a restructured 1986 WHO health promotion policy which materialised from the Ottawa Charter and which 'puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of health consequences of their decisions and to accept their responsibility for health' (WHO, 1986). This led to a series of health promotion conferences and health care strategies (particularly curative health care) but it was not translated as holistic approaches tackling social determinants of ill health (Koivusalo and Ollila, 1997; Gideon, 2000; Ollila, 2011).

The policy of decentralisation was disguised under the principle of transferring power from distant and inefficient central bureaucrats to states and municipalities as a way to democratise health systems (Lakshminarayana, 2003). This is not only very controversial because of the introduction of these policies under dictatorial regimes, but also because evaluations of decentralisation efforts in Latin America show that the policy objectives are rarely met (Atkinson, 1995). In Mexico, for example, the initial phases of decentralisation led to a deterioration of care (Homedes and Ugalde, 2005).

The Internal Political Moment

The Brazilian HSRs were implemented in three phases, two during the mid-1980s and one in the early 1990s. The first one consisted of the decentralisation of service delivery from the Ministry of Health (MS – Ministério da Saúde) and INAMPS to states and municipalities, called the 1983 Integrated Health Action (AIS - Ações Integradas de Saúde) (Paim, 1986; Cohn, 2003; Pinheiro et al., 2005). The second phase occurred in 1987 and 1988 with the creation of the Unified and Decentralised Health Systems (SUDS - Sistemas Unificados e Decentralizados de Saúde), which furthered administrative decentralisation by transferring staff and facility control to state and municipal health secretariats (Weyland, 1995). These two initial phases were part of a wider package of first wave neoliberal reforms in the region (Ewig, 2010).

From 1980 to 1983, political proposals of extending coverage to the rural population and the urban poor became more and more unrealistic as public sector spending on social security and health services was on the brink of collapse (Paim, 2003). By this point, the effects of the 1978 Alma-Ata Conference were being felt strongly across Latin America (Cordeiro, 1991). A new political discourse based on the priorities of the Declaration of Alma-Ata - i.e. primary health care and social participation – was presented as an alternative to the status quo (Cordeiro, 1991). In fact, different from most Latin American countries, Brazil's reforms were - at least until the mid-1990s - majorly influenced by the internal leftist medical movement (Cordeiro, 1991). Gerschman (2004) notes that the movement was also influenced by 1970s alternative health experiences in some Brazilian municipalities; the Italian sanitary movement; and PAHO. Additionally some authors point to the Alma-Ata Declaration and to WHO's Health for All strategies as a source of inspiration and reinforcement (Elias, 2003; Weyland, 2007; Bahia, 2011). There was no alteration to the power system but the leftist movement managed to create an intense discussion around the democratisation of health (Weyland, 1995).

HSR was far from the movement's initial goal (Weyland 1996a). Its beginning focused on local and distributive demands rather than larger reformist quests (Cordeiro, 1991). This was due to strong links with clientelistic networks which represented business-oriented interests and resisted any changes to the status quo (Weyland, 1996a). The movement gathered momentum and support when it was able to put together a strong group consisting of representatives of all sectors of society from which the most vocal were health care professionals from the public service and the Brazilian Association of Collective Health Graduates (ABRASCO – Associação Brasileira de Pós-Graduação em Saúde Coletiva) (Cordeiro, 1991; Cohn, 2008). As seen in Chapter I, ABRASCO along with CEBES pushed for the wider adoption of collective health in detriment of public health, that is, it pressed for the expansion actions and programmes aimed at all determinants of health and ill health (Rodrigues Neto, 1997).

The movement was led by the academic Sergio Arouca as well as by the democratic fronts of the clandestine Brazilian Communist Party (PCB – Partido Comunista Brasileiro) and the recently formed Workers' Party (PT – Partido Trabalhista) (Cohn, 2008). This ensured the participation of worker unions of key sectors of the metropolitan region of São Paulo

and of progressive sectors of the Catholic Church (Cornwall and Shankland, 2008). A paediatrician who took part in the reformist negotiations notes that the movement was formed by thousands of supporters that had in common an interest in promoting the right to universal health (Interviewee 6, 15.11.12).

Social Movement's Demands and the 1980s Health Reforms

A few victories were achieved in the early 1980s. Initiatives such as the Health Integrated Actions (AIS - Ações Integradas de Saúde) and the Hospital Admittance Authorization (AIH - Autorização de Internação Hospitalar) were proposed towards the creation of a new and unified health system (Paim, 1986; Pinheiro et al., 2005). The AIH and AIS were implemented in 1982 and 1983, respectively as a form of guaranteeing that publicly funded private services were paid for by global costs of services (not the actual spending by each patient) affording some control over private sector (Pinheiro et al., 2005). These initiatives decentralised planning and administrative control but still allowed profit-seeking behaviour (Paim, 1986). Major problems arising from AIH include the focus on medical assistance, the unequal funding of health establishments and uncontrollable space for corruption (Rodrigues Neto, 1997; Luz, 2006).

In 1983, policy priorities were reassessed in the format determined by renewed commitments with the IMF and other international lenders propelled by economic crisis' wide foreign debt (Barroso, 1984; Álvarez, 1990). This culminated in the growth of the already existing movement for social and economic justice originated in the medicine academic milieu, entitled the Movement for the Sanitary Reform (Movimento pela Reforma Sanitária) (Cohn, 2008). The movement pushed for comprehensive preventive care and access to basic services to everyone, but with special attention to the poor (Cohn, 2008). Also in 1983, the Third National Feminist Meeting was held in Brasília to discuss a national feminist position vis-à-vis the government in terms of birth control, abortion and family planning. In this sense, feminists started to engage with the Ministry of Health and its bureaucracy leading eventually to the creation of monitoring structures in federal and state levels but at the price of having some of the movement's leaders co-opted by the system (Álvarez, 1990).

A protracted transition to democracy favoured the steady growth of anti-regime groups and social movements while fissures in party politics allowed feminists to access the PMDB structure and to use some of the 1983 feminist agenda to influence the national family-planning programme (Macaulay, 2006). As a result, and as a reaction to criticisms against the PSMI, in 1983 the Ministry of Health introduced the vertical reproductive health agenda called the Comprehensive Women's Health Programme (PAISM - Programa Assistência Integral a Saúde da Mulher) (Vianna and Lacerda, 2004). A high profile feminist explained that PAISM was the result of a semantic strategy constructed by the feminist activism and strategising of the 1970s (Interviewee 32, 22.09.12). It was the translation of the 1960s American emblem for women's sexual freedom called 'Our Bodies Ourselves' ('Nosso Corpo nos Pertence') and therefore had the primary aim of promoting sexual and reproductive rights related to the exercise of sexuality and freedom of family planning (Interviewee 32, 22.09.12). Its design was not aimed at protecting and/or promoting maternal health or reducing maternal mortality (although it would, tangentially) (Interviewee 32, 22.09.12).

All respondents see PAISM as a great women's right but almost all of them find its implementation disappointing. PAISM was a set of partial and exceptional scattered experiences created with the influence of the feminist movement, which after the establishment of transition to democracy and the return of political actors in exile went on to press for social rights (Corrêa, 1993; Ávila, 2009). Nonetheless, population control motives were often masked in PAISM at federal, state and municipal levels while appropriating the reproductive rights discourse defended by women's feminist movement and calling for a holistic approach to women's health (Álvarez, 1990). PAISM was created in 1984 as a vertical and separately managed programme; excluding reproductive health issues from important and stronger programmes such as the National Programme on STD - HIV/AIDS (Corrêa and Piola, 1999).

In 1985, the Nation Council for Women's Rights (CNDM – Conselho Nacional dos Direitos da Mulher), now the Special Secretariat for Policies on Women (SPM – Secretaria Especial de Políticas para Mulheres), was created under the new democratic presidency of Tancredo and Sarney (Corrêa, 1993). CNDM as a consultative body with independent budget and staff was part of the Ministry of Justice and framed within the scope of the

CEDAW Convention (Macaulay, 2010). It was an initiative of the women's movement but it is unclear if international instruments produced at the 1984 Amsterdam and the 1985 and 1987 Nairobi Conferences contributed much to its discussion and creation (Álvarez, 1990). Nevertheless, a crucial appeal came in the mid-1980s from the National Confederation of Rural Workers (CONTAG – Confederação Nacional dos Trabalhadores na Agricultura). CONTAG pushed for overreaching and comprehensive health reform in response to the failures of the medical establishment to provide equal treatment to urban residents and rural poor (Costa, 2009). At the same time, the term of President João Figueiredo (1979 – 1985), the last authoritarian president, was coming to an end. This fostered political momentum for a redistributive health reform (Weyland, 1996a).

Consequently, in 1986, the VIII National Health Conference created the Constitutional Health Charter envisioning a unified health system (Cornwall and Shankland 2008). The conference was highly influenced by the Brazilian Centre of Health Studies CEBES (see collective health section of Chapter I) and the publication *Health in Debate* (*Saúde em Debate*) (Rogrigues Neto, 1997). In spite of meeting great opposition from medical business and other profit-seeking conservative forces which were opposed to the reduction of curative treatments in exchange for better preventive measures and basic services, the movement managed to secure important support from the heads of the Ministry of Social Security and Action (MPAS - Ministério da Previdência e da Acao Social) (Weyland, 1996a). This was largely due to the intra-institutional conflicts and to greater space given to opposition politics during the transition to democracy (Cordeiro, 1991).

In 1986, the same year of the VIII National Health Conference, a National Conference on Health and Women's Rights (*Conferência Nacional de Saúde e Direitos da Mulher*) was assembled as a forum to the discussion of women's health rights, but controversial issues such as abortion and contraceptives seemed to trump efforts to produce a national reproductive health agenda (Costa, 2009). Also, alliances with the Catholic Church formed during the authoritarian government and reinforced by the Sanitary Movement were still too strong to permit the rise of feminist issues to the mainstream health sector reform (Ávila, 1993). There is also reason to believe that internal divergences within the feminist movement created other obstacles (Ávila, 1993). Therefore, political and religious forces avoided creation of gender-sensible policies and the participation of social actors in the policy making process which led to the restriction of reproductive care to pregnancy

related services (Álvarez, 1990). Most guidance orienting reproductive health issues to be included in the health reform came from the VIII National Health Conference (Brasil, 1986).

Meanwhile, the reformist president Tancredo Neves (March 1985 – April 1985) was replaced by José Sarney (1985 – 1990) who from 1986 to 1988 led a Constitutional Assembly (Assembléia Constituinte) for the creation of a new Federal Constitution grounded on democratic principles of social justice (Cordeiro, 1991; Cohn, 2003). The 1988 Constitution incorporated the ideals of the Constitutional Health Charter and created the Unified Health System (SUS – Sistema Único de Saúde) (Brazil, 1988). Article 194 of the 1988 Constitution merged the traditional concepts of social insurance and health and introduced the concept of social security – the first involves formal workers as beneficiaries while the second provides for universal coverage (Brazil, 1988). Article 196 recognised health as a right along with the individual and collective right to access health services (Brazil, 1988). Article 198 defined that the SUS would be decentralised, solely directed by each sphere of government and with the participation of the community (Brazil, 1988). And, Article 226, paragraph 7, instituted the right to family planning (Brazil, 1988).

The Institutionalisation of the Health Reform Movement's Principles and Actors

The Constitution idealised a system that guaranteed all the underlying determinants of health and ill health (Cordeiro, 1991). It consisted of two inter-connected subsystems: (i) a public system with universal access and (ii) a private system with limited access, referred to as the supplementary system (Lobato, 2000). The supplementary system includes private plans with voluntary affiliation as well as prepaid health plans and insurance companies (Lobato, 2000). It was clear at this point that the design of the 1980s reforms were already responsible for the fostering of neoliberal interests. Nonetheless, when inquiring about the effects of decentralisation on social justice, all interviewees strongly rejected any questioning on decentralisation right up front. For example, a legal professional involved in health policy implementation replied with the following:

“The political decentralisation that occurred in health care in 1988 was crucial in order for all federal entities to work in healthcare, with

municipalities in organising their territories actions and health services.” (Interviewee 36, 27.11.12)

This pattern of responses was the same with other interviewees from all policy networks. The most common argument in favour of decentralisation is based on Brazil’s continental dimensions. See below an excerpt from an interview with a nurse working at a public health facility in the State of Rio Grande do Sul:

“Interviewer: Why, in your perception, was decentralisation used as a model for the health sector reform in Brazil?

Interviewee: Administrative, financial and managerial decentralisation, is very important in a country with so many nuances, with completely different realities and various local and regional specificities...The municipalisation of health [...] was an important milestone for the decentralisation process... We have to consider that decentralisation from states to municipalities, often came with many responsibilities and actions to be performed without the transfer of funding required from the union [federal government].

Interviewer: Do you think that decentralisation was effective?

Interviewee: Yes, slow, with endless regulations, decrees, laws... advances and setbacks... but necessary and irreversible... Each municipality must manage its resources and apply them according to their local needs and priorities, while respecting Health Councils, the Municipal Health Plan, existing budget, discussions with your community...” (Interviewee 31, 29.10.12)

The making of the 1988 Constitution was marked by feminist pressures, notably the National Women’s Rights Council (CNDM - Conselho Nacional dos Direitos da Mulher), for the legal recognition of women as full citizens and of women’s reproductive rights (Ávila, 1993). The Women’s Parliamentary Caucus set up during the transition to democracy was guided by NGOS such as Feminist Research and Advisory Center (CFEMEA) which was founded in 1989 and the participation of the Feminist Network on Health, Sexual Rights, and Reproductive Rights (RedeSaúde) in the keeping of reproductive rights as a priority (Macaulay, 2010) were crucial. The movement was reasonably influential from mid-1980s until early 1990s. It managed to influence the final text of the 1988 democratic constitution as well as PAISM (see above) (Macaulay, 2010).

Members elected for CNDM were nominated to the newly created National Commission for the Study of Human Reproduction Rights (Comissão Nacional de Estudos dos Direitos da Reprodução Humana) (Ávila, 1993). The first presidents of CNDM, Ruth Escobar and Jacqueline Pitanguy, taking inspiration from the First National Congress of Black Women held in 1988, pushed for a Committee for Black Women, now the Special Secretariat for the Promotion of Policies on Racial Equality (SEPPIR) (Caldwell, 2010; Macaulay, 2010). From 1988, the CNDM also worked in many operational policy issues and conducted regular cross-sectoral meetings with the Ministry of Education on non-sexist schoolbooks, and with the Ministry of Health to promote information on reproduction and contraception and ensure provision of legal abortions (Macaulay, 2010). This guaranteed the right to reproductive self-determination and access to reproductive health services (Corrêa and Piola, 1999).

At the same time, members of the sanitary movement such as Sérgio Arouca, Eleutério Rodríguez Neto, José Saraiva Felipe and Hésio Codeiro were nominated to high profile posts within the unified health system (Weyland, 1995; 1996a; Rodrigues Neto, 1997). This guaranteed continuum but at the price of co-opting advocates into mainstream politics (Weyland, 1995; 1996a). Additionally, the fight for political, economic and institutional power divided the post-1988 health movement, compromising in this sense the very reasons that unified these divisions in the first place (Paim et al., 2011). This created opportunities for new political formations (Baptista, 1996). The left wing was diluted into 3 new parties the PT, PDT and PCB, the centre into PMDB and PFL and the right (authoritarian) wing into PDS (Baptista, 1996). Later the PSDB was created by dissidents from PMDB, and PL, PV, PSD and PRN emerged as totally new parties (Baptista, 1996).

In 1989, the PT, the political party supported by the sanitary movement, was defeated in the first democratic presidential elections since the coup (Paim et al., 2011). With the election of Fernando Collor (of PRN), the representatives of the movement were strategically replaced by the opposition with parliamentarians aligned with private sector interests (Bahia, 2011). Collor interfered with the political proposals and legacy of the 1988 Constitution (Luz, 2006). From then on, health policy making and reform was only justified if seen as key to market development and functioning (Bahia, 2011).

As the democratic transition was completed, political parties crystallised rent-seeking and clientelistic interests thus functioning as gatekeepers between the state and social movement's demands (Macaulay, 2006). Incapacitated to set a strong foothold in the party system, feminists were left at the margins (Macaulay, 2006). By the beginning of the 1990s, the PT was the party who most consistently pushed for feminist policies (Htun and Power, 2006). Although they did not face organised party-centred and values based opposition in Congress, feminist policies faced dispersed opposition from the Catholic Church (Mattar, 2008).

From Transition to Consolidation: Women's Rights and Exclusionary Discourses

A researcher specialised in preventive medicine analyses the obstacles limiting women's rights activism in Brazil through two levels of discussion, first: the health sector is not a promoter of health (culture and services are organised in terms of illness) and, at the same time, Brazilian society functions and replicates an elitist and exclusionary power system which blocks most social justice projects (Interviewee 37, 27.09.12). Secondly: there is no legal culture ('a lei não pega'), i.e. rights are perceived only from a purely legal perspective and not from an ethical perspective (Interviewee 37, 27.09.12). In terms of maternal health activism, this means that maternal mortality reporting remains restricted to an epidemiological definition that enables good reporting but that is incapable of registering the circumstances of death particular to each context (such as structural violence) (Interviewee 37, 27.09.12). This frivolous commitment to rights in general, makes the political exercise solely based on the right to health almost impossible.

For a member of an international organisation working with a maternal health project, in Brazil there was only the rhetorical recognition of maternal mortality as a problem (Interviewee 3, 28.09.12). The State fails to prioritise and protect women's right to health and to acknowledge its duty to regulate and monitor public and private maternal health services (Interviewee 3, 28.09.12). In the global arena, Brazil is defined as a country that defends and abides by international human rights but domestically it resists engaging with maternal mortality cases or defining or accepting its responsibilities over the many systemic failures, resulting in maternal deaths (Interviewee 3, 28.09.12). Improvements in

underreporting and misclassification of deaths since the first international measurements in the 1980s served as political leverage, and for the legitimization of the discourse, portraying the country as a model for success in the region (Interviewee 3, 28.09.12). This could not be further removed from reality.

Although the 1980s reforms were successful in eliminating legal discrimination, expanding coverage and ‘equalising’ rural and urban health care, effective access to health care to urban and rural poor was not enhanced (Weyland, 1996a: 160). Reproductive health services were also far from being holistic and accessible to urban and rural poor (Álvarez, 1990). Combined with extreme regional disparities and the need to reduce expensive curative treatments, this posed an enormous challenge to the following decade (Weyland, 1996a). See the Table 5 below:

Table 5 – 1980s HSRs in Brazil

Year	Type of Participation	Main Actor	Outcomes	Key Actions	Feminist Support
1982-83	AIH and AIS – control of private capital control over public health sector and decentralisation of planning and administration of services	Ministry of Health and INAMPS	Profit-seeking behaviour still allowed along with highly centralised health financing	Promote universal health through the decentralisation of health services	Yes
1984	PAISM – integrated women’s health care programme regulating fertility	Interdisciplinary group formed by Division for Maternal-Child Health, Ministry of Health, after a Parliamentary Inquiry - CPMI	Vertical implementation of few isolated family planning initiatives	Streamline the concept of women’s rights to integral health care	Yes
1986	8 th NHC – movement towards ‘Sanitary Reform’ and setting of basic principles of unified health	Sanitary Movement	Loose and aspirational rights not immediately translated to policy arena	Change the model of care by creating a new health system and new principles	Yes

1987	SUDS – unified, hierarchical and partially centralised system focuses on primary health care	8 th Ministry of Health and INAMPS	Furthered administrative decentralisation by transferring staff and facility control to state and municipal health secretariats	Decentralise health services and policy making and implementation to fight clientelism and inequality	Yes
1988	New Constitution – art. 194 recognises the right to social security merging the traditional concepts of social insurance and health; art. 196 establishes health as a right and SUS as a substitute of SUDS; art.198 defines the SUS as decentralised, solely directed by each sphere of government and with the participation of the community; art. 226 § 7° institutes the right to family planning.	Constituent Assembly	Successful in eliminating legal discrimination, expanding coverage and ‘equalising’ rural and urban health care, effective access to health care to urban and rural poor was not enhanced	Recognise fundamental rights and create a legal framework for fundamental rights claims	Yes

1990s and Beyond: The Democratic Consolidation and The Second Wave Neoliberal Reform

The External Governance Structure

The 1990s was a decade marked by the growth of transnational women’s rights networks consisting of epistemic communities formed by international organisations and its regional counterparts and policy legacies formed by non-governmental organisations (Corrêa and Piola, 1999). The growth of the national women’s movement was also largely influenced by new networks created in to the United Nations International Women’s Year conference held in Mexico City in 1975 (Álvarez, 1990). The national preparation processes related to it (and other United Nations conferences) stimulated further feminist organising and provided legitimacy and structure to a rights-based discourse (Álvarez, 1990). It also served as catalyser of institutionalisation of gender perspectives and machineries and professionalisation of feminist movements (Lebon, 2010). This was initiated by middle class women who then drew women from all classes pushing for a regime change (Álvarez, 1990).

Simultaneously, the dominance of neoliberal ideology as launched by the Washington Consensus limited social redistributive policies and propelled a series of retrenchment strategies (Lebon, 2010). Legal reforms for women's rights were pushed by middle-classes through regional networking spaces such as the World March of Women network and the World Social Forum, but little was achieved in national grounds (Lebon, 2010). Even though in the late 1970s and the 1980s there was a growth in feminist groups, and in spite of the return of internationally articulated political actors – men and women - in exile until 1979, international reproductive rights were set aside in favour of population control discourses as defended by the Ford Foundation since 1974 (Ávila, 1993; 2009; Petchesky, 1990; Citeli, 2005). This happened because a wider movement for democratisation grew larger and stronger, leaving other issues such as reproductive freedom and racial equality to the side (Ávila, 1993).

Women's movements were faced with discrimination from the right-wing as well as progressive opposition and were relegated to 'secondary' politics (or 'secondary contradictions') (Álvarez, 1990). Male-dominant parties of the left and centre-left did not align with the feminist position anymore (Álvarez, 1990). This incurred in a break from the initial anti-government feminist discourse for one in which the government was held accountable for the provision of appropriate, non-coercive, and wide-spread family-planning (Lebon, 2010). Feminists were quite vocal on the government programmes' failure to link reproductive health services to other health-related issues involving women (Álvarez, 1990). By the beginning of the 1990s, the rights-based discourse permeated feminist language and oriented political strategies (Lebon, 2010). In the case of black feminists, discrimination also came from white feminist women and black men acting for racial equality (Caldwell, 2010). From the 1980s, black feminists have been instrumental in calling attention to intersectionalities and new concepts of equality and justice. The question of whether and how to insert feminist claims through party systems increased tensions among feminist activists. After the 1980s, this became acute as parties became more and more important to feminist claims (Caldwell, 2010).

By the early 1990s, Latin American countries economies, already recovered from the 1980s debt crisis, began to rely more heavily on market-oriented approaches to social policy making (Almeida, 2002). As in the case of the Peruvian 1990 neoliberal HSRs,

epistemic communities shaped the interests of national political actors, encouraging in some instances the disregard of previous policy legacies such as labour unions and medical associations (Ewig, 2010). Hence, in the case of Peru, Malthusian population control epistemic communities influenced HSR by replacing professional policy legacies (Boesten, 2010). This was part of the global diffusion of second wave neoliberal social policies (Cornwall, Gideon and Wilson, 2008). Global reports such as the 1993 World Development Report: Investing in Health and the 1994 Averting Old-Age Crisis - which pushed for decentralisation and hospital autonomy and self-sufficiency - were particularly important to the neoliberal phenomenon (Mesa-Lago, 2008). The report formed an international technocratic alliance of cost-containment policies geared towards countries with health sectors with low per capita spending (Costa, 1996).

This shaped the main characteristics of the 1990s' Latin American social policies such as the introduction of fees for services, means-testing, a targeted basic package of health services, and decentralisation of the administration of municipal secretariats and local health clinics (Ewig 2006). In this way, privatisation and decentralisation were introduced as a condition of loan agreements between Latin American countries and the World Bank and the IMF (Ewig 2006). At the end of the 1990s, the World Bank bilateral aid scheme lent seven hundred million dollars to Brazil for unspecified health allocations (Petchesky, 2003). This afforded the bank considerable control over the national health and human rights policies (Petchesky, 2003). This 'overhead' substantially shaped second wave neoliberal health sector reform in Brazil and contributed to the advancement of neoliberal interests through the appropriated use of women's rights rhetoric.

The Internal Political Moment

The political scenario in the 1990s was not very favourable to the sanitary movement. The clientelistic president Fernando Collor de Melo (1990 –1992) was elected and the old federal health structure was changed as to transfer the INAMPS from the realm of the Ministry of Social Security (MPS - Ministério da Previdência Social) to the Ministry of Health (Weyland 1996a; 2007). All the same, the MPS replaced INPS (Collins et al., 2000). The movement leaders had reduced participation in Collor's government and had little

access to the head of the Ministry of Health, Alcení Guerra, a former INAMPS official from the authoritarian period (Weyland, 1996a).

In 1990, the SUS was regulated by the Health Organization Law (LOS - Lei Orgânica da Saúde) comprised of Organic Law 8.080/90 and Complementary Law 8.142/90 (Lobato, 2000; Baptista, 1996). The LOS sub-divided the SUS into three sectors: a public sector; a privately contracted sector funded by public sector; and a private sector funded by insurance schemes (Buss and Gadelha, 1996). It incorporated a host of public providers, hospitals and primary health centres in the realm of federal, state, and municipal governments (Lobato, 2000) and also included private profit and non-profit providers under contract to the public system (Buss and Gadelha, 1996). Furthermore, in 1991, with the approval of the Organic Law of Social Security (LOSS-Lei Orgânica de Seguridade Social), the system was divided into health, social security and social protection (Baptista, 1996). This structure put health as a social security sub-sector represented only as one of the three elements described before (Baptista, 1996). Moreover, LOSS did nothing to further regulate and integrate SUS' constitutional principles (Baptista, 1996).

In spite of this intricate three-pronged structure, ideals of taking health policy closer to the communities were far from being effective. Indeed, the LOS partially re-centralised several measures back to federal government (Gomez, 2008). The LOS gave the federal government the right to define norms for contracting private providers and to control the fiscal transfer of federal revenues to states and municipalities for SUS initiatives (Gomez, 2008; Weyland, 1996a). This was a result of pressure coming from medical business, INAMPS bureaucrats and clientelistic politicians who resisted the creation of a new health care law (Weyland, 1996a).

Also, a new planning system called the Basic Operational Standards (PAS - Piso de Atenção Básica) was established in 1991, and further regulated in 1993 and 1996, envisioning greater decentralisation to state and municipal governments which would also gain managerial and bureaucratic responsibilities in providing health care services (Gomez, 2008). The system started to work through Basic Operational Norms (NOB - Normas Operacionais Básicas) approved by the executive branch of the federal government and resolutions and norms expedited by the Ministry of Health (Baptista, 1996). The creation of these autonomous laws fell short of implementing decentralisation

as foreseen by the 1988 Constitution (Levicovitz, Lima and Machado, 2001). For example, NOB 91 (re)centralised while also municipalising some responsibilities (Levicovitz, Lima and Machado, 2001). It municipalised health care with an intent to weaken states and the project of a unified health system (Baptista, 1996).

The Problematic Implementation of Decentralisation Principles under Second Wave Neoliberalism

A member of one of the Council for Municipal Secretariats (CONASEMS - Conselho de Secretários Municipais) explains that decentralisation of health suffers from three problems: (i) insufficient budgeting, mostly from the federal and state levels as municipalities are proportionally the main source of financial resources; (ii) poor governance, the little resource available is lost due to administrative-managerial deficiencies; and (iii) asymmetrical relationship between federal entities that impedes independent entities from entering into equal pacts or agreements (pactuacao) (Interviewee 6, 15.11.12). Commenting on the last point the interviewee affirms:

“Agreements is a strong word for the situation faced by federal entities [...] The Ministry of Health, which raises the majority of funds, instead of distributing the funds to the three spheres as it is supposed to do according to the law, ignores the law and conditions transfers to the implementation of its decisions, and even worse, it pretends to be entering into agreements.” (Interviewee 6, 15.11.12)

The respondent adds that municipalities are the main source of health sector funding for one simple reason, their managers are closer to the people that elected them and in this sense are subjected to more political pressure to fulfil demands as well as to engage with voters. This interaction, he argues, is a benefit of the decentralisation. In terms of the disengagement of federal and state levels, he states that:

“Health, in my opinion, does not generate collective satisfaction, even when it does more than it does not, even when it provides more quality than its absence. I feel that ‘doing’ health brings more dividends [than benefits] to the [public] administration.” (Interviewee 6, 15.11.12).

Additionally, efforts to implement reproductive health initiatives were particularly hindered after the making of the 1988 Constitution (Corrêa and Piola, 1999). Reproductive health issues tended to run parallel to discussions related to overall health care and reform (Mattar, 2008). This can be explained by institutional turmoil, economic crisis and political resistance (Weyland, 1995). Nevertheless, significant employment laws were passed implementing the 1988 Constitutional clauses that afforded protection to pregnant women and mothers (Vianna and Lacerda, 2004). These laws, for example, institutionalised paid-maternity leave in the case of childbirth and adoption, coming closer to realising women's right to gender equality and freedom from sexual and reproductive discrimination (Corrêa and Piola, 1999).

Articulation of the feminist policy legacies with feminist epistemic communities grew stronger after Brazil held the Rio 1992 Conference (Corrêa, Alves and Januzzi, 2006). Rio 1992 formalised principles of sustainable development and asserted women's crucial role in its achievement (Galli, 2002). Rio 1992 created a momentum for the reassessment of several issues (Galli, 2002). During the time of the Conference parallel interest-specific meetings were held including one panel towards the effective implementation of PAISM led by the Feminist Network of Health and Reproductive Rights (Rede Feminista de Saúde e Direitos Reprodutivos) (Corrêa, 1993). Simultaneously, starting in 1993, a set of health reforms extending the minimum package of services sprung around Latin America soon after the publication of the World Bank's neoliberal report 'Investing in Health' (Mattos, 2003; Weyland, 1996a). 'Investing in Health' was targeted at a complete reorientation of health systems through cost-effectiveness approaches to health care, and use of the indicator for discount healthy life years gained – DHLV (World Bank, 1993; Costa, 1996; Mattos, 2003). This analytical framework was supported by a series of economic, epidemiological and clinical analytical studies commissioned by the World Bank (Costa, 1996). This set of recommendations was also condoned and promoted by the WHO and the Pan-American Health Organization (PAHO) (Weyland 1996a).

Even though, most policy makers in Brazil rejected the World Bank's market-oriented efforts, a preventive and primary health care strategy was established with the financial incentive of the WB and PAHO seeking to provide a full range of quality health care to families in their homes, at clinics and in hospitals in 1993-1994 (Mattos, 2003). By then, Brazil's health system was in severe deficit as most of the budget was allocated to social

security instead of health (Weyland, 1996a). This marked the beginning of a series of policy-based loans with the World Bank and the International Development Bank (IDB) majorly sought during the administration of President Fernando Henrique Cardoso (1995-2002) (Weyland 1996a).

Family Health, Family Planning and the Women's Rights Agenda

In 1994, the Ministry of Health headed by Henrique Santillo created a national primary health programme, the Family Health Programme (PSF - Programa Saúde Família) sustained by United Nations Children's Fund (UNICEF) - through its in-country representative Halim Antônio Girade - and WHO (Weyland, 2007). PSF was approved by experts from the MS, SES, SMS and international consultants and experts in primary health care (Viana and dal Poz, 2005). PSF was the successor of the Health Community Agents Programme (PACS - Programa de Agentes Comunitários de Saúde) which was founded in 1991 and focused on reducing child and maternal mortality in the Northeast (Almeida et al., 1999, Viana and dal Poz, 2005; Weyland, 1996a). PSF was a primary health care programme inspired by the PACS but aimed at reaching a wider population in all regions of Brazil (Weyland, 1996a; Bahia, 2011). PSF consisted of breaking down the health care system into communities of four to five thousand users and providing each segment with a doctor-led team (a doctor, a nurse and a number of community agents) (Weyland, 1996a). PSF was adopted as a reorientation of the health care model and as a strategy towards the strong municipalisation of health (Heimann and Mendonça, 2011). Although PSF is responsible for considerable achievements, particularly in the area of child mortality and vaccination, it was responsible for the fragmentation of the health system and the portrayal of maternal health as an instrumental value.

Determining Women's Reproductive Future through Public Health Programmes

Prior to 1995, little or no strategies were being implemented as a way to effectively safeguard women's reproductive futures. At the time, PAISM was to be included in Brazil's

public health basic package but was marginalised shortly after due to lack of political interest (Ávila, 2009). From 1995, PSF entered a period of fusion with PACS and then its expansion to other municipalities with a focus on providing better minimum packages to all rural areas (Heimann and Mendonça, 2011). Furthermore, at the same time, PAISM started to be implemented as part of primary health services across municipalities in different degrees (Brasil, 1984).

In 1996, a family planning law was passed for a set of actions related to fertility and access to family planning information and care, to be mainstreamed by SUS (Vianna and Lacerda, 2004). At the time, several members of the feminist movement have questioned its ability to afford women access to unbiased information and freedom of choice (Corrêa and Piola, 1999). After 1996, international pressure coming from Beijing and Cairo afforded visibility to the reproductive health agenda following the trend of other Latin American countries such as Mexico and Peru (Langer et al., 2000; Ewig 2010).

Supplementary initiatives of health care provision were created from 1996 onwards whereby municipal government and health care professionals were joined together on behalf of the increase of quality of primary health care and public participation (Costa, 2009). These were hybrids between PSF and PAISM emulated in the Cuban family doctor scheme (Weyland, 1996a). The most famous and successful ones were implemented in the cities of Niterói, State of Rio de Janeiro and São Paulo, State of São Paulo, the later called Health Assistance Programme (PAS – Programa de Atendimento à Saúde) (Weyland, 1996a).

In 1998, with the appointment of José Serra to health minister, the PACS and PSF network was expanded again but generating criticisms of the uneven expansion and its small coverage of households in large urban areas (Viana and dal Poz, 2005). Some scholars argue that PACS and PSF went beyond the logic of minimum packages and challenged the model of health care (Viana and dal Poz, 2005). It is contended that PSF is a model for basic care (*atenção básica*) instead of a primary health care programme (Cohn, 2011). According to this argument, PSF encompasses a group of actions and services based on the need of the population and that extrapolate primary medical care (Heimann and Mendonça, 2011). In fact, from 2003 to 2010, during the PT government under President Lula administration (2003-2011), PSF went through a period of planned consolidation

(Cohn, 2011). However, the implementation of PSF was far from perfect. PSF has its own financing scheme which impeded it from being integrated into SUS (Heimann and Mendonça, 2011). As a result, it has worked as a parallel programme for the poor and vulnerable population (Viana and dal Poz, 2005).

Interestingly, an activist from the black women's movement working with violence as an issue, said that pro-poor programmes rhetoric, non-white women's real experiences and expectations were not taken into account when designing programmes such as PSF and PAISM (Interviewee 22, 17.09.12). As a result, there is no strategic implementation of racial equality policies within the health sector fighting against problems such as institutional violence, the lack of sufficient health workers and material in rural localities and/or intersectionality in health status (Interviewee 22, 17.09.12). This contributes to the widening of the health gap between white and non-white women and to the continuation of longstanding pre-conceived ideas of what being non-white means in terms of life expectations and legal entitlements (Interviewee 22, 17.09.12). Maternal mortality strategies, more specifically, do not divide its targeting in terms of desegregated racial data and its prevalence over an issue and/ or locality over another (Interviewee 22, 17.09.12).

Also, with Lula, CNDM was transformed in the Special Secretariat for Policies for Women (Secretaria Especial de Políticas para Mulheres - SPM) and was transferred from the Ministry of Justice to the President's Office. SPM's head was afforded minister status (although not acting effectively as a Ministry) and a seat in cabinet (Macaulay, 2010). On a more positive note, Lula's rejection of CNDM's structure led to the creation of stronger gender policy executive structures in all three levels of government. In the federal level there was the SPM (substituting CNDM), and in the state and the municipal level, Women's Secretariat, Women's Coordinating Committees, or Women's Advisory Units, depending on the case (Macaulay, 2010). In 2003, Lula created the Commission of Maternal Mortality as part of the Ministry of Health (Vianna and Lacerda, 2004). The SPM under Lula was responsible for creating the National Plan on Policies for Women in 2004, special gender-related parliamentary committees and the Second National Plan on Policies for Women in 2007 (Interviewee 26, 30.08.12). The latter was responsible for an emphasis on sexual and reproductive rights (Interviewee 26, 30.08.12).

Women's Rights in Contemporary Politics: Neoliberalism and Populism

In spite of PT's criticisms of CNDM's clientelistic political links and the replacement of CNDM by SPM, no change was observed in 'realpolitik', i.e. the materialistic groundings of decision-making (Macaulay, 2010). Although human rights rhetoric were widely promoted since the rise of PT to power, Lula's two terms in government were marked by underspending on social welfare out of which forty per cent was often allocated to basic health care programmes and to the populist conditional cash transfer programme, Bolsa Família (Interviewee 30, 09.11.12). Lula's successor, Dilma, has so far also continued with PT's paradoxical public policy agenda by which large amounts of funding are dedicated to conditional cash transfer programmes, while little funding is spent on structural changes such as in health and education (Galli, 2012). These political decisions have had drastic effects to left-wing politics. Contrary to what was expected, neoliberal macroeconomic policies, usually combined with pro-poor 'maintenance' social programmes, also created more inequality and exclusion from which marginal women were hit the hardest (Macaulay, 2010).

Moreover, contemporary social reality is marked by a growing social identity crisis in the social movements (Cohn, 2011). Since the end of the 1980s, there was a decrease in participation and mobilisation capacity particularly involving health issues (Cohn, 2011). More importantly, this can also be explained by the diffuse opposition from the Catholic Church – re-emerging under new conservative wing since the rule of Pope Benedict XVI in 2007 (followed by Pope Francis I in 2013) - and evangelical Christian churches which moved away from religious caucus framing public debates on issues of personal morality towards a rights-based discourse (Macaulay, 2010). In fact, key members of religious caucuses became part of the bureaucracy and were capable of initiating a while political strategy to exert influence within the State institutions such as the Ministry of Health (Interviewee 27, 03.08.12). The combination of these factors is largely responsible for the portrayal of feminism and women's rights as an outdated issue. For instance, when asking a nurse practising in the State of Rio Grande do Sul about the main impediments to feminist activism in Brazil, the following answer was given:

“I have no idea ... Gone are the days of the ‘burning bras’, the fight for the right to vote, etc... Today women participate in all segments [of society]... Diversities exist and must be addressed, in my view, as a human being and not in relation to gender.” (Interviewee 31, 29.10.12)

A public health specialist clarifies that current perspectives around feminism are also influenced by internal divisions within the movement itself (Interviewee 37, 27.09.12). Health reforms were mainly driven by second wave feminists who are just as exclusive as they are inclusive (Interviewee 37, 27.09.12). Second wave feminists, many who took at some point high profile positions within the State bureaucracy or in international organisations, are reluctant to include other groups or even strategies that are inclusive of those groups (such as men’s perspectives or men’s health concerns into the reproductive rights agenda for example) out of fear of being sidetracked or even marginalised from their own strategies (Interviewee 37, 27.09.12). In the midst of this discussion, third wave feminists are bound to be won over or to be engaged in activities that are not necessarily related to or geared towards advancing the feminist agenda (Interviewee, 37, 27.09.12).

With the weakening of the feminist movement - internally due to ruptures and externally due to a rhetoric portraying it as an unqualified and unnecessary movement - activists were marginalised from mainstream politics and suffered from the lack of support from the organisations they belonged to (Interviewee 27, 03.08.12). And, with the surge of global commitments for the achievement of the MDGs, women’s rights expertise became sought after during the institutionalisation of global initiatives (Interviewee 27, 03.08.12). Feminists took on consultancy positions within the government and, through the mediation of international contracts, they shifted their position from civil society to service providers (Interviewee 27, 03.08.12). This was problematic as it challenged the continuity of radical and oppositional political activism.

Hence, even though the Brazilian initiatives introduced in the late 1990s were aimed at providing holistic and equitable access to reproductive health services, they have fallen short of living up to the challenge. The initiatives address only economical and technical resources directly related to the right to health care and ignore wider political and social contexts related to the underlying determinants of health. Mainstream HSR usually focus

on financial and efficiency issues while reproductive health reform advocates focus on issues of access and quality care (Petchesky, 2003). This enables a constant influx of retrogressive policies and programmes that incurred the loss of crucial institutional and political memory (Interviewee 26, 30.08.12). See the summary of key initiatives below in Table 6:

Table 6 – 1990s HSR in Brazil

Year	Type of Participation	Main Actor	Outcomes	Key Actions	Feminist Support
1990	Laws 8.080 and 8.142 – operationalizes the constitutional provisions on SUS	National Congress	Municipalisation of health services rendering and unclear rules on transfer of budgets through 3 levels of government and agencies	Promotes and protects the right to health and establishes rules for the organisation of health services	Yes
1991	PAS – beginning of a series of basic operational standards norms envisioning greater decentralisation from federal to state and municipal governments	Municipal governments and municipal health secretariats	States and municipalities gained managerial and bureaucratic responsibilities in providing health care services	Supplements initiatives of health care provision to increase quality of primary health care and public participation	Yes
1994	PSF – national primary health programme providing a doctor-led team to communities of four to five thousand users and	Ministry of Health	Uneven expansion and small coverage of households in large urban areas	Implements a strategy to streamline primary health care reorienting the model of health care	No

Conclusion

This chapter has observed that Brazil has fallen short of its commitment to effectively provide quality and efficient healthcare equally to all (Pribble, 2010). To a large degree this is due to the failure of the neoliberal project (as embodied by the Washington and post-Washington consensuses) to provide equal opportunities and development and to the failure of pro-poor policies to remedy these deformities (Saad Filho, 2004; 2007). In addition, to a smaller degree, federalism impacts the development of the welfare state new politics and patterns of welfare state provision by being more vulnerable to pressures in

regards to fiscal retrenchment and less responsive to the necessary social policy reforms (Banting and Corbett, 2002; Obinger et al., 2005).

In the case of Brazil, a competitive form of federalism and a highly centralised health financing combined with administrative decentralisation provokes the breakdown of political alliances and the appearance of strong transnational policy networks (Vianna and Machado, 2009; Ribeiro, 2009). Discourses and strategies occurred in policy debates become more fluid and contingent upon the national and international political environment, conservative and progressive parties, social movements, coalitions and religious organisations (See Yamin, 2000; Guzman et al., 2010).

During the 1980s and 1990s, some interest groups were particularly strong: the Catholic Church, the neoliberal market-oriented elite and the Malthusian and neo-Malthusian population control movements (Ávila, 1993; Corrêa, 1993). All the same, family planning and reproductive rights were strongly demanded by the feminist movement as early as the late 1970s (Álvarez, 1990). Nonetheless, feminist constituencies did not manage to gain political legitimacy in a way to effectively influence the 1980s and 1990s health sector reform. This positions Brazil far from the idealised fallacy of democratic and liberalising transnational economic project of state modernisation (Ribeiro, 2009). Indeed, the 1980s and 1990s national project to expand and universalise citizenship rights and to re-democratise the state is far from being accomplished. Pressure on the public agenda for political and institutional transformations, in the pattern of developmentalist government intervention, new federative relations and new relations between the government, macroeconomic policies and society, hurt the formulation of public policies that effectively benefit the fulfilment of the right to health (Ribeiro, 2009).

Overall, Brazil's public health system suffers from low levels of financing and investment; competition of resources among federal levels; poor quality services; excessive participation of private companies and limited accountability (Lobato and Burlandy, 2000). That is, cherry picking the easy, less costly, low-risk procedures and services while leaving the state with the costly ones, including rectifying the private sectors' failings is a measure of excessive concentration in the more profitable ends of health care. This burdens poor and vulnerable families disproportionately where women are a majority (Corrêa et al., 2005). The marginal role of women's organisations during democratic transition and the

subsequent period explain to a certain extent the limited commitment to women's reproductive health and rights (Corrêa et al., 2005). For this reason, in the next chapter, I will take a step back and look at the 1980s and 1990s HSR as a way of defining the reasons and forces that have shaped the current health policies in Brazil.

The next chapter will discuss federalism, fiscal retrenchment and decentralisation in order to situate it in terms of the partial privatisation of health created by the design of the 1980s and 1990s health sector reforms in Brazil. It particularly looks at the effects that privatisation and decentralisation had over women's rights activism on maternal health and their widespread effects over mainstream policy making rhetoric and the perceptions of key actors working with such themes.

Chapter VII - Is it Private? The Effects of Privatisation and Decentralisation on the Characteristics of Maternal Mortality Reduction Strategies and Discourses

Introduction

Shiffman and Smith's (2007) fourth aspect of analysis is issue characteristics. This aspect points to the features of maternal health and mortality as a public health issue and its importance (or its perceived importance) in comparison to other health-related problems. This aspect is divided into three factors: indicators; severity of issue in relation to others; and effective interventions. As previously discussed, one additional factor has been added to this framework for the purpose of this analysis. The fourth and final factor relates to the intrinsic and instrumental value of initiatives, i.e. the inability of the international community to afford real value to health initiatives that benefit women only, without dealing with women as an instrumental value to something else such as childbirth or childrearing (van Olmen et al., 2012).

The two first factors informing this aspect have already been dealt with, to some extent, by previous chapters. In brief, so far it was possible to observe that maternal mortality rates are seen as credible indicators and some effort is dedicated to (at least in principle) addressing high rates of deaths registered by this indicator. It also became clear (particularly in Chapter VI) that maternal mortality reduction is not seen as a severe issue and, therefore, not as important as other issues such as child mortality or HIV/AIDS. As a result, this chapter's discussion focuses on the effectiveness of interventions and the intrinsic and instrumental values attached to each initiative. That is, it analyses the interventions that are proposed and implemented as a means of addressing maternal mortality as a problem. Additionally it traces the discourses built and streamlined by different policy legacies and epistemic communities as a way of determining the real value that was attached to maternal mortality as an issue.

Previous chapters have discussed the structure of and the history behind the creation of Brazil's current health system. They focused on the main principles behind the public

health reforms of the 1980s and 1990s and reflected upon the relationship between a human right to health rhetoric and the real outcomes arising out of this new model of health care and provision. This chapter looks specifically at the effects of the use of decentralisation discourse, in its many variations, in the achievement or underachievement of better health outcomes in maternal mortality reduction strategies in Brazil. The chapter is not targeted at defining and/or analysing the many different ways the term decentralisation was used and implemented. Nonetheless, a brief analysis of the evolution of the use of the term and the politics associated with its different uses is necessary. In this sense, rather than looking at the history of privatisation of the health sector in Brazil, this chapter studies the evolution of privatisation discourses embedded in the decentralisation and maternal mortality reduction strategies. It carefully unveils the use of privatisation language by the rhetorics used in HSRs in order to understand their overall effects on the discursive processes involved in maternal health policies. This chapter's analysis enquires who benefits from decentralised maternal mortality strategies.

Social exclusion and vulnerability occurs in different levels depending on groups and individuals (Vera-Sanso, 2010). There are those who are excluded from all social services, those who are excluded from one service but not another, those who are excluded from good quality social services and those who opted to self-exclude themselves from mainstream services (Abel and Lloyd-Sherlock, 2000). Differences will be observed along time in every context and even among members of the same group (Vera-Sanso, 2010). All the above factor into the various health statuses pertaining to individuals and groups of a society. The next section will address the existing scholarly discussion on the effectiveness of HSRs in the reduction and elimination of social exclusion and vulnerability.

Scholarly Discussion on Effectiveness on HSRs Interventions and Values

Health sectors were initially seen as non-productive and subject to economic growth for resources but this logic changed when health sectors were conceptualised as a driver of economic growth (Mills, Bennett and Gilson, 2008). This shift comprised several different discourses: the basic needs approach put forth in the 1970s embodied in the Alma Ata Declaration, the rights-based approach, and WHO's financing strategy of 2000 that defined health as instrumental to economic development, which was translated into parts of the

MDGs (Cornwall and Nyamu-Musembi, 2004). Mills, Bennett and Gilson (2008), argue that the latter is part of a larger international consensus that was able to build up financing targeted at the health sector and attract big international players such as the Bill and Melinda Gates Foundation.

On the other hand, these new platforms have been responsible for the creation of new public-private partnerships and reignited the discussion concerning vertical and horizontal programmes, all of which use discourses emphasising the importance of strengthening health systems (Atun, Bennet and Duran, 2008). Albeit these platforms created political momentum and gathered more financial resources for health systems research, the effectiveness of such strategies was considerably impaired by donors' push for quick fixes, i.e. 'the magic bullet' (Mills, Bennett and Gilson, 2008: 4). Scholars point out that health system strengthening strategies remain in the rhetorical arena and do not take into consideration the complex issues related to health systems and health sector reforms and the real debate that should indeed accompany it (Mills, Bennett and Gilson, 2008).

In the period between the 1980s and the 1990s, welfare state practices oriented by solidarity principles were replaced by neoliberal theories emphasising individual interests (Koivusalo and Ollila, 1994). In Latin America, this meant the pursuit of cost-effectiveness and the change of service delivery by including public-private initiatives, private companies and non-governmental organisations (Murray and Elston, 2005). In Brazil, SAPs rhetoric influenced the decentralisation of the provision of public health services in 1984-1988, so to: (a) transfer responsibilities, administration, and implementation of social programmes from the national to state, municipal levels and private providers; (b) create social control of the allocation of public social expenditures to better reach vulnerable localities and groups; (c) enable increased citizen participation in decision-making; (d) to 'spread the benefits of growth'; (e) integrate regions; and (f) use resources efficiently while developing poverty stricken and vulnerable areas (Rondinelli, 1981a: 133; Iriart, 2004).

This chapter demonstrates through the analysis of interviews with key actors, that decentralisation of the health sector led to the transfer of responsibility from the national to the local levels reducing the levels of accountability and creating more space for the participation of private companies in the provision of health care and in policy making and implementation. This chapter looks at the link between decentralisation discourse and

privatisation. It particularly gives emphasis to the creation of policy spaces and the diffusion of neoliberal rhetoric as part of the mainstream model of decentralisation and its implications to maternal health policies. It relies on secondary data and primary data to establish these conclusions.

The following sections will serve to establish that the implementation of decentralisation of the health sector in Brazil was always coupled with a market driven discourse and practice whereby private sector companies were perceived as better health providers and therefore public incentive was given for their expansion through purely private and/or public private partnerships. This consolidated the previous model of care while appropriating a health and democracy discourse.

The first section will delineate the theoretical and context-specific characteristics of decentralisation in Brazil. The second section will contend that federalism aligned with decentralisation has, in spite of overspread rhetoric, resulted in the deterioration of the health sector. The third section will define depoliticisation and policy spaces as key aspects to understanding policy failures of decentralisation. The fourth section will briefly discuss the model of partial privatisation implemented in Brazil in which the participation of the private sector in maternal health services serves as an impediment to strategies aimed at improving maternal health outcomes. The fifth section will establish that the discourses associated with decentralisation in the newly created policy spaces are in fact political projects which in their majority serve to benefit and advance neoliberal interests.

Effectiveness of Interventions: The Theoretical and Context-Specific Characteristics to Decentralisation in Brazil

Decentralisation and its Colonial Roots

Decentralisation was in one of its various formats imposed on Brazil during colonial rule. It was introduced by the Portuguese Crown as part of a project called 'capitanias hereditárias' created to transfer political responsibility to lower levels of government and transform Brazil into a federal state (Saldanha, 2009). As regional oligarchies fought to

increase their power, the 'capitanias hereditárias' model was then transformed into a political project against the monarchy (Viana and Machado, 2009). In this sense, federalism was introduced by the Portuguese colonisers but was pushed forward by the local elites whose wish was to break away from economic exploitation and move towards political independence and a republic form of government (Gadelha, 2007). Soon enough, federalism and decentralisation became political emblems that represented (at least in rhetoric) a break away from economic exploitation (Leite, Vasconcelos and Lima, 2011). This was, as in other cases of introduction to key political concepts in Brazil (see, for example, the previous chapter for the history of fundamental rights), an elitist movement that was completely dissociated from the interests of the overall population (Leite, Vasconcelos and Lima, 2011).

Saldanha (2009) traces this history to argue that Brazil is actually a 'false federation' with an inefficient decentralisation that fails to deliver on real social representation ('representatividade social'). Similarly, Campos (2006b) contends that the implementation of decentralisation in Brazil failed to acknowledge some outdated formats and limitations as a neoliberal guideline. In this sense, these scholars argue that the problem lies with the values of inequality inherent to the historical implementation of federalism in the country (Campos, 2006b; Saldanha, 2009). Experts in social participation and decentralisation in Brazil deconstruct the assumption that the institutionalisation of political participation leads to a symbiotic relationship between the State and democracy (Cornwall, 2002; Viana and Machado, 2009). They do so by arguing that although democracy requires strong State institutions for its completion, representativity requires a much more complex system in which political will is indispensable (Atkinson, 2002).

Saldanha's (2009) study brings forward a very important historical account of federalism, and it demonstrates that recent Brazilian history is marked by an inconstant pattern of shifts from centralisation to decentralisation and then backwards, to the same extent. It confirms what has already been established by previous studies in the same area, i.e. the lack of political commitment to the democratic value usually attached to decentralisation rhetoric and its use for elitist political purposes (Atkinson, 2002; Gadelha, 2007). These accounts reject the usual, that is the temptation to say that governance failures in post-colonial contexts are solely the result of colonialism and, therefore, to portray as the only solution to democratic deficit the introduction of gradual and progressive reforms moving

away from the past and shifting towards the future. However, the recent history of decentralisation of the health sector in Brazil paints a much more complex picture. The compelling strength of the values advanced by decentralisation rhetoric has made it possible for decentralisation to move from the political/administrative realm to other spheres of government promoting more inequality without putting it to judgement (Atkinson, 2002). This happened in quite a rapid and unforgiving way.

Decentralisation and the Build-up of the Reformist Movement

Health sector decentralisation was implemented in Brazil as part of a wider health and democracy project at the forefront of the sanitary movement's demands (Paim, 2003). These demands were part of a historical moment of resistance and political upheaval against the military dictatorship (Paim, 2003). It was very much an internally formed political movement but oriented by external ideals and ideas. For instance, decentralisation of health was introduced as one of the principles of the movement for health reform but, as noted above, was introduced in Brazil during the colonisation period (Saldanha, 2009). Moreover, the name of the movement was originated in the Italian health sector reform and then reinforced in 1986 by PAHO and then by academic research, alternating its mention with a positive and/or negative dimension (Escorel, 1998). In fact, the model of care proposed by the reform project was based on regional experiences of the organisation of health services such as those applied between 1974 to 1979 in the State of São Paulo and the State of Rio de Janeiro (Cohn, 2003).

The theoretical dimensions of the sanitary movement have origins in left-wing research developed in the end of the 1950s and beginning of the 1960s then consolidated by two crucial studies published in 1975 by Arouca and Donnangelo (Arouca, 1975; Donnangelo, 1975; Paim, 2003). Although both studies were equally important to the development of the basis for a radical movement for reform, Arouca's work gained more prominence which reflected upon his leading position in the movement before and after its institutionalisation (Paim, 2003). Arouca's and Donnangelo's criticisms departed from biomedical models of curative and preventive health by using Marxist dialectical and historical materialism (Arouca, 1975; Donnangelo and Pereira, 1976).

This theoretical framework meant that its political base would lie within academia, more specifically at the Departments for Preventive Medicine at the University of Sao Paulo and of Campinas and the Institute for Social Medicine at University of State of Rio de Janeiro (Escorel, 1998). This concentrated the initial political articulation efforts to the southeast region (Fleury, 2003). Soon, the worker's movement of Sao Paulo and the student's movement of Sao Paulo and Rio de Janeiro became part of the early forms of the social democratic movement for health sector reform (Paim, 2003). Progressively, the movement gathered support from other groups such as feminists and religious organisations (Osis, 1998).

The reformist movement's political strategy focused on spreading this new discourse throughout society and considered the State bureaucracy as the privileged space for action (Escorel, 1998). In recent history, the first formal appearance of the rationale supporting decentralisation of health occurred at the III National Health Conference of 1963 (Brazil, 1963). Its activism was particularly strengthened through positive results arising out of pilot projects implementing decentralisation, participation and new organisation of care in the southeast in 1974 and 1979 (Escorel, 1998). As explained in more detail below, decentralisation became once again a key to persuasion strategies and a symbol of opposition to authoritative forms of government.

Well, why does it matter? It matters because the reformist movement's political strategy particularly shaped the way discourse was formed and introduced in the State bureaucracy. This then led to the appropriation, transformation of this discourse by the bureaucracy and then re-appropriation by social movements which will be discussed in the following sections. Furthermore the primacy given to class struggle by leftist academic theory and by the agenda of the main social movements associated with the sanitary reform had a profound effect on the way women's rights to health were advocated and placed within and/or outside its discourse.

Decentralisation and Structural Adjustment Programmes' Rhetoric

Decentralisation became fashionable in Latin America in the 1980s with the effects of new structural adjustment programmes and recommendations produced by international organisations such as the World Bank (Rondinelli, 1981a). What is not often transparent is that decentralisation was at that time coupled with privatisation of services through solely private contract or public-private partnerships (Campos, 2006b). Campos (2006b) argues that decentralisation meant legitimating the discourse whereby the market should be seen as responsible for providing services. This devolution of power to the market remained true to neoliberal values but used the rhetoric of the advancement of rights and social participation in order to gain legitimacy (Cornwall, 2002). What would supposedly be the cure to the financial crisis of health systems never really delivered its rhetorical promises in Latin America (Mesa-Lago, 2007).

In Brazil, the movement toward decentralisation was part of a previous movement pushing for the municipalisation and the rejection of a strong authoritative central State (Paim, 2003). Campos (2006b) argues that Brazilian health sector reform came late to the wider discussion of reform in the region as well as elsewhere in Europe and it adopted concepts (such as decentralisation) that were considered by some academics studying reforms elsewhere as outdated and incapable of achieving efficiency and equity in health. Perhaps, this insistence of an 'outdated' form of organisational reform can be linked to decentralisation's historical background in Brazil and to its use as a strategy against abusive forms of government (Saldanha, 2009).

Despite dissident arguments, decentralisation was effectively transferred from discursive practice to reality (Campos, 2006b). However, in the absence of a critical appraisal, it became a structural arrangement with laws, norms and values that instead of serving as instrumental value towards the consolidations of democracy, it became itself the intrinsic value, the end in itself (Atkinson, 2000). Moreover, Campos (2006b) argues that the logic of decentralisation does not produce results that are in agreement with the logic of health systems; it produces autonomy at the tip of the systems that tends to isolate municipalities, generate little cooperation and therefore fragments the system.

Municipalities that are able to develop their infrastructure are benefited by decentralisation while the opposite happens to the ones that do not (Baptista, 1996). Specific programmes are only implemented at the will of the municipal executive leaving important health agendas marginalised (Levcovitz, Lima and Machado, 2001). In addition, as explained in a previous chapter, federal norms such as the basic operational norms - NOBs that attempt to create incentives for the implementation of national flagship programmes tend to focus on a federal/municipal relationship which not only disengages state governments but also increases the competition between municipalities and states (Levcovitz, Lima and Machado, 2001).

Women's health is barely part of the central mainstream decentralisation agenda and hardly ever recognised by municipalities (Lakshminarayanan, 2003; Mayhew, 2003). For example, Rio de Janeiro, one of the sites of the development of the sanitary movement, had in 2006 only 15% of coverage in PAISM (Campos, 2006b). As already explained, PAISM is to this date the most progressive programme in terms of women's right to health. However, there is no real commitment to the effective decentralisation of PAISM and its successful implementation at the local level. This demonstrates that in Brazil, as elsewhere, the processes of decentralisation create disjunctures between policy-making authority of higher levels of government and the implementation capacity at the levels of service provision (McIntyre and Klugman, 2003). Those responsible for the making of policies do not always share the same values and interests of those responsible for managing and implementing their delivery (McIntyre and Klugman, 2003). This particularly challenges reproductive health services which have always historically been at the centre of very heated and contentious policy discussions (Lakshminarayanan, 2003).

There is a clear dissociation from policy making to policy implementation in Brazil (Htun and Power, 2006). But this is not the only piece of the puzzle. As seen in the previous chapter, there are also complexities associated with the political strategies created by social movements. Campos (1988) questions, for example, the real radical character of the sanitary reform project expressed at the VIII National Health Conference. He argues that the reformist's strategy to build momentum through its insertion into bureaucracy essentially meant that it would act in continuity to the old health model by consolidating its political-administrative structure of health care (Campos, 1988). Moreover, as the sanitary movement was institutionalised in the SUS bureaucracy, it did not expressly reject

privatisation by flagging up the implications of expanding capitalist practices to social sectors; as a result the implementation of the sanitary reform was incapable of preventing the neoliberalisation of the health system (Weyland, 1995).

In fact, the overall Latin American experience has proven that health sector reforms have mostly served to deepen the social-economic divide, sharing little of the success afforded to economic development of the region (Mesa-Lago, 2007). The heterogeneous structure created by decentralisation increased social inequality and fragmented the social order in which the State is seen as failing, or impeded deliver *of* the minimum services required by its citizens (Fleury, 1995). Social security is co-opted by the different political interests of the elite transforming regular citizens into clients of the State bureaucracy (Mesa-Lago, 2007). The depoliticisation of social demands strengthens the bureaucracy and suppresses any political expression and exercise of citizenship (Flinders and Buller, 2006). Radical social participation is replaced by bureaucratic processes and channels which have a clear objective of privileging the private sector (Travassos et al., 2000). Bureaucratic social spaces generate more accountability through more social participation in the monitoring of health budgets but do not democratise the policy and decision process (Brock, Cornwall and Gaventa, 2001).

Indeed, decentralisation meant central governments transferred the full responsibility of providing health care to local governments and civil society, while retreating from any space of accountability and/or responsibility (Fleury, 1995). Nonetheless, Tendler's (1997) case studies in the State of Ceará have shown that decentralisation creates instead a three-way dynamic in which state government, municipal government and civil society operate simultaneously, and, in this situation, state governments were found to be considerably stronger than municipalities taking away some traditional powers and devolving others at will (Tendler, 1997). This active presence of the state government was the key to guaranteeing the success of the reformist programmes in Ceará (Tendler, 1997). Tendler therefore concluded that the path to good governance is a bit more complicated than the one advocated by decentralisation (Tendler, 1997).

A historical analysis of the Brazilian case indicates that decentralisation created space for an improved social control but this was not enough to afford power to low level councils and committees in a way that it actually impact policy strategically. The neoliberal

discourses and rationale became more and more embedded in the social structures, transforming the whole context in which the sanitary reform ideals are inserted into and implemented at. In conclusion, decentralisation promotes inequity as it drives market forces and stimulates regional heterogeneous development with no ability to guarantee the implementation of specific programmes or the achievement of particular health goals (Gershman, 2004; Campos, 2006b; Fleury, 1995; Saldanha, 2009).

The next section will explore the role of federalism in the deterioration of services. This will serve to deconstruct an argument that is usually put forward by reformists: that a federal State such as Brazil requires a decentralised system of governance across all sectors. In a sense, the aim of the following section is to argue that there is a discursive system whereby federalism and decentralisation reinforce one another, but that this mutually reinforcing relationship does not always prove to be productive, certainly not for the Brazilian movement for health and democracy.

Federalism, Decentralisation and Power Distribution: Better Services?

The literature on bad governments in developing countries has given rise to a body of literature by bilateral and multilateral donor institutions, western governments and NGOs where advice is given as to: (i) reduce the size of government's bureaucracies by contracting out services, privatising and decentralising; (ii) terminating policies and programmes that created flexibility and corruption; and (iii) subjecting public agencies to market forces (Tendler, 1997). Mainstream development often filters everything in the belief that the superiority of the market is capable of solving many problems of government, economic stagnation and poverty (Wilson, 2012). Nonetheless, these blueprints for a desired future often disregard the differences across and within countries that live by importing ideas (Sikkink, 1991).

Following global development trends and as noted in the section above, decentralisation and federalism were seen by the sanitary movement as crucial to power distribution and the improvement of intergovernmental relations; all in the name of freedom (Paim, 1986). This adoption departs from the often mistaken assumption that central governments have

superior knowledge of performing regulatory and capital-intensive activities, while local governments and civil society are presumed to be better at outreach (Tendler, 1997). Decentralisation is seen, as already noted above, as the appropriate response to abuses from central power (Leite, Vasconcelos and Lima, 2011). Indeed, practitioners and researchers used the evidence used by international and regional experiences and policy documents to insist on the need to change existing centralised systems (Tendler, 1997). But, little attention was given to studying the role of central government in decentralisation in order to confirm or refute the aforementioned assumptions (Tendler, 1997).

Brazilian fiscal decentralisation started at the end of the 1970s and was consolidated in 1988 with the enactment of the new federal constitution (Rodrigues, 1994). It was the answer to the financial crisis of a central authoritative State and to a military regime (Rodrigues, 1994). In Brazil, the restructuring of federal relations were presumed responsible for correcting regional imbalances (Leite, Vasconcelos and Lima, 2011). Simultaneously, local entities were presumed to be better at allowing people to control and participate in policy decisions (Leite, Vasconcelos and Lima, 2011). This created a discursive system whereby federalism and decentralisation reinforced one another. However, surprisingly, federalism and decentralisation resulted in low participation by the central government in the provision of services and low public spending in health, all of which indicated its overall low priority in the political agenda (Fleury et al., 2010).

In a federal State such as Brazil, no other form of organisational model is seen viable (Afonso, 1994). Fiscal federalism is seen as being concerned with wellbeing and, therefore, as crucial to ensuring greater autonomy for localities by establishing political rights and financial resources and establishing federal units with clear cut responsibilities (Leite, Vasconcelos and Lima, 2011). However, decentralisation in Brazil does not follow a “national or rational logic” (Rodrigues, 1994: 369). It is not the result of a negotiated process between involved parties (i.e. federal entities); it does not enjoy transparency; and it only truly represents the deconcentration of responsibility with no real transformation and/or transference of real power to lower levels of government (Prud’homme, 1995). This inverts the policy process and affects its implementation.

As with decentralisation, federalism emerged simultaneously with the economic concept of the market in order to create cohesion that promoted market relations (Tendler, 1997).

Leite, Vasconcelos and Lima (2011) argue that federalist institutions conform and reform the distribution of power among actors geographically. This is because institutional arrangements are seen as always transient and part of a continuous negotiating process (Leite, Vasconcelos and Lima, 2011). Rather than consolidating the democracy, it challenges the resistance of its actors and institutions in the face of unpredictable changes.

Brazil is the only country with a universal health system where private spending wins over public (Leite, Vasconcelos and Lima, 2011). In many countries, multiple arrangements of federalism and decentralisation were implemented as an instrument of democratic radicalisation (Prud'homme, 1995; Campos, 2006b). All these models share the belief that decentralisation is the way to consolidate primary health care, which in turn would guarantee better levels of health care at lower costs (Rondinelli, 1981a). However, in Brazil the mechanisms for financing health policies and implementation are very fragile, which is combined with the use of macroeconomics, prioritisation and institutionalism (Leite, Vasconcelos and Lima, 2011). That is, the distribution and use of resources are regulated by a series of intricate norms (the basic operational norms - NOBs) that create a system of priorities based on complicated standards and on business oriented values stimulating competition in between federal entities (Baptista, 1996/1997; Levicovitz, Lima and Machado, 2001). As a result, the mechanisms for financing public health have a tendency to put issues into artificial binaries of economic/non-economic and technical/political, which in turn contribute to the depoliticisation of health financing as an issue (Baptista, 1996/1997; Levicovitz, Lima and Machado, 2001). In such case, federalism and decentralisation arrangements only serve to reinforce and replicate the pre-existing model of health care and all the inequalities embedded within it (Fleury et al., 2010).

All 27 states and 5,562 municipalities of Brazil operate within a legal paradox whereby privatisation and citizenship are equally encouraged by the Federal Constitution and its regulating norms and laws (Bahia, 2011). The 1988 Constitution recognises citizenship rights while also permitting the provision of social services by the private sector (Brasil, 1988). This is problematic as it is often related to the rise in the power of conservative elites (Lima, 2007). More importantly, private participation prevails over public investment and provision (Bahia, 2011). In 2011, public spending corresponded to 46 per cent of total health spending, leaving health agencies with insufficient budgets to achieve their

mandates (Leite, Vasconcelos and Lima, 2011). As a consequence, views on reforming the public sector place excessive faith in the actions of the “user”, or worse “client”, of public services (Tendler, 1997). Therefore, the health sector deterioration of infrastructure is caused by merely rhetorical discourses, depoliticisation and elimination of any perception of collective project of society (Leite, Vasconcelos and Lima, 2011). The next section will discuss the definitions of depoliticisation and of policy space in order to explain their importance to the HSRs processes.

Decentralisation, Depoliticisation and Policy Space

Griffiths (2003) elaborated a comprehensive review of publications on healthcare organisation to reveal that studies related to the organisation, direction and management of healthcare systems have not sufficiently explored the relationship between organisation sociology and sociology of health and illness. This, Griffiths (2003) concludes, is the result of mistaken assumptions claiming rational decision making and overly technical processes have been extensively challenged. That is, challenges to biomedical models of care are seen as sufficient to understand the fixation with ‘technical’ policy making when these are in reality not capable of exploring all the interests and strategies involved in progressive and conservative political developments in the HSRs arena.

The dynamics of decision making at local level is extremely important to implementation of policies and reforms (Ewig, 2006). It is important because it enables an understanding of organisations as well as individual interactions within and across these organisations (Fleury et al., 2010). Historical changes demonstrate the cyclic and continuous shifts in policy making and implementation (Atkinson et al., 2000). Evidence points to transformation of original intentions behind the reform, almost always without any transparency (Weyland, 1995).

Therefore, Griffiths (2003) argues that there is a need for a theoretical model to understand the complexity of health systems and health sector reforms by focusing on the relationship between actors and interest groups for what she calls the ‘theory of countervailing powers’. This theory demands for macro-meso-micro level analyses that take into consideration the differences among and across the different levels of

government (Goetz, 1995a; Elson, 1994). Although for the purpose of this thesis Griffiths' (2003) theory will not be fully explored, its two key concepts, depoliticisation and policy space, will be used to understand the difficulties of implementation of women's rights in HSRs in Brazil.

Policy making is a process whereby ideas, interests and institutions interact (Gasper, 1996). It traces how and why a particular agenda is formed as well as improving understanding of the consequences of policy decisions and implementation (Bakker, 1994). The analysis of policy networks and policy space is very relevant to understanding policy change (Ewig, 2010). It enables reflection over the relationships between policy actors and the manner in which the discourses can affect policy analysis and engage with policy actors (Gilson et al., 2008). Notwithstanding, in lower and middle income settings, policy analysis is still underdeveloped (Gilson et al., 2008).

The main problem with the policy analyses of health sector reforms is that they tend to ignore the fact that planners and policy makers who work in bureaucracies tend to seek control rather than to facilitate development activities, which in turn inhibits the kinds of analysis and planning that are most appropriate to dealing with them (De Vos et al., 2006). Moreover, policy makers tend to rely on recommendations from international development organisations, which by large call for a rationalistic approach to decision-making (Cassels, 1995). In this sense, complex social problems are reduced to systematic analysis and technical authoritative conclusions that, in spite of a 'scientific' discourse, are far from being value-free and, certainly, inherently not oriented towards ameliorating economic and social inequality (Wilson, 2012).

Any conflicts, values or politically radical arguments are rejected and replaced with goals or plans of action (Almeida, 1999). Political conflict is avoided and any politics removed from decision making arenas (Flinders and Buller, 2006). Planners and policy makers are then advocated as the only ones capable of determining the correct courses of action and implementation (Tendler, 1997). Rondinelli (1983a) argues that most policies geared towards reforming the political economy of developing countries were in fact political experiments with no foundation in real and systematic scientific findings and at times rejecting the existing scientific findings.

As a solution, Rondinelli (1983a) proposes that development projects should be at the cutting edge and for this reason, given flexibility for continuous redesign. Although I share Rondinelli's (1983a) opinion in terms of the depoliticisation of political spaces and the problems involved in recent implementation of social policy in developing countries, I do not agree that projects should be redesigned without thorough reflexivity and reassessment. Yes, political decision-making is continuous or cyclical which may require immediate adaptation, but carrying out policy changes with no regard to real scientific systematic analysis of the problems of implementation is not only not advisable but also quite imprudent.

Argumentation, i.e. discourse, is the real fundamental piece in the policy process (Evans, 2011). Language shapes policy making as well as implementation (Massey, 2013). As policies are trickled down through all levels of government, they are changed and (re)adjusted in order to better fit the context and interest in which they are supposed to be used in (Petchesky, 2003). At 'street level', the policy that is implemented (or the way it is implemented) may be considerably different from its initial guidelines and principles (Lipsky, 1980). This disjointed nature of policy processes and their knock-on effects can be largely responsible for policy outcomes that are diverse from those advocated by mainstream political rhetoric (Htun and Power, 2006). In cases of public reforms that aim at decentralising services, this phenomenon becomes more acute as strategic policy expertise is lost in the face of this new framework of authority (Evans, 2011). At this instance, local level workers are left to rely on their own knowledge to make sense of new policy environment which in the end leads to insufficient management capacity to develop the service (Evans, 2011).

Depoliticisation and Muted Discourse

Depoliticisation has been widely explored in the European context but not to the same extent in Latin American studies on politics, governance and public policy (Massey, Hall and Rustin, 2013). Flinders and Buller (2006) define depoliticisation as a tactic of politics that intends to shift the political arena through the use of processes and procedures that act as a means of reducing costs of political transactions. If narrowly understood,

depoliticisation can then be distinguished between different types of depoliticisation tactics that may interact and complement one another: (i) institutional (principal-agent relationship is designed to release to some extent the agent and its sphere of responsibility from short-term political considerations); (ii) rule-based (adoption of specific decision-making rules); and (iii) preference-shaping (use of rhetorics “portray certain issues as beyond the control of national politicians”) (Flinders and Buller, 2006: 299).

At the global level depoliticisation has been promoted by the World Bank and United Nations as a means through which developing countries can enhance state capacity and market credibility (Flinders and Buller, 2006). As such, it altered market expectations in the credibility of policy making, reduced the political overload while affording greater strategic capacity to higher levels of government and isolated politicians from criticisms and responsibilities arising out of any policy failure (Wilson, 2012). Therefore, depoliticisation creates non-issues which become muted discourse (Wilson, 2012).

Muted discourse can be understood here in terms of Foucault’s (1980) theory on the political economy of truth. Foucault (1980) traces the history of repression and the effects of power in order to analyse the instrumentality of discursive practices. Discourse, he argues, has the ability of determining what will or will not be included in the mainstream discussion, and even more importantly, what will fade into invisibility (Foucault, 1980). He uses an example from the History of Sexuality to demonstrate that, for instance, ‘bourgeois’ society repressed infantile sexuality by refusing to speak of it and/or acknowledge its existence and, as such, “sexuality became far more a positive product of power than power was ever repression of sexuality” (Foucault, 1980: 121).

Haraway (1991) also relies on the deconstruction of language and its use to ignore the unitary theory of ‘truth’ to postulate that discursive categories need to be placed in terms of their historical context. Hence, the social positioning and partialities of the proponents of different discourses need to be problematised in order to comprehend the existing power relations that populate these spaces of construction/insertion/transformation of mainstream discourses (Haraway, 1991). A historical problem arises, namely that of discovering a positive rhetorical strategy of appropriation and incorporation as erasing or policing difference and obliterating the authority of political speech and action (Foucault, 1980). This thesis advances the claim made by many others that the key to overcoming the

difficulties in the implementation of social justice strategies lies in re-politicising the same arenas that have been depoliticised by neoliberal policy networks (Costa, 2009). In this sense, the role of this study is to provide a historical account of depoliticisation to support other similar claims made by other researchers previously.

Harriss, for example, traces the creation, development and diffusion of the term social capital from Robert Putnam's theory to its wide advocacy by the World Bank and its elaboration globally, regionally and nationally as development policy's 'missing link' (2002: 7). Social capital originated from a simple notion of networking and social value and was transformed into a highly technocratic and inaccessible development term used to objectify people and exclude non-elites from policy making (Bourdieu, 1984). In this sense, well-intentioned scientific work may be co-opted into a hegemonic machine that instrumentally uses social sciences in order to obscure power inequalities and advance a particular political agenda (Harriss, 2002).

As already noted in Chapter I, social capital as it is defined by the World Bank creates a system whereby previously politically charged and established terms are appropriated, transformed and then re-shaped to fit into a capitalist framework (Harriss, 2002). For instance, the term participation (before community development) was re-framed as a mandatory practice of development policy while at the same time removing from it all its radical politics (Cornwall, 2002). Instead of promoting inclusion in decision making processes it was shifted towards the use of local organisations (voluntary or not) for the delivery of services based on a 'self-help' model coupled with extensive cuts in public spending (Leal, 2010). This in the end means that problems caused by power imbalances are dealt with as purely technical matters and are therefore dealt without any apparent involvement of politics (or at least without progressive political left movements) (Leal, 2010).

The most important conclusion that can be drawn from Harriss (2002) findings is the strategic depoliticisation focuses (and therefore impairs), not what is included in the development discourse, but what is excluded and how it occurs. Mainstream development discourse and policy tend to select concepts and scientific data that it finds suitable to its interests and ignore everything else (Cornwall, 2010). For example, as Harriss very cleverly notes, counter hegemonic contributions to social capital were and are still ignored

up to this date (2002). The most flagrant of those being Pierre Bourdieu's (1984) notion of social capital as an instrument of power which in fact replicates social classes and the inequalities associated with them.

Haggard and Kaufman (1997: 264) name this political manoeuvre of depoliticisation through invisibility as 'muted tendencies towards polarisation'. According to their research, in countries experiencing democratic transitions, electoral change and new political strategies are responsible for placing structural discussions in a binary that either approaches issues in terms of their economic or non-economic problems (Haggard and Kaufman, 1997). The political economy of democratic transitions relies on a bargaining model of regime change in which resources are brought by different actors to the negotiation table, but the importance of each resource is neither evident nor is it linked to the underlying economic and social conditions (Buss and Gadelha, 1996). As a result, negotiations are often focused on solving pending economic crisis (created by the authoritarian governments), demanding short-term economic relief which then circumscribes all policy reform efforts (Haggard and Kaufman, 1997). This theory questions the central causes of breakdown of recent democracies as being solely related to economic factors by classifying this binary as being artificially created by political strategists (Haggard and Kaufman, 1997).

In similar terms, Bakker (1994) stated that among international organisations there is widespread agreement on the elements of restructuring but little recognition of the gendered nature of processes of structural and institutional reform. Most reforms suffer from what Bakker calls 'conceptual silence' which she defines as "the failure to acknowledge explicitly or implicitly that global restructuring is occurring on a gendered terrain" (1994: 1). Mainstream reformist discourses make use of 'neutral' language and aggregate terms as imperatives and do not deconstruct the context in which these would be inserted in (Wilson, 2012).

This refusal to take into consideration asymmetrical power relations in the construction of new terms and discourses silences women's experiences and blocks any strategy for resistance and/or change (Wilson, 2012). The phenomena can be best observed by the areas Bakker (1994: 2) identifies as suffering from a 'process of explicit deregulation', i.e. without proper norms, and of 'implicit deregulation', i.e. with norms that are neither

effective nor adequate. New global systems push for the reduced political agency and capacity of governments to self-regulate while governments try to reclaim these spaces by re-regulating depoliticised spaces (Leal, 2010). In fact, Berry (2010) argues that criticism is not accepted as it is seen as a threat to the already fragile development sector and even more fragile international human rights movement, therefore creating 'invisible issues'.

In sum, SAPs discourses have embedded reforms with re-privatisation interests that mostly benefit the reconstruction of the private sector (Almeida, 1999). These discourses are framed in terms of a reinforcement of the male standard of political and economic citizenship (Bakker, 1994). More recently, this has been done via the appropriation of discourse claiming human rights as social enablers of change. Current mainstream human rights rhetoric is all about control over women's bodies and lives but little to do with their choices and freedom (Berry, 2010). The narrow rhetorical space whereby strategies are put in place through these campaigns concentrates on international agents - in all spheres but prominent globally (Berry, 2010). Little space is left to question what happens when health systems and development agents are coupled to produce targeted outcomes (Almeida, 1999). The same can be observed in other studies of neoliberal policies coded practices and muted discourses around invisible issues such as racism and racialising, which silence women's experiences by deliberately ignoring how intersectionality profoundly affects their lives and the effects of the policies claiming to change them, leading in the end to a 'muted white privilege' of neoliberal elites (Davis, 2007: 354).

It is therefore possible to identify the following types of discourses which may be involved in this systemic depoliticisation of women's rights to health: (i) neoliberal deterministic with a push for system convergence; (ii) gender and social policy; (iii) health and democracy (human rights); (iv) decentralisation; (v) rights-based discourse. The analysis of the discourses used in interviews by members of these policy networks makes it possible to map out the respondents' reluctance to discuss a subject or their outright denial due to its difficult approach or evident discomfort to expose or challenge a particular topic perceived to be sacred or established (Llewelyn, 2007).

Political Spaces and Policy Spaces

Public health policy spending can be justified in two ways: improving access to health services to poor and marginalised and improving the overall wellbeing of the population (Kenneth and Mills, 1982). Although the targeted approach may have some benefits it does have some perverse side effects arising out of a discourse that enables the public policy maker to decide to benefit from improved health (Travassos et al., 2000). Health will rarely be a priority for governments, therefore the health demand for resources is always weighted against other, and often opposing, interests chasing financial investment (Almeida, 1999). The health agenda is subsumed by political swings and efficiency-based requests (Gill and Gilson, 1994).

Health planning or health policy decision making are influenced by a plethora of actors (Gill and Gilson, 1994). The discourses created by the confluence of actors from different policy networks and backgrounds usually make use of terms such as participation, negotiation and consultation, which in theory are related to some degree to increased influence in policy making, but apply them loosely (Cornwall, 2010). Kenneth and Mills (1982) look at the presence of local interest groups in the health planning process and find that terms are usually appropriated and transformed. In fact, as will be established in this thesis, terms are appropriated, transformed and re-inserted into the discursive arena with little transparency as to their origins and their purpose.

Moreover, the formalisation of the participation of individuals and social movements in health councils and committees put limits to the articulation of demands (Kenneth and Mills, 1982). Furthermore it presumes that participation and structural arrangements are capable of promoting collaboration and exchange (Leal, 2010). Informal arrangements, appropriate skills and commitment are just as important for collaboration, if not more important (Tendler, 1997). Cornwall (2002) calls for the development of studies on the praxis and micro-politics of participation. The scholar points to the study of new development blueprints as a way of understanding the widening of political spaces created by the establishment's new forums that complement conventional models of participation (Cornwall, 2002). She argues that the comprehension of political spaces can considerably

improve strategies that target the quality and legitimacy of democratic decision-making (Cornwall, 2002).

The use of space as an analytical category of analysis of participation explores issues of power and difference in the micro-politics of participation as a situated practice (Leal, 2010). Cornwall (2002) uses this framework to call for a development praxis that locates new spaces for participation in terms of their political, social, cultural and historical context. Although not limited to the study of policy outcomes, this research was part of a wider project that calls for studies and strategies that are capable of translating new types of citizenship to human rights practices that actually reach out to the people they are directed at (Cornwall, 2002). The most interesting contribution this research makes to this thesis is flagging up the importance of diversity of spaces in the making, shaping and taking of these same spaces (Cornwall, 2002).

Cornwall (2002) defines political spaces as arenas where voices and ideas are expressed simultaneously to others. In this sense, policy space would be shaped by different actors with diverse interests and knowledge through the interaction as an exercise of agency (Leal, 2010). The latter would therefore be marked by the exclusion of those who are not part of policy alternatives and the first would, by default, be marked by its openness and flexibility to change and inclusion (Brock, Cornwall and Gaventa, 2001). Nonetheless, political spaces are always constrained by their spatiality and membership (Price-Chalita, 1994). Price-Chalita (1994) argues that the boundaries of political spaces can be explained by the 'appropriation of the spatial' not only by those that are creating these spaces but also by those who are serving as mediators in these same spaces. Price-Chalita (1994) uses the example of empowerment discourses to say that they are articulated in terms of placement (empowerment) and displacement (not empowerment) which assume the participation in a particular political space as sufficient for the exercise of citizenship. This replicates an idealised notion of the political space as being enough to guarantee democratic participation in its fullest (Leal, 2010).

Lefebvre (1991: 2) alludes to a set of social spaces or 'space of spaces' to identify the abstract dimensions in which limits are characterised by the use of a very specific language. This not only stresses the plurality that marks these spaces but also the problem of the production of knowledge, that is, of translating logic spaces (theory) to reality (praxis) (Lefebvre, 1991). It removes the ethereal notion of space to emphasise the

actors and contents that engender these sets of spaces and how these are collectively created (Lefebvre, 1991). Lefebvre (1991) goes further to add that theories disregarding this duality between logic and reality consists of a political manoeuvre whereby technocrats in their offices (as creators of 'truth') become completely dissociated from society (and the social practice this 'truth' results in). Subsequently, in the case of intended concealment of the relations of the 'production of social spaces' (in terms of social relations of reproduction and relations of production), language becomes a discursive practice that serves to advance an ideology without making it available for challenge (Lefebvre, 1991: 68). In this sense, the study of space is capable of noting: (i) the political use of knowledge; (ii) the ideology it is designed to conceal; and (iii) the embodiment of a 'technical utopia' (Lefebvre, 1991: 9). This represents a move away from fragmentation, separation, disintegration and decentralisation (Lefebvre, 1991).

This is because, as Lefebvre (1991) says, the space is produced socially as a means of exerting control over others. He determines then that spaces are based on power and difference (Lefebvre, 1991). This power is exerted in the mediation of the knowledge which is awarded with legal authority (Lefebvre, 1991). From this theory it is then possible to infer that all spaces will therefore be social constructs that replicate existing power inequalities (Lefebvre, 1991). Lefebvre's (1991) arguments can then be extrapolated to policy spaces in a way of affirming them as socially produced categories of policy making and implementation that limit and/or permit room for change.

Human geographers have studied the social production of space extensively (Marston, 2000). This scholarship highlights the intricate relation between the production of space and scale and its relevance to social reproduction and consumption (Marston, 2000). In sum, according to this theory, spaces and scales are relational and therefore serve to reinforce one another as well as the inequalities they replicate (Marston, 2000). The importance of this assumption for politics and policy cannot be underestimated. Spaces, certainly policy spaces, are constituted and reconstituted around capitalist standards of production (Marston, 2000; Massey, 2006). As a result, policy spaces become unresponsive to non-capitalist power-relations and to the way political positions are constructed and dealt with (Massey, 2006). The challenge here becomes understanding the space in its full multiplicity and social dimensions (Massey, 2006).

Similarly, Lipsky (1980) focuses on 'place' instead of 'space' for a more localised account of the outcomes of public policies and the reasons behind their successes and failures. Lipsky's (1980) seminal work on 'street level bureaucracy' contends that the place of encounter between the government and its citizens is located in the interaction between citizens and government officials. This interaction is regulated by the discretion (and some other exceptional instances) of these local bureaucrats who may have substantial influence on people's lives, particularly in the case of marginalised and poorly resourced individuals (Lipsky, 1980). This finding is confirmed by the Tendler's (1997) research in Brazil that affirms that the positive outcomes of decentralisation of health services in the State of Ceara were not necessarily related to the organisational reform but to, among other things, the motivation and commitment of the people implementing the programmes in each locality.

Lipsky's (1980) work has nonetheless been criticised by others such as Evans (2011) who has argued that the theory assumes local managers and 'front-line workers' to be part of a uniform group and, in the case of the latter, are merely driven by self-interests. Evans (2011) suggests the theory of 'street level bureaucracy' should be extended to include the role of managers and of professionalism. Another criticism that could be made is that Lipsky (1980) uses market language (such as 'clients' as users) instead of a terminology (solely) grounded on citizenship rights. Those critiques do not take away the most important conclusion from Lipsky's (1980) argument which is quite simple: local level bureaucrats have decision making powers that may change the whole scope of implementation of a particular programme, prevent its implementation and/or contribute to its full completion.

Fraser (1995) challenges Habermas' (1981) theory of the public space - that is created based on a public/private dichotomy in which a diffuse web of public institutions would be capable of producing consensus out of rational choices - to propose a feminist reading that envisages removing the public space from an idealised realm and defining it as a site of power struggle. Fraser's (1995) framework is precisely the scope in which the discussion of the policy space is to be placed throughout this thesis. This scope allows for the same deconstruction of discourses based on commonalities and consensus as developed by Haraway (1991; 1998). It challenges the notions of legitimacy of political mediation grounded on ideas of the existence of homogeneous groups (Haraway, 1998).

Policy space is neither abstract nor reductionist; it is never empty or bereft of sociability (Lefebvre, 1991). It is a product of historicity, occupied and ruled over (Lefebvre, 1991). It legitimises the unequal exercise of power by critically and strategically subverting 'knowledge' (Lefebvre, 1991). It can be defined here as the gap in decision making and implementation that assumes a circular, repetitive and simultaneous character in account of the unclear and heterogeneous use of policy throughout the State apparatus (Evans, 2011). In sum, policy space can be understood as the locus where political interests of different policy networks are met in order to influence policy making and implementation while shaping the mainstream policy discourse and the praxis and micro-politics of participation. It is the place of production and reproduction of the hegemony of a group over another through human mediation via the instrumentalisation of a specific discourse (Lefebvre, 1991).

The next section will study the role of policy spaces and depoliticisation in HSRs by specifically looking at the partial privatisation of health care in Brazil. It contends that decentralisation enabled the expansion of neoliberal politics by multiplying policy spaces and depoliticising key thematic areas.

Decentralisation and Privatisation

Gatekeeping and re-categorisation of discourse and their social functions are representations of social control and power struggles (Mohanty, 1988). Fragmentation and integration in implementation practices are crucial to understanding the interface between policy making and policy outcomes (Htun and Power, 2006). Considerable work delineates the participation of the private sector³¹ on health but little research traces its relation to the public health system and government agencies' strategies (Griffiths, 2003). This gap fails, in a sense, to acknowledge that medicalisation is stimulated by external agents (Grindle, 1996).

³¹ Some scholarly discussions in the area of HSRs use the term 'commercialisation of health' to denote those actions and strategies that lead to a wider participation of the private sector, for-profit and non-profit, in health design and delivery (Mackintosh, 1992; 2002; Mackintosh and Tibandebage, 2005). I expressly use privatisation as I think this better represents the Brazilian context. Privatisation, in this sense, is represented here as the pinnacle of neoliberalism.

Local decisions of individual actors shape health outcomes and the overall process of policy implementation (Lipsky, 1980). 'Policy ethnography' as a methodological approach seems to suggest that an improved understanding of policy failures can be driven by the study of policy implementation through the observation of policy makers, policy managers, health care professionals and patients and their interaction (Griffiths, 2003: 63). It recommends looking into the aspects and processes of policy making and implementation by using ethnomethodology (Griffiths, 2003). This method should then be coupled with a historical analysis to allow for a comparison of policy strategies in order to provide insights into social exclusion that is constructed, reproduced and supported through the use of rhetoric (Wilson, 2012). What 'policy ethnography' seems to suggest is that there is a need to look at the cross-over for discourses, at different levels and at formal and informal spaces, that influence aspects of policy that replicate existing power relations, perspectives and agendas (Baptista and Mattos, 2011b).

The next sections use some of the Griffiths (2003) tools for 'policy ethnography' to study the sophisticated use of language by impersonal bureaucracies and policy networks. It aims to complement previous researches on macro-meso-micro level policy analysis of decentralisation in Latin America (Atkinson et al., 2000; 2005a; b; Gideon, 2000). It relies on interviews with key actors and secondary literature for this analysis.

Privatisation and Maternal Health: Better Health Outcomes?

Maternal health care cannot be limited to primary health care. It involves all levels of care and requires an active promotion of wellbeing and other social determinants of health (Murray et al., 2008). Health system performance, particularly local provision of services, can be measured by looking at government policy, international maternal health recommendations and existing tools and evidence (Atkinson, 2007). Institutional pre-conception and discrimination is quite evident in maternal health care facilities (Victora et al., 2011). Low income and immigrant women are often the target of lower quality and transient care (Galli, 2002).

The shrinking of the public sector during the authoritarian governments in Latin America created a momentum for policy change aimed at increasing public spending on the health

sector and the State's role in providing and overseeing healthcare (Almeida, 2002). In Chile, for example, this resulted in the decentralisation of the health sector in 1980 which created 26 autonomous healthcare entities in charge of primary health (Murray and Elston, 2005). User resources were divided between the public sector and private insurance companies as mandatory contribution to public services was no longer required (Gideon, 2001). As a result, and as all income strata received incentives or encouragement to hire some sort of private insurance, a highly interventionist and technological maternal health care was put in place (Atkinson et al., 2005b). In this instance, the medical profession was indicated as leader and main beneficiary of public sector reform (Murray and Elston, 2005). Murray and Elston (2005: 707) found that most obstetricians in Chile became involved in what they call 'dual practice', i.e. a stable public sector job coupled with private sector responsibilities and revenue. The treatment awarded by the same obstetricians to patients depended on their social status which was determined by their location (Murray and Elston, 2005). In this duality of practice, high and middle income individuals were examined through private practice and low income individuals through public practice (Murray and Elston, 2005).

Private practice was not only fostered by the promise of higher paying services but also by the perception that it afforded doctors social status, professional autonomy, fame of professional success, individualised clientele and little or no external control over decision making (Gideon, 2000). Individuals also sought private services not only under the impression of being awarded better social status, but also of being provided higher quality care (Gideon, 2000). However, in reality, the private health insurance (the ISAPRE system) submitted doctors to pre-established charges facilitated by vouchers and refunds which at times constrained the practice of exorbitant pricing or any similar abuse, but in the long run it meant that doctors were frustrated, pressured to have more patients and with reduced time for each appointment as a result provided lower quality care (Murray and Elston, 2005). This completely shifts the relationship from one based on rights and entitlements to one based on the provision of consumerist services. This in turn affects the language used in differing discourses offering diverse effects to political strategies using and/or relying on them.

This in turns means, for instance, that programming the commencement of labour becomes a practice in the private sector which attempts to overcome the timing constraints imposed on the doctors' routines (Murray and Elston, 2005). Nevertheless, a personalised

and in-person care meant that the majority of women receiving private sector treatment delivered their baby through a caesarean section, only leaving a small minority not being reliant on a caesarean section or forceps against two-thirds in the public sector (Murray and Elston, 2005). Doctors constantly pushed for elective caesarean section claiming it to be more convenient for them and the patient as well as relatively safe and simple (Murray and Elston, 2005). These practices carry on under the disguise of modernity and have been given an extended life in the awakening of a discourse defending it as a matter of privilege to be desired as fashionable and exclusive. Therefore, conformity with operative birth culture must be reinforced by the use of discourse (Haas, 2010).

In a sense, this produces a mentality that is quite characteristic of the market: individuals are objectified and their health decisions become numbers. On the other hand, this produces a perception in the public sector that the private sector is capable of absorbing the remaining health demand and does so in a better way. Data is seldom produced differentiating health outcomes on the private sector and public sector. This is often confirmed by global initiatives. For example, the Safe Motherhood Initiative determines that maternity referral systems are essential to the reduction of worldwide deaths (Shiffman and Smith, 2007). This recommendation trickled down to a series of measures at national levels aimed at improving formal arrangements towards achieving the specific indicators of good referral as expressed by the Safe Motherhood Initiative (AbouZahr, 2003). However, little or no effort is put into discovering the referral care needs of the poor and marginalised and the effects existing models have on them (i.e. indirect and direct maternal mortality causes and their predominance in one particular area at a specific moment in time) (Galli, 2002). This lack of appropriate information and misguided action result in all sorts of negative health outcomes.

The availability and access to emergency obstetric care is known to reduce maternal mortality but little is said in terms of the effects of its voracious introduction to health systems (Galli, 2002). Complicated models such as the WHO pyramidal structure creating multiple levels of facility and treatment do little to actually improve maternal health outcomes (Atun, 2008). Sub-optimal care, poor technical abilities, outnumbered referral facilities and overcrowding are among some of the reasons of the failure (Barot, 2011). The several cases where 'textbook referral system advice' is bypassed or non-complied with are proof to user's lack of confidence in the quality and/or efficiency of care (Murray and Pearson, 2005: 2207). Decentralisation, in this instance, may weaken the links

between high-end technical facilities and rural health establishments (Lakshminarayanan, 2003). Also, as demonstrated by a recent study of ‘near-miss’ obstetric complications in Burkina Faso, little attention is given to women who survive birth complications and therefore to the medical (i.e. maternal morbidity) and non-medical disruptions caused to women’s lives (Storeng et al., 2010). This points not only to the problem created by a constrained agenda setting but more importantly to the limits of a strict international definition of maternal mortality and health (Storeng et al., 2010).

Tendler (1997) looks at a case study from the state of Ceara, northeast Brazil, to argue that hiring services within the private sector might be positive if instead of focusing on fewer, larger and more sophisticated suppliers (supply-driven), public bureaucracies gave preference to hiring and training informal sector businesses (demand-driven). Contrary to the mainstream discourse, Tendler (1997) finds that explanations for good performance across the case studies rely on: 1) dedication of workers to jobs; 2) state government recognition of good performance and creation of motivational campaigns; 3) workers’ volunteer spirit; 4) greater discretion and flexibility of tasks limited the capacity of supervision but at the same time guaranteed a certain level of compliance; and 5) decentralisation created an enthusiasm about participation and accountability.

One of the respondents confirms Tendler’s (1997) findings:

“One of the problems [of the public health system]. We lack content guided by an evidence-based practice. Health still rarely works with management protocols and work routines. The main actor is the doctor and he is unhappy, for various reasons, with the public health system and the multiple bereavements in relation to medicine itself.” (Interviewee 6, 15.11.12)

Fleury (2007) provides a contrasting approach to the analysis of privatisation and HSRs in Brazil. In her opinion, the agenda of the sanitary reform movement is considerably different to the agenda of other social movements that already existed before and/or were formed after 1988 (Fleury, 2007). Fleury (2007) contends that the political strategy of the reformist movement was not only compromised by its institutionalisation (see above) but also by the movement’s decision to isolate the HSRs discussion from others taking place at that time. The isolation of health was a double sword, it protected (to a certain extent) the sanitary reform ideals from liberal market forces, but at the same time it consolidated a public policy that was not properly appropriated by governments, leading to a real paradox

(Interviewee 13, 14.11.12). As a result, health policy became bereft of any real influence and coming politically from radical social movements that articulated social equality (Interviewee 13, 14.11.12). As a consequence, SUS privileged a system neglecting local unit management and development while at the same time promoting decentralisation (Interviewee 30, 09.11.12). Lastly, SUS was incapable of altering the model of health care (Interviewee 2, 30.10.12).

Values: Perceptions around Privatisation in the Discourses used in Maternal Mortality Reduction Strategies

Evans (2011) notes in a case study of social workers in the United Kingdom that recent public services reforms have clearly introduced a market discourse to the implementation of policies. This use of neoliberal discourse was in part responsible for the rupture between senior managers and their teams (local managers and practitioners) as senior staff seemed to identify with an entrepreneurial (business) culture while their teams shared a culture of professionalism (Evans, 2011). In essence, one group seemed to be purely focused on reaching target ('the letter of the policy') and another on the processes that enabled the accomplishment of the fulfilment of the spirit of their professions ('the spirit of the policy') (Evans, 2011). This dissociation seems to clearly add another layer to public policy analysis that surely highlights the importance of the policy process.

The presence of this duality in discourse, particularly through the expression of business oriented values, is quite clear in activists' discourses for maternal health in Brazil. As Cornwall and Gaventa (2001) put it, neoliberal discourse often focuses on the rights of the collectivities while also using language such as users, consumers and choosers. Traces of these discourses can be observed in health sector reforms and women's rights activism in Brazil. For example, the discourses used by one particular sector of the movement for the humanisation of birth, which is dominated by middle-class women, particularly focus on the groups' rights as consumers of health services. See below:

"Interviewer: So, how do you define yourselves?"

Interviewee: We are a network of activists who are consumers of health services. We are a wide movement mainly composed by middle class women who have undergone traumatic birth experiences.” (Interviewee 12, 28.11.12)

This group articulates among themselves and with others through the use of international language and tools:

“Interviewee: We are a ‘grassroots’ digital articulation that attempts to demonstrate the cracks in the biomedical model of maternal care by providing women with information.” (Interviewee 12, 28.11.12)

When inquired the reason for using this type of language, the same informant demonstrates hesitation and confusion. See the excerpt from the interview:

“Interviewer: Why use the word consumers which seems to relate more to a service provision relationship and not users which is related to health as a human right?

Interviewee: Oh, I did not know that. Then please change it to users not consumers.” (Interviewee 12, 28.11.12)

The written mission, objectives, values and principles of this particular group demonstrates that this is not a mere confusion related to the interview setting. The group’s written objective claims to aim, for instance, at providing ‘high quality products and services’ for the promotion of a healthy attitude towards birth and pregnancy. This demonstrates the pervasive use (intentionally and/or unintentionally) of neoliberal language throughout the spectrum of maternal health activism. At one side there is the objectification of individuals by neoliberal policy networks for market purposes, but at the same time there seems to be a certain confusion surrounding the uninformed use of widespread mainstream neoliberal language.

Deciphering the articulation and the codes that envelop the real interest behind maternal health discourses is important in the historical and institutional analysis of maternal mortality reduction strategies (Fleury, 2009). It permits a critical and analytical comprehension of the policy process and political praxis (Baptista and Mattos, 2011b). In this sense, mapping out the use of neoliberal rhetoric is capable of measuring the failure and/or success of human rights strategies in terms of their capacity to subvert the institutions and institutional discourse (Mackintosh, 1992).

Fleury (2009) reasons that all Brazilian health sector reforms were to some extent based on a notion of crisis. Indeed, reforms were grounded on a general reformist motto (not limited to the movement for sanitary reform) demanding the transformation of society in the face of multiple failures in governance (Santos and Faria, 2003). In view of this, health researchers debate over the social reform project's capacity to actually promote change (Interviewee 13, 14.11.12). At the same time, scholars seem to be in agreement in regards to the main reasons for the failure of the overall reformist project, i.e. the institutionalisation and depoliticisation of the movement as well as its reductionist focus on policy making and implementation within the scope of the public health system (Interviewee 13, 14.11.12).

In fact, for researchers, the real problem with the recent Brazilian reforms lies in the municipalisation and extensive participation of public-private partnerships in health care (Interviewee 13, 14.11.12). The municipalisation increases the number of policy spaces and then the influence of the private sector in policy making and in the delivery of health care services (Interviewee 13, 14.11.12). This leads to a pattern of destitutions as public-private partnerships are not bound by the social contract ("responsabilidade social") and public accountability rules ("prestação de contas") (Interviewee 13, 14.11.12). This peculiarity reflects the contradictory dynamics of public policy making and implementation in the country.

Since the military government was in office, public investments were removed from public hospitals in favour of the construction of private hospitals borrowing credit from social security (Interviewee 13, 14.11.12). This design persisted in generating a vicious cycle of low public investment and high private financing fuelled by a rhetoric of unattainable costs of health in the face of the need for promotion of austerity measures (Interviewee 13, 14.11.12). This mistaken encouragement of an ever-shrinking State fails to acknowledge its rupture to the social contract and its inability to effectively oversee and guarantee the implementation of rule of law (Interviewee 13, 14.11.12).

Academics often argue that the expansion of public private partnerships (and other models of public-private collaboration) demonstrates a clear influence of international neoliberal models of health care in Brazil (Interviewee 13, 14.11.12). This position portrays bureaucracy as a business and its products as consumerist goods, i.e. the State stops hiring workers but instead buys work, in the figurative and literal sense (Interviewee 13,

14.11.12). This tilts the social justice scale towards the renouncement of social rights and the embracement of commercialisation by individuals (Interviewee 13, 14.11.12).

Health professionals in charge of implementing policy, on the other hand, criticise the political part local managers play in the further commercialisation of health which impedes full compliance with laws and programmes seeking to institute the human right to health (Interviewee 35, 15.11.12). Managers use their discretionary mandates to encourage the hiring of costly services through private establishments (Interviewee 35, 15.11.12). For example, mammography equipment is mostly located within the private sector while the ones that are in the public sector are not in use (Interviewee 35, 15.11.12). This demonstrates the excessive targeting based on primary health care and a simultaneous objectification of health and illness.

Similarly, policy makers point to three crucial failures of the public health system: (i) insufficient assets; (ii) inappropriate local management at municipal level; and (iii) failure to recognise good performance and dedication of personnel (Interviewee 30, 09.11.12). Out of the three, underfunding is indicated as the most serious one (Interviewee 30, 09.11.12). Members of parliament are unable to reverse this state of affairs due to a strong presidential role and its tendency to advance the centralisation of economic decisions, but the decentralisation of operational packages (Interviewee 30, 09.11.12). The solution, in their view, would be regionalisation (the organisation of the health sector in clusters) as opposed to the decentralisation (the transfer of responsibility to each individual federal entity) (Interviewee 30, 09.11.12).

Moreover, policy makers also recognise that progressive women's rights strategies are often co-opted by neoliberal policy networks. One respondent specifically uses PAISM as an example to say that:

“Holistic care [integralidade] is one of the challenges of professional practice, there are problems that go from inefficiency to failure. PAISM is an excellent idea that opted for a holistic practice. Comprehensiveness comprises above all the promotion, protection and recovery of health. Many defend it as the comprehensive care for health recovery [integralidade do cuidado de recuperação da saúde]. Also, we need to be less naive and acknowledge that economic interests also defend holistic care. I am pretty sure that the medical, industrial and commercial complex fight for holistic care even more than other technical sectors.” (Interviewee 6, 15.11.12).

Lawyers argue that the political strategy for the depoliticisation of the right to health is relentless (Interviewee 36, 27.11.12). They say that the right to health has been de-valued through a judicial praxis perpetrated by pharmaceuticals and private insurance companies looking at defining health provision in terms of consumerist logic (Interviewee 36, 27.11.12). In comparison, judges see the judicialisation of health, in particular reproductive health, as a way to expand the reach of existing legal definitions in the face of an increasing conservative parliament (Interviewee 21, 09.11.12). Some doctors that provide abortion services in public hospital also defend the increasing of links with the judiciary in order to guarantee the exercise of legal medical practices without moralistic influences and barriers (Interviewee, 11, 07.11.12).

Legal professionals, in general, defend the regionalisation of the health sector as way of creating a more efficient use of public resources with the creation of a support network based on geographical location and proximity (Interviewee 36, 27.11.12). This would in turn encourage the 'regionalisation of decentralisation' rather than the substitution of decentralisation by another model (Interviewee 36, 27.11.12). The problem in this argument is the mistaken assumption that resources are scarce when in fact resources exist but they are used for the promotion of market-oriented interests instead.

Feminists argue that health, women's health in particular, has become an election scapegoat (Interviewee 17, 19.11.12). Women's rights demands often collapse in the face of stronger claims made by the financially resourceful neoliberal policy networks and the politically resourceful religious caucuses (Interviewee 17, 19.11.12). Reproductive rights are therefore transformed into a bargaining chip with occasional and unpredictable progresses subjected to political appointments (Interviewee 19, 22.11.12). In this sense, feminists say that they do not see an alternative to decentralisation and often associate it with the promotion of horizontal programmes (Interviewee 19, 22.11.12). Although feminists may have a good point in rejecting vertical health programmes, this association between horizontality and decentralisation is artificial.

Members of international organisations advance the claim that holistic maternal health care is only attainable through a slow political process (Interviewee 40, 16.11.12). The key to their argument revolves around investing in health research as a means of promoting a health system grounded on a praxis based on scientific evidence (Interviewee 38, 01.11.12). These organisations nonetheless recognise a complete disregard to scientific

evidence in Brazil during the creation of public policy priority and the establishment of blueprints for investment (Interviewee 40, 16.11.12).

In a final analysis, independent of who may be deemed accountable for the system's failures, it is clear that control is relinquished generating a double benefit to political elites: the first being economic, arising out of contracts benefiting private companies usually bound to politicians; and the second political, originating in the power over codes and jargon that ruptures public policy cohesiveness and at the same time guarantees the maintenance of existing inequalities. This pattern towards commercialisation of health is not usually associated with decentralisation by actors but the importance of political strategies and control over policy space is recognised. In brief, decentralisation is curiously shielded from criticism or reflexive analysis and praxis is dissociated from the intrinsic values of the project pushing for health as a right.

The next section will attempt to establish that the use of decentralisation as a term and as a discourse was part of a neoliberal political project to push for further privatisation through the depoliticisation of the right to health and pulverisation of radical activism.

Decentralisation Term and Discourse as Neoliberal Political Projects

Institutions are the main site for the introduction of reformist discourse (Paim, 2003). All institutions, particularly those pertaining to health sectors, are inherently biased (Mackintosh, 2002). They embody ideas and values of a particular society and replicate them within its system and outside it (Mackintosh, 2002). For this reason, institutional change of ideas and values happen slowly and incidentally (Turshen, 2007). New discourses are therefore inserted into a political space populated by established and conflicting ideologies (Doyal, 1995). The success of any project geared at changing discourse lies in its ability to dialogue and appeal to existing ideologies and elite economic and social policy networks (Sikkink, 1991). Commonly, new discourses are framed in terms of existing ideologies not necessarily because of their alignment with their values or ideas but of their capacity to mobilise support (Sikkink, 1991).

In Latin America a few alternative economic models were perceived as available after WWII: (i) liberalism; (ii) developmentalism; (iii) national populism; (iv) and socialism. In the 1970s and 1980s a fifth model called industrialisation was added to the list (Sikkink, 1991). Both national populism and developmentalism emphasised import-substituting industrialisation and downplayed exports based on intense vertical policy making and centralisation of power (Weyland, 1996a). Both were simultaneously counter-hegemonic and hegemonic models of development (Sikkink, 1991). Arguably, a developmentalist model permitted continuity in economic policy making in Brazil as elites were more united around basic elements of a single model of growth (Almeida et al., 1999).

Neoliberalism has, in short, become hegemonic as a mode of discourse (Massey, 2013). The process of neoliberalisation entailed 'creative destruction' of previous institutional frameworks and powers and of traditional divisions (Harvey, 2005). That is, this process is completely devoid of ethical value appropriating and transforming discourse to gain legitimacy and to simulate an ethical realm of its agenda, maximising its reach and frequency of the advocated practices (Massey, 2012). The political-economic story of neoliberalisation explains the critical engagement with mainstream development discourse and serves as a framework for identifying its political and economic arrangements (Haas, 2010).

Neoliberalism introduces 'rational choice' to policy making (Harvey, 2005). Rational choice theories say that policy makers will choose policies that maximise their goals (promote aims) but there is no focus of preferences (survival - to stay in office and substantive - ideas that can be implemented by executive (Sikkink, 1991). In reality, survival and substantive strategies are inseparable and inform one another (Sikkink, 1991). Also, rational choice theories fail to acknowledge its political nature, that is, that a policy decision based in rational choice is just as biased and interest-driven as any other approach.

Thus, the construction of new discourse tends to ignore its primary task which must be to transform society and not to reform institutional development practice (Leal, 2010). Appropriation as leading to depoliticisation changes the meaning of key terms and reframes political strategising by legitimising the mainstream and de-legitimising the creators of these terms (Massey, 2013). That is when, in the words of Leal (2010: 5), "buzzwords become fuzzwords". Policy success becomes dependent on policy networks'

ability to include their demand on the mainstream agenda and also on their capacity to exclude others.

Decentralisation usually presupposes participation which also shares a quite contentious history. The use of the word participation echoes of colonial reformers and serves the pursuit of the neoliberal policy agenda being totally divorced from its radical roots (Cornwall, 2010). Leal explains that the term participation was created by counter-hegemonic radical social transformation groups but, throughout the 1980s and 1990s, as the term was legitimised and institutionalised by global development its radical proposal was changed into a neoliberal word reduced to a series of packages and techniques, slowly losing its philosophical and ideological meaning (Leal, 2010).

Tobar (1991) makes a distinction between the term 'decentralisation' and decentralisation discourse to argue that the term has become a 'political chameleon' that changes according to the interests it serves. In this sense, he contends that decentralisation discourse has spread more easily than the actual processes for the transfer of power (Tobar, 1991). An analysis of the historical uses of the term demonstrates that it has been polarised against centralisation in the different development models and the discourses associated with them and their particular economic strategies (McIntyre and Klugman, 2003). There is therefore a gap between the context in which the decentralisation process is presented and the form by which it is conceived politically, leading to a deficit in its legitimacy (Lakshminarayanan, 2003).

Lobo (1989) distinguishes three types of decentralisation: (i) horizontal, i.e. from direct administration to indirect administration; (ii) vertical, i.e. from top levels to lower levels of government; and (iii) State-society, i.e. civil society is attributed with the responsibility to deliver public services. Vertical decentralisation, which is the dominant in Brazil, only benefits federal entities that already have a well-developed and well-funded bureaucracy favouring monopolies and clientelism (Lobo, 1989). In the same sense, Tobar (1991) explains that the term decentralisation has not always carried a positive value. The author separates the views on decentralisation into two types: (i) a part of government bureaucrats that argued for efficiency and an organisational model that would promote economic growth; and (ii) a part of government bureaucrats that defended a model that took into account cost-benefit analysis for the optimal use of resources (Tobar, 1991). The

first were against decentralisation and any other models targeted at promoting the development of less privileged regions (Tobar, 1991). The later were in favour of decentralisation as they saw it as a necessary process for the improvement of governance and equitable distribution of resources (Tobar, 1991).

Although Tobar's division can be seen as problematic for the current scenario, he emphasises how the push for decentralisation in the 1980s by the World Bank and other UN agencies such as PAHO facilitated the diffusion of a positive discourse in defence of decentralisation (Tobar, 1991). This discourse was supported by a series of commissioned studies that afforded decentralisation an extra technical layer and appeal (Tobar, 1991). Tobar (1991) confirms Gideon's (2000) findings in Chile which concluded that in fact the term decentralisation is used to mean the deconcentration, devolution and delegation of power interchangeably. Tobar (1991) argues that at first sight this arguably unimportant use of all three concepts without any distinction may seem harmless but, in truth, it is part of a political strategy (or strategies) consciously geared towards removing transparency from these processes.

Frequently, decentralisation is in its many discursive formats only entails the transfer of administrative power and responsibility with no corresponding transfer of financial and human resources (Gideon, 2000). Decentralisation discourse argues to have reformist intentions through reform but in fact it promotes reform with an intention to give continuity to the dominant social system (Atkinson, 1995). Decentralisation can be instrumental to a wider and bigger political project aimed at achieving equality in health, but transparency in terms of the real intentions behind decentralisation is necessary for the real transformation project to move forward (Cornwall, 2002). Decentralisation may serve democratic values if indeed intrinsically pursuing these values (Cornwall, 2002). I, however, argue that decentralisation may not always be the best organisational format for certain health care sectors specifically because of the democratic plurality created by the new spaces of policy making, albeit that political places are devoid of any politicisation. Rather than a technical tool, decentralisation is very much of an administrative toy for the political elite. Decentralisation serves mechanisms that reinforce the apparatus of domination and control of political elite over individuals.

Decentralisation multiplies the spaces for negotiation which require more resources and sophistication on the part of networks of interests (Lakshminarayana, 2003). It serves to protect the central power because decentralisation is coupled with a discourse of modernisation of the State (Mayhew, 2003). Moreover, it is often accompanied by the: (i) privatisation of public services; (ii) third party contracting or delegation of public responsibilities of market forces; and (iii) establishment of taxes charging the use of public services (Tobar, 1991). These initiatives act in opposite direction to equality. Decentralisation is therefore unveiled as neoliberalism's answer to the Welfare State crisis (Tobar, 1991).

Conclusion

This chapter demonstrated through the analysis of secondary literature and interviews with key actors that decentralisation of the health sector in Brazil led to the transfer of responsibility from the national to the local levels reducing the levels of accountability and creating more space for the participation of private companies in the provision of health care. It traced the history of the administrative decentralisation to confirm that this was in fact a colonial political project that was solely aimed at developing the market and improving efficiency levels. However, with the diffusion of the term to national elites, decentralisation became a symbol of political resistance and opposition to authoritative forms of government. The same dichotomy was observed in the transition to democracy when decentralisation was included as one of the principles of the sanitary movement for health reform.

This analysis also deconstructed assumptions surrounding federalism and decentralisation as mutually reaffirming organisational models. It used secondary literature to establish that federalism actually incurs in the deterioration of services by fragmenting the implementation of programmes and policies and increasing the competition among federal entities, particularly between the states and municipalities. In a sense, rather than reclaiming the importance of decentralisation, the analysis of federalism indicates that in fact it negatively affects it. Decentralisation is usually unchallenged in federal government

leading to an uncritical distribution of responsibilities with no accountability and no attention given to the replication of existing power inequalities.

Moreover, this chapter discussed the role of policy spaces and depoliticisation in the decentralisation of health services. It advanced the theory that decentralisation creates new spaces for policy making and implementation which then requires a change in political activism and strategising. The multiplicity of spaces then demands more resources and more sophistication from policy networks to guarantee presence and influence. The sophistication in policy spaces is often expressed with an equally daunting 'technical' requirement. That is, to participate in and to discuss at a particular policy space one must be proficient in the jargon of the field and its ever changing status. This impairs less resources policy networks and depoliticises certain issues by placing them under the veil of 'technicality'. This is particularly detrimental to reproductive health services which have, throughout history, been placed in contentious policy arenas where powerful and sophisticated policy networks pressure for its depoliticisation and its use through a reductionist approach to rights.

This chapter also analysed the privatisation of health care in Brazil and established that the implementation of decentralisation of the health sector in Brazil was always coupled with a market driven discourse and practice, whereby private sector companies were perceived as better health providers and therefore public incentive was given for their expansion through purely private and/or public private partnerships. This consolidated the previous model of care while taking appropriation of a health and democracy discourse.

In conclusion, this chapter established that decentralisation was in fact appropriated by the mainstream neoliberal policy networks and transformed in order to become more suitable to market-driven interests. This appropriation, transformation and re-appropriation have not occurred in a transparent or even visible manner. The lack of transparency, coupled with the effects decentralisation actually had on political activism, considerably depoliticised the women's rights agenda and impaired progressive strategies for the promotion of maternal health.

Chapter VIII - The Trouble with the Curve: Conclusions on the Implications of Health Sector Reforms for Reproductive Health and Rights

Introduction

This thesis looked at how the different policy networks pushing for a women's rights agenda participated in the framing and use of social justice discourses during the 1980s and 1990s health sector reforms in Brazil and how it affected maternal mortality reduction strategies. Focusing specifically on maternal mortality, the thesis explored: (i) the way coordinated social policy making, implementation and state institutional capacity changes maternal health activists' discourses; (ii) explains the reason why the implementation of the decentralisation programme was different from its philosophical constructions created by social movements, and why, at the municipal level, its praxis has become closer to neoliberal reforms' rhetoric; and (iii) to what extent the different institutional levels (global, national and municipal) affected the specific characteristics of the reform's policy programme, and its overall effects in the interplay between the human rights-based approach as a technical tool and its ethical origins, i.e. human rights as a political project for social justice.

To address the questions exposed above, I conducted a historical mapping and policy analysis of health policies related to women's rights, maternal mortality reduction strategies and decentralisation in Brazil. The historical mapping done through the analysis of policy documents and academic literature was complemented by an in-depth case study. The case study was composed of a series of forty seven individual interviews with key policy actors - academics, policy makers, policy implementers (medical and legal professionals), activists from the women's rights movement and members of international organisations - who participated or still participated in policies and programmes related to the 1980s and 1990s health sector reforms, with an emphasis on maternal health and/or mortality. All interviews were carried out as a way to understand the nuances in political activism related to the processes of decision-making and implementation of maternal

mortality reduction policies and programmes in Brazil. The results arising out of individual interviews re-asserted one another as if constitutive of a series of individual case studies. In light of the common results arising out of all interviews, I proposed the use of a Foucauldian discourse analysis as a necessary feminist approach to the study of power and the production of knowledge. That is, I used feminist Foucauldian literature to argue that it is crucial to trace *the background of?* discursive processes in order to understand the modes of production, the meanings of, and the control of knowledge. I also explained that this method of analysis of discourse not only requests us to distinguish between the different positionalities, but also to adopt a clear and specific positioning as a way to improve feminist scientific and political knowledge. In sum, to adopt a feminist Foucauldian approach means to reject all 'truth' claims, including ours as researchers, and understand that all academic work is also a type of discourse that departs from a particular political standpoint, in this case a feminist standpoint. In this sense, by looking at ideas and exclusions and exclusionary effects, one is capable of thoroughly analysing the role of networks and processes influencing social policies. This in itself is capable of expanding the feminist agenda for more transparent and inclusive knowledge production that is necessary in advancing feminist claims for social justice.

In this sense, the analysis arising out of the wider case study was able to lead to a series of conclusions on the policy implications of using social justice discourses for the decentralisation of maternal health and women's rights. Furthermore, by answering the above-mentioned questions with such an innovative methodology, the analysis was able to confirm the research's hypothesis. That is, the use of social justice discourses in mainstream policy debates and by women's rights policy networks contributed to the marginalisation of reproductive health and impaired the implementation of maternal mortality reduction strategies in Brazil in the last three decades. The next sections summarise the key findings with a brief description of the goals achieved by each chapter while at the same time reassessing the key findings in detail; and conclude by highlighting the importance of this research in establishing the way forward for feminist research and praxis.

Previous Chapters and their Role in the Production of Feminist Knowledge

Women's movements have been increasingly important in policy making and politics in Latin America (Haas, 2010). The effectiveness of women's rights strategies is very reliant on strategies, perceptions and contexts (Mesquita, 2011). Yet, studies on women's movements often cloud the problematic assumptions impinged upon these movements by the development literature; and the tendency to marginalise discussions on the political and institutional context in which their strategies are inserted into (Molyneux, 1998). There are many types of women's movements, progressive and conservative, and not all of them are associated with demands for full citizenship and equal rights (Molyneux, 1998). When women's movements in special feminist movements make use of discourses on citizenship and rights (universal rights of citizenship or international human rights) they do so by associating themselves with an agenda for social reform (Molyneux, 1998). The different uses of these discourses prescribe priorities which lead to different results.

Considering this gap in the literature, and while analysing the results arising out of a carefully constructed case study looking at women's rights strategies aimed at reducing maternal mortality in Brazil, the previous chapters have been able to establish four arguments not only linked to women's human rights activism but also applicable to the wider human rights movement. Firstly, the adoption of a political philosophy of rights into mainstream development discourse tends to obscure the differences that need to be drawn between human rights and human rights-based approaches (Cornwall and Molyneux, 2006). Development praxis fails to distinguish between the instrumental value of human rights-based approaches versus the intrinsic value of human rights and their capacity to advance the human rights project (Cornwall and Nyamu-Musembi, 2004). There is a wide diversity of rights-based approaches which do not necessarily abide by human rights principles and objectives, and secondly there are considerable challenges and limits to human rights implementation, even in the case when they do abide by principles and objectives (Beracochea, Evans and Weistein, 2010).

Secondly, human rights discourses are often appropriated by conservative networks that have completely different principles and objectives from the ones advocated by radical

human rights activists. In the context of fieldwork I observed that approaching health sector reforms in terms of mainstream concepts such as decentralisation and efficiency (as it is usually associated with decentralisation), and all their neoliberal underpinnings, is not always useful as these concepts often conceal neoliberal government's hidden purpose of advancing elitism and privilege while gaining legitimacy through the instrumental use of progressive language. For example, in theory, efficiency and decentralisation (in their most progressive formats) could help advance social equality (Petchesky, 2003). However, efficiency and decentralisation, like many other terms subjected to the pressures of neoliberal times, have been reshaped and repackaged as a purely technical standard for policy framing and decision making (Petchesky, 2003; Massey 2011). As a result, these terms are coupled with equally problematic constructs. For instance, vertical programmes' cornerstones lie in efficiency-driven tasks and goals (Atun, Bennett and Duran, 2008). Notwithstanding, vertical programmes' ability to achieve efficiency (narrowly conceptualised) makes it impossible for us to reject them all together. This is because categories are artificially placed in oppositional terms. That is, and making use of the same example, vertical programmes are presented as the only alternative to horizontal programmes. These reductionist approaches diminish oppositional proposals by discrediting their ability to deliver on efficiency at all. Indeed, horizontal programmes are not able to, and should not, achieve changes so rapidly (Atun, Bennett and Duran, 2008). Moreover, no attention is given to the fact that the use of narrow forms of efficiency as a parameter is only relevant if instrumental to something else more valuable, such as human rights as a social justice project.

In addition, substantial research has already demonstrated that this obsession with health sector efficiency has led to a series of unsuccessful organisational reforms in Latin America in the 1980s and 1990s (Mesa-Lago, 2008). For instance, decentralisation was advanced as an underlying social justice premise and a necessary 'technical' aspect of health sector reforms in the region (Collins, 1989). This, however, was done without any critical political appraisal (of decentralisation as a neoliberal political project) or deconstruction (of its real effects at the local level) (Collins, 1989). In spite of the mainstream rhetoric, political elites do not promote decentralisation for social justice purposes, but in reality do it in order to advance clientelistic interests and networks (Atkinson, 1995). While situating the Brazilian case in terms of broader debates in the literature, I was able to observe from my field study that the use of these neoliberal

concepts furthers political elites' interests by shifting the discussion of health sector reforms from political values to technical and depoliticised terms and parameters. However, if we are, and I would assume here we all are, serious about pushing for real social equality in health, should we not use social justice as the marker (or parameter) rather than (now) empty concepts such as efficiency and decentralisation?

Thirdly, my empirical findings demonstrated that the policy analysis of health sector reforms should be expanded beyond formal spaces and process in order to also include informal spheres; from governmental institutions and political organisations to networks and groups of interest. In this sense, looking at the informal rules in place in informal spaces and the processes by which these rules operate would provide us with a better insight into what is often an invisible side of policy making and implementation (Baptista and Mattos, 2011b). In addition, I believe that assessing these issues from different, and perhaps less politically charged platforms, such as the analysis of policy spaces, could enable a different kind of discussion and theoretical construction into what are the real constraints and possibilities of strategies focused on improving health outcomes (Tendler, 1997; Massey, 2006). This dual analysis of informal spaces and processes, coupled with the analysis of formal spaces and processes, provide a better reading of the use of social justice discourses in practice and can therefore trace the effects of such discourses as well as the visible and invisible changes imposed on them.

More specifically, neoliberal policy spaces, in other words those spaces that co-exist with neoliberalism as a hegemonic doctrine, display social relations while displacing them in favour of market-oriented interests (Corwall, 2002). Representations of production as a hierarchically superior activity versus reproduction as inferior, conceal all the complexities of reproduction itself: reproduction in a biological sense; in terms of replication of labour classes; and in relation to social relations of production (Marston, 2000). That is, the role of the space in the ordering of things is concealed so as to impose a particular neoliberal 'knowledge' on society (Lefebvre, 1991). The representations of these spaces are embodied in mainstream discourses which are coded with 'technical' language (Culpepper, 2002). This symbolism divides discourses into those that are accepted, and in this sense overt, frontal and public and those that are not accepted, and therefore characterised as transgressive (Flinders and Buller, 2006). Rather than embracing a multitude of

intersections, policy spaces serve to further exclude marginalised voices by legitimating and fetishising a particular set of values (Foucault, 1991).

I therefore contend that to decentralise without recognising the gendered dimensions of health sector, and of every space really, is to accept the replication of embedded inequality that is legitimised through the discourses promoting health sector reforms in the first place (Doyal, 1995; Massey, 2006). The overestimation of the structural reform's capacity to deliver on its promise to reduce the democratic deficit is nothing more than a fallacy (Mackintosh, 2002). The use of discourse on space (physical and non-physical) leads to a spatial practice (and also the other way around) that multiplies sites of exclusion and amplifies the potential of dogmatic replication (Standing, 1997). That is, if space is not considered in its totality and for its social dimension, it will never be capable of subverting the current status of subjugation of one social group by another.

Finally, fragmented models of promotion of health based on particular segments of society (such as the promotion of primary health care for all but secondary and tertiary health care only to the well-off) tend to be based on an idea of reforms as enablers of social inclusion through the expansion of global citizenship that is socially constructed (Abouharb and Cingranelli, 2007; Turner, 2008). This is problematic because, from its conception, social citizenship was directly associated with economic production and therefore for many years dominated by men participating in the formal labour market (Turner, 2008). This patriarchal and capitalist heritage meant that frameworks based on the notion of social citizenship were doomed to replicate the same inherently unequal values and objectives (Turner, 2008). This is the case of mainstream development frameworks; these rely on a type human rights discourse that is tied to a heterosexual, patriarchal and neoliberal view of citizenship which reproduces a political society that only affords a secondary role to women (Turner, 2008; Roseneil et al., 2013). As a result, the failure to deconstruct this partial approach to human rights impedes any systematic thinking about family, reproduction and citizenship and their correlation to individual entitlements/rights (Roseneil et al., 2013). Thus, as mainstream development is grounded on a human rights-based approach based on a socially constructed notion of citizenship, it (intentionally and/or unintentionally) tends to provide moral cover for processes already put in place but whose existence should actually be questioned (Almeida, 2002). Even more, it leads to fragmented programmes that create a blueprint for health care that take for granted the

complexities inherent in each context where these are applied and, therefore, promote an unexpected (and unwanted) shift in individual and collective subjectivities (Berry, 2010). By controlling discourses around biological processes, the State is able to use these programmes to produce self-disciplining subjects that do not threaten the State's (and political elites') power (Agamben, 1995). That is, policy elites subvert the principles and objectives of the radical human rights project in order to guarantee the unequal *status quo* from which they benefit from. In sum, influencing discourse around biological processes is a mechanism that the neoliberal State uses to produce subjectivities that are able to be subjugated (Marston, 2000). This is because biological processes and discourses hold a privileged position in subject-making and pregnancy and birth are the most important sites for shaping this subjectivity (Foucault, 1980).

The four key findings are further explored in the following sections. More specifically, the next section briefly discusses all previous chapters and their importance in understanding maternal mortality strategies while answering to Shiffman and Smith's (2007) theoretical framework. Then, there are four separate sections highlighting the details of the four key findings. These sections are succeeded by a discussion of the importance of the key findings for future research and feminist praxis. The last section then summarises the conclusions established by the previous chapters and connects them to the affirmatives above.

Recalculating: The Importance of Analysing Women's Rights Movements in Health Sector Reforms as a way for a Better Policy Praxis

In spite of recent social policy reforms, inequality is still widespread in Latin America (Stepan, 1991; Weyland, 1996b; Hoffman and Centeno, 2003; Homedes and Ugalbe, 2005; Mesa-Lago 2008; UNDP, 2010). Although 'the Brazilian myth' is often constructed and advanced by international actors such as the World Bank, careful research (including those reflected on international reports) demonstrates that in reality Brazil's social policies

are conflicting and paradoxical (UNDP, 2010). The government of Brazil has implemented a series of policies aimed at the reduction of social inequality (Sánchez-Ancochea and Mattei, 2011). These policies are part of a wider political package proposing poverty reduction measures such as conditional cash transfers including the Bolsa Família (Sánchez-Ancochea and Mattei, 2011). The promises and expectations on the capacity of these programmes of actually tackling the poverty gap in the country were and are numerous. However, the rhetoric of change has not been accompanied by a comparable positive development and impact (Chant, 2006). One of the shortcomings of conditional cash transfers, and the poverty reduction packages promoting them, is that they perpetuate inequality by reinforcing socially constructed roles, in particular asymmetrical gender roles (Molyneux, 2007). Hence, although Brazilian poverty reduction packages have been named as an example of success by some international actors such as the World Bank, thorough research has established that these policies will only result in long term and structural change if coupled with a real commitment to the reduction of inequality (Sánchez-Ancochea and Mattei, 2011). In sum, poverty reduction packages will only work if populist attitudes are drastically changed in favour of political inclusive strategies benefiting lower classes and historically marginalised groups.

In Brazil, political activism for the reduction of health inequality has been oriented by egalitarian philosophical constructions such as universalism (Molyneux, 2007). The literature on this suggests that despite the introduction of regulatory measures to increase efficiency and reduce inequalities in the health sector, health care access and provision remains extremely unequal across the country (Diniz, d'Oliveira and Lansky, 2012). Some research even suggests that recent reforms have in fact contributed to the increase of inequalities and problems in the health sector (Almeida et al., 2000; Almeida, 2002). Over the past decades, health interventions have reached almost universal coverage (Diniz, d'Oliveira and Lansky, 2012). However, people in vulnerable and lower income groups experience more difficulties in getting access to quality services and women are still disproportionately affected (Diniz, d'Oliveira and Lansky, 2012). In fact, health policies defining and dealing with motherhood are embedded in sexist and racist values (Galli, 2002).

Brazil has made significant progress in tackling challenges in some areas of the health sector and some indicators have improved and benchmark standards met (Almeida et al.,

2000). In particular, successful policies have been identified in areas dedicated to programmes such as HIV/AIDS, immunisations and child mortality (WHO, 2003). Despite broader economic growth in Brazil and a public budget that grows accordingly, reproductive health indicators have remained poor (WHO, 2010). Access to most maternal health interventions increased sharply while regional and socio-economic disparities decreased notably (Diniz, d'Oliveira and Lansky, 2012). However, although the country has the capacity of reducing maternal mortality rates, it has not expressed a sincere commitment in dealing with the issue (Almeida, 2002).

In this sense, and in order to deconstruct the 'Brazilian myth' as explained above, Chapter I highlighted the importance of unpacking the use of human rights approaches, mapping the different human rights discourses, and determining their effects over discourses and strategies pushing for the reduction of maternal mortality. This chapter also explained that the research hypothesis predicts that reproductive health services have been marginalised by the Brazilian health sector reform processes and that this affected the maternal mortality reduction initiatives over the past three decades. Chapter I identified Shiffman and Smith's (2007) framework as a key to the systematic analysis and therefore the understanding of the existent power dimensions between and within the discourses used by the different policy networks promoting decentralisation in health sector reforms in Brazil. It identified Shiffman and Smith's (2007) model as a theoretical framework for the thesis by noting the importance of analysing maternal health and priority setting through the scholar's list of four aspects explaining the complexities related to political activism around this issue. The four aspects are related to: (i) the strength of policy networks; (ii) the ideas supporting their political activism; (iii) the context in which this activism is inserted into; and (iv) the characteristics of the issue they seek to address (Shiffman and Smith, 2007). These aspects were key to the chapter's analyses and for this reason were the main themes of four chapters, Chapters IV, V, VI and VII.

Chapter II discussed existing scholarly debates in order to construct a system of interlocking theories drawing on a process of interpretative social policy and Foucauldian discourse analysis. This system of interlocking theories sought to determine why reproductive health services in Brazil have not benefited from the supposed advantages of decentralisation. It situated the Brazilian case study within wider debates of health sector reforms in Latin America, inequalities of access in health care and its implications on

women's right to health and gender equity (Bossert, 1998; Atkinson et al., 2000; Ewig, 2010). It explored how transnational, national and local policy legacies and epistemic communities are important in influencing the use of a reproductive rights discourse and its association (or dissociation) with a population control agenda (Doyal, 1998; Shiffman et al., 2004; Bloom and Standing, 2008; Ewig, 2010).

In this sense, Chapter II clarified that, while all of the main chapters were oriented towards answering within Shiffman and Smith's framework (2007), they all tried to identify the three main characteristics that determined the success or failure of maternal mortality initiatives: (i) maternal deaths are not as common as other high-burden disorders such as HIV/AIDS and malaria; (ii) accurate measurement of maternal mortality is technically difficult; (iii) the interventions to avert maternal death are not as simple and cheap as other health-related problems such as diseases preventable by vaccines. Chapter II also highlighted a crucial point that was not included in Shiffman and Smith's framework (2007); this relates to the inability of the international community to afford real value to health initiatives that benefit women only without dealing with women as an instrumental value to something else such as childbirth or childrearing.

Chapter III complemented Chapter I by explaining the methodological tools that were used to test the aforementioned research hypothesis. It explained that a case-based study was the method chosen for collecting empirical data and that this method aimed at providing an empirically-grounded explanation for the marginalisation of reproductive rights from health sector reforms design and implementation (Mitchell, 2006; Small, 2009). It also noted that feminist standpoint epistemology and interdisciplinary feminist research (or feminist theories of intersectionality) was used for the analysis of the data collected (Martin, 1987; Haraway, 1991; Harding, 1993; Letherby, 2002; McCall, 2005; Hesse-Biber, 2007).

Chapter IV analysed the strength of maternal health policy networks, factor one of Shiffman and Smith's (2007) framework. It discussed the international and regional maternal mortality initiatives particularly in terms of feminists' political strategies and participation in policy making and all the correlated demands for policy change. The chapter traced the different political strategies implemented by the women's movements aimed at institutionalising women's integral health care principles and practices globally. In the first section, there was an outline of the global context and the efforts aimed towards

maternal mortality reduction, mainly the key United Nations conferences and strategies and the reductionist approach created by the Millennium Development Goals.

Chapter V attempted to understand the role of ideas in building internal consensus and gathering external political support, factor two of Shiffman and Smith's (2007) framework. It outlined the Brazilian context, the current status of women, its demographic transition, the national programmes and feminist's political strategies. It discussed Brazil's public policy agenda and mainstream discourse versus the real effects they have had on overall public health, and more importantly, on maternal mortality rates. It relied on the results collected from interviews performed with key actors of the public health movement. In doing so, it argued that in spite of their best endeavours, feminists' late engagement with maternal mortality discourse and policy making allowed space for the expansion of conservative politics and a step back in the health and human rights agenda, which in itself led to a slow reduction of maternal deaths. Its final section concluded that despite formal legal measures put in place, maternal mortality rates are now reduced at an incredibly slow pace. Moreover, as maternal health, a political space for dispute and contention, became more and more populated by conservative religious caucuses, public health policies took a turn for the worse; essentialising women and failing to tackle the real problems behind health inequality.

Chapter VI established the importance of the social, political and historical contexts for social policy making, factor three of Shiffman and Smith's (2007) framework. It presented the history of the pre-1980s as well as the 1980s and 1990s health sector reforms, its policy networks and policy making. It sought to compare the objective of health sector reforms with the real impacts they create. In the period of HSRs between the 1980s and the 1990s, welfare state practices oriented by solidarity principles were replaced by neoliberal theories emphasising individual interests and efficiency (Koivusalo and Ollila, 1994). In Latin America, this meant the pursuit of cost-effectiveness and the change of service delivery by including public-private initiatives, private companies and non-governmental organisations (Mesa-Lago 2008). In Brazil, SAPs rhetoric influenced the decentralisation of the provision of public health services in 1984-1988, so to: (a) transfer responsibilities, administration, and implementation of social programmes from the national to state, municipal levels and private providers; (b) create social control of the allocation of public social expenditures to better reach vulnerable localities and groups; (c) enable social participation in policy making and implementation; (d) to promote economic

development in an equitable manner; (e) integrate regions; and (f) use limited resources more efficiently (Rondinelli, 1981; Iriart, 2004). This chapter looked at interviews with key actors of the public health reform movements in order to establish that the feminist movement was marginalised from mainstream health sector reforms' policy making and implementation, including decentralisation processes.

Chapter VII traced the characteristics of maternal mortality as a political issue, factor four of Shiffman and Smith's (2007) framework. It enquired who benefits from decentralised maternal mortality services and strategies. It discussed the partial privatisation of health particular to the Brazilian context in order to situate the knowledge acquired on health sector reforms and to understand the implementation of decentralisation as the 'magic bullet'. This chapter demonstrated through the analysis of interviews with key actors that the decentralisation of health led to the transfer of responsibility from the national to the local levels reducing the levels of accountability and creating more space for the participation of private companies in the provision of health care. Chapter VII deconstructed neoliberalism and its different phases of implementation as a way of understanding how market-driven forces and projects such as the Washington consensus and post-Washington consensus have influenced new neoliberal policies and health sector reforms in Latin America. It also addressed emerging discourses on pro-poor economic policies, federalism and fiscal retrenchment by positioning these issues in terms of the current Brazilian health system and wider distributive social policies. This chapter demonstrated through the use of literature review and the analysis of interviews with key actors that the blind support gathered around decentralisation strategies failed to acknowledge the indirect consequences of implementing it in a country as diverse and unequal as Brazil.

In light of all the findings mentioned above, the following section will map out the different policy networks working with maternal health policy in Brazil in order to situate them, in the subsequent section, in terms of the different discourses that conflict and impede an homogeneous agenda setting. Most importantly, it highlights the veiled character of some of these discourses and its importance for feminist praxis.

Driving Forward: Reassessing Human Rights Discourses for the Advancement of a Feminist Agenda

As this thesis demonstrated, health sector reforms in Latin America have produced diverse outcomes for reproductive health (Cottingham et al., 2010). Reforms were either positive and/or negative to reproductive health (Almeida, 2002). However, given that general health reform analysts usually do not share the values of reproductive health advocates, the negative effects of reforms seem to be highly prejudicial to women's reproductive and sexual health, as well as their general wellbeing morbidity and mortality (Lubben et al., 2003). Most, if not all, Latin American countries have reported to have had overall negative experiences in terms of achieving effective reproductive rights and well-being (Meier, 2010). That is because reforms normally aim to overcome weak management structures and lack of performance incentives, leaving essential reproductive programmes aside (Berer, 2002).

Taking this into account, I traced the history of the human right to health in order to dissociate it from a praxis using a human rights-based approach. I argued that while the human right to health is linked to a social justice project that can be traced to fundamental rights' radical activism, the rights-based approach is associated with a more recent mode of health promotion that is based on technicality and depoliticisation as a strategy. In order to explore this affirmative, the previous chapters analysed the historical trajectory of maternal mortality reduction strategies by discussing the national programmes and institutions created for the promotion of women's right to health in Brazil. It noted that feminists strategically articulated with the leftist movement for health reform in order to establish consensus around a new conceptualisation of women's health care. This strategy was capable of institutionalising this discourse through the creation of a progressive programme (PAISM) and its subsequent policies. However, a brief reading of the history of the institutionalisation of the discourse for women's integral health care demonstrates that this strategy was not capable of building a bridge between policy making and implementation.

As already mentioned, Shiffman and Smith's (2007) framework for determining the capacity of global maternal health initiatives to achieve political priority status was used to inform the theoretical thread of this thesis. Shiffman and Smith's (2007) model analyses political strategies in terms of four aspects: (i) the strength of political actors; (ii) the role of ideas in portraying the issue; (iii) the context in which these strategies are inserted into; and (iv) the characteristics of the issue and its position in relation to other interventions that affect the proposed means of addressing the issue. This thesis was organised so that each of these aspects were explored in detail in a separate chapter. These aspects helped me to systematically organise and analyse the data available. In turn, this in-depth analysis resulted in the four key findings I repeatedly mention throughout this conclusion. However, before pointing out the thread that unites these findings and its importance to social policy research, I will shed light on the networks that are identified and on the main discourses I speak of. I do this because I think these key findings are intrinsically related to the policy networks participating in social policy and the discourses advanced by these same networks,

Realpolitik: Policy Networks' Interests, Values, Professional Concerns and Hidden Agendas

As noted in Chapter I, the networks dealt by this thesis were divided and analysed through the division of key policy players in five separate policy groups: (i) policy makers participating in the government's bureaucracy; (ii) health and legal professionals in charge of implementing health policy; (iii) women's rights advocates (feminists and non-feminists); (iv) researchers; and (v) members of international organisations (UN agencies and non-governmental organisations working at the global level). However, it is crucial to note that, as demonstrated in Chapter V, for example, all networks could be broken down into schools of thought or advocacy. Indeed, for the purpose of this analysis, I highlighted the different streaks that I noticed in women's rights advocacy in Brazil. By doing this, I observed that women's rights advocates could be roughly divided into those working with: (i) freedom of choice and legal abortion advocacy; (ii) activism for the humanisation of birth; and (iii) demands for the visibility of issue of widespread violence – domestic, sexual and/or institutional.

I also noticed that these categories are as useful as they are limiting. That is, in dividing activists into their political focus, I was able to identify the conflicts that exist in between these groups but at the same time I failed to encapsulate the flexible and ever-changing positions these activists usually hold. Feminists are usually identified as freedom of choice and legal abortion advocates but this does not mean that feminists do not work within the realms of humanisation of birth and/or of widespread violence. They do work within those streaks but dedicate less energy and resources to these. In this sense, these policy networks that I mention here are mostly about thematic focus and strategies arising out of the exercise of their political positions. Subsequently, the fact that I did not divide the other policy networks into different streaks does not mean that they do not exist. I merely thought that these were not relevant to this analysis. In fact, I did take these differences into account during my interviews and analysis as I think that it is in acknowledging these nuances that we may become better equipped to efficiently advance a comprehensive human rights agenda.

Moreover, Shiffman and Smith's (2007) framework is mainly concerned with collective action and its capacity to subvert existing power structures. The scholars point out that the power of actors connected, defining and describing maternal health as an issue is crucial to inhibit and/or enhance political change (Shiffman and Smith, 2007). This aspect is divided into four factors: policy networks' cohesion; leadership; guiding institutions; and civil society mobilisation. Using this framework as a guideline, I was able to notice that the historical trajectory shaping the interests, values, professional concerns and hidden agendas of each policy network was very important in determining the type of discourse advanced by them as the way these networks chose to advance these same discourses. For example, as noted in Chapter V, women's rights advocates tend to be the most vocal and transparent group out of all these networks, feminists, in particular. Radical feminists have, for instance, a tradition of not shying away from controversial discussions and demands and are often quite upfront about the fact that they are usually in opposition to the mainstream. This generates resistance from the mainstream and considerable backlashes from conservative right-wing groups. Feminists, as a larger group with varied feminisms, are taken as too progressive and portrayed in a negative manner by, for example, ultra conservative religious organisation, and are not only challenged for their opposition to the mainstream but for their advocacy of sexual and reproductive rights. So although not all feminist strategies are available to the public, their political standpoint is.

This, in my opinion, serves as an example to other policy networks of the type of political transparency that is necessary to human rights discursive praxis and policy making. The importance of transparency will become more evident in the subsequent sections which analyse the different discourses and their impact on sexual and reproductive rights.

Wrong Signals: Main Discourses Identified, Neo-Malthusian Networks and their Influence over an Overarching Policy Discourse

I was able to notice that all five separate policy networks were in one way or another related to a Neo-Malthusian discourse; either by rejecting it, by accepting it or by pretending to reject it, while in fact pushing for it. In that regard, following that as a parameter of analysis, I could roughly divide the discourses rejecting Neo-Malthusian values into a part: of women's rights advocates, i.e. feminists; of health and legal professionals, i.e. collective health advocates; of researchers, i.e. collective health researchers and a great part of human rights researchers; and of members of international organisations. Secondly, the discourses openly accepting Malthusian values were the ones associated with conservative policy networks such as: a part of women's rights advocates; a great part of the movement for humanisation of birth and a smaller part of the movement against all forms of violence against women; a considerable part of health and legal professionals, particularly self-identified with the social hygiene movement or with an orthodox religious organisations; and an increasing number of policy makers who are associated with as orthodox religious organisations. Lastly, the discourses that reject Neo-Malthusian values while in fact advancing them were: the majority of the policy makers participating in the government's bureaucracy; the majority of members of international organisations; a part of the women's rights advocates, in particular from within the movement for humanisation of birth; and some researchers. Moreover, these discourses competed with and/or were internalised by other discourses such as: the one defended by some members of international organisations, legal professionals and human rights researchers who see human rights as a radical project for equality (Vasak, 1977); the one created by collective health researchers and advocates defending health reforms as an enabler of social inclusion (Standing, 1997); the one fought long and hard for by feminists creating a political project for the transformation of unequal power relations (Fraser, 2013);

or the one advanced by most policy makers using the idea of a modern nation-State for legitimacy purposes (Stepan, 1991).

This pervasiveness of Neo-Malthusian discourses can be traced back to the history of the eugenics movement in Latin America (Stepan, 1991; Boesten, 2010). As Stepan (1991) argues, the Latin American example is relevant as it challenges common understandings on eugenics and therefore the political construction and praxis of Malthusianism and neo-Malthusianism. These examples, in Stepan's (1991: 3) words, give us "an expanded sense of the parameters of eugenics". This is certainly the case of Brazil. In Brazil, as in many countries of the region, motherhood was instrumentalised by the eugenics movement in its historical trajectory of nation building (Stepan, 1991). In this sense, population policies in Brazil have always been linked to an ideal of the modern State and of the ideal citizen (Stepan, 1991). This idea of the ideal citizen was often based on a European heterosexual and patriarchal model of the family (Oliveira, 2003). This European model was transplanted to the local scenario during the colonial period and sedimented in the post-colonial period with the rise of eugenics theory (Oliveira, 2003). As the eugenics movement gained space in Brazil, so did its influence over Brazilian policies (Oliveira, 2003). Basically, Brazilian eugenics was based on the so-called 'whitening theory' ('teoria do enbranquecimento') which demands that people from African descent reproduce with those from European descent in order to create a mixed race offspring which in their view would be a more 'acceptable' race (Oliveira, 2003: 60). This discourse was coupled with the one for the creation of a modern nation and was based on the triple association sanitation-eugenics-civilisation (Oliveira, 2003). This 'moralising hygiene' saw public health as a site of control, and lower income black people as the subjects of this control (Oliveira, 2003: 81). In this sense, maternal health as a site of resistance against gender and racial inequality suffered from the influence of the eugenics movement which transformed the landscape of State and of maternal health policy making to the large detriment of the black women's movement (Tosold, 2007).

The Obscure Adoption of a Political Philosophy of Rights: The Fuzzy Relationship Between Intrinsic and Instrumental Values

There were several international conferences recognising the strengthening of health services for the delivery of basic health care with regards to the high levels of maternal mortality globally. The linkages and affinities between the organisations forming the policy network responsible for creating global human rights standards for maternal health was never very clear. Institutions such as the WHO, UNFPA, UNICEF and the World Bank have very different mandates and approaches to human rights. Also, these organisations are to different levels more or less volatile to internal divisions and/or external influences which determine their ability to fulfil one linear process towards the achievement of a goal. For maternal mortality strategies, this meant that international conferences have always suffered from changes in paradigms, at times portraying maternal health as an intrinsic value and at others as instrumental, i.e. rejecting Neo-Malthusianism or accepting it, purposefully or not.

The most important global maternal mortality strategy to this date is the 1987 Safe Motherhood Initiative. It was created by the WHO, UNFPA and the World Bank and was launched in eighty countries across the globe, including Brazil. Although the Safe Motherhood Initiative was capable of building political momentum around maternal health, it did not provide the strategy with a charismatic and respected leading figure. This affected the continuum of measures and networking driving the central strategy forward. Additionally, as a result of lobbying performed by World Bank technocrats since 1985, the initiative mostly served to add on the neoliberal rhetoric of progressive, i.e. extremely slow and ineffective, human rights achievement.

The strong links of neoliberal discourse and Neo-Malthusian values are highly present in maternal health policies in Brazil. For example, Chapter VII looked at the implementation of decentralisation as a principle of health sector reforms in Brazil and was able to establish that women's rights rhetoric was not translated into real and improved health outcomes. The data collected from policy documents, secondary literature and semi-structured interviews with key actors indicated that, in spite of the mainstream rhetoric,

maternal health is still used as political bargaining tool and therefore not afforded with priority status or, more importantly, not really perceived as a value in itself. This dispute for the control of hegemonic women's rights discourses is an expression of Brazil's highly unequal and patriarchal society and its incapacity to acknowledge the importance of maternal mortality to women's lives by refusing to remove women's rights from a women-only realm.

Appropriating Directions: The Importance of Discourse Analysis and The Meaning of Mutant Discourses

The implementation of the human right to health is crucial for the success of maternal health and mortality policies. However, at the global level there was clear competition for control over how the human right to health is conceptualised and what that means to the global health agenda. Although the WHO has always been at the forefront of advancing health as a right, it suffered from internal divisions as well as an ever increasing influence from the World Bank. As a result, there was not only no clear homogenous guidance from the WHO as the organisation in charge of defining the human right to health and/or coordinating mechanisms that formalise health as part of the human rights project, but also there was the co-optation of the mainstream human-rights based approach towards the achievement of the right to health by the World Bank which reduced it to efficiency-driven 'technical' goals.

The Safe Motherhood Initiative was too preoccupied with receiving support (or at least not suffering from frontal opposition) from conservative policy networks and to a certain extent disregarded the importance of feminists as the basis for its political endorsement. Due to this, the initiative was therefore not capable of mobilising the grassroots and pushing for attention to the issue at the national levels. This was undoubtedly responsible for the lack of engagement of Brazilian feminists with the strategies put forth by the initiative as well as the complete disengagement of maternal mortality as a human rights issue.

The women's movement in Brazil suffered since the 1970s from internal divisions. Although all divisions were grounded on social justice ideals, only freedom of choice and abortion activists systematically promoted reproductive rights and demanded its inclusion in the political agenda. As the reproductive rights ideas did not resonate internally throughout the movement, no agreement was reached within the movement in terms of the appropriate definition and approach for maternal health and mortality. This lack of agreement over maternal health policy and priority, combined with a complicated history of the human right to the highest attainable health, have been problematic for maternal health advocates. This is because the lack of a clear and agreed-upon language for advocacy and lack of strong leadership resulted in the fragility of these discourses vis-à-vis more pervasive discourses, such as the one for neoliberal production and consumption and the one for population control. Moreover, this fragility meant that these discourses could be easily appropriated and transformed for the benefit of a completely different political agenda. These mutant discourses used the language of human rights to acquire legitimacy but were completely divorced from human rights values as a political project of radical and structural change.

For instance, Chapter V demonstrated that the dispute for the control of the mainstream discourse on global maternal mortality strategies resulted in a reduced capacity to mobilise individuals and organisations mostly because of its inability to afford feminists, and more widely women's rights advocates, power over the maternal health agenda. Indeed, maternal health was portrayed differently by the different sectors of the women's movement. It has been dealt with as a non-issue by freedom of choice advocates; as a health concern but not necessarily as a reproductive rights issue by activists for the humanisation of birth; and as a non-priority issue by violence against women militants. In a sense, maternal mortality initiatives were painted externally through different lenses and therefore suffered from a clear lack of identity and purpose. This placed the initiatives at a fragile state leaving considerable space for their appropriation by conservative policy networks. This in my opinion, is the main reason why global and national initiatives have not been very effective in reducing maternal mortality rates in the country.

Moving Beyond Formality: Policy Spaces and The Issue of Transparency

Shiffman and Smith (2007) affirm that the political and social context inhibit or enhance support for maternal health initiatives at time. The historical moment in which political actors operate to determine the limits and opportunities of their strategies and acknowledging them is important for the design of successful frameworks of action (Shiffman and Smith, 2007). This aspect is therefore divided into two factors: political moments; and platforms for collective action. Chapter VI focused on discussing the influx of new social justice discourses in the pre-1980s, 1980s and 1990s in order to establish that the design of health sector reforms in Brazil have in fact contributed to the marginalisation of reproductive health and rights.

In Brazil, the build-up to the transition to democracy as well as the political cornerstones of the 1980s constituted historical opportunities for political activism in the area of health. At that time, conditions were favourable to political and policy change as the movement for health reform grew stronger and more vocal in its opposition to the authoritarian government. The reformist movement played a key part in formulating the new democratic Constitution of 1988, which foresaw the creation of the universal public health system (SUS). Unfortunately, neoliberal discourse did not take into account or reflect on the activism of the 1980s. The second wave of reforms in the 1990s reinforced the fragmentation of the health system, the participation of the private sector in health care and the decentralisation of responsibilities without the correlated financial resources.

The reformist movement's political strategy for advancing social justice values included the creation of a health reform project that would be capable of attracting the support of different movements originating from grassroots. Although, this strategy was capable of joining different policy networks together, it also had the side effect of marginalising particular issues that were not seen as a priority to the leftist movement strategy. As key members of the sanitary movement took high profile places within the bureaucracy, good governance structures were put in place towards the decentralisation of social participation

in health policy making and implementation. The creation and maintenance of decentralisation norms and institutions only enabled limited collective action for the revision of budgets and targets with little or no power in the design of new policies. The institutionalisation of this particular social movement had negative effects on maternal mortality strategies as feminist participation and demands became more and more marginalised. This marginalisation, I contend, did not occur in formal spaces but, in reality, in the informal negotiations that took place during the period of democratic transition. In this sense, I argue that it is important to look at both formal and informal processes of policy making in order to better understand the limits and possibilities to women's rights praxis.

Human Rights Models of Health: Affording Legitimacy and Diverting Purpose?

Shifman and Smith's (2007) final aspect of analysis relates to the specific features of maternal health as a public health issue and its perception in comparison to other health-related problems. This aspect is divided into three factors: indicators; severity of issue in relation to others; and effective interventions. As noted in Chapter I, there is an additional point that is not included in this list which relates to the intrinsic and instrumental value of initiatives, i.e. the inability of the international community to afford real value to health initiatives that benefit women only, without dealing with women as an instrumental value to something else such as childbirth or childrearing (van Olmen et al., 2012). Chapter VII looked at the partial privatisation of health care in Brazil and its relation to the decentralisation of maternal health services, and was able to map out the instrumentalisation of maternal health by an ever increasing neoliberal health sector.

Indeed, the Brazilian Ministry of Health has commissioned several studies to create a good national maternal mortality indicator as well as an effective means of monitoring the progress of the indicator. This was able to significantly reduce underreporting of maternal deaths and increase popular understanding around it as an issue. Nonetheless, it has not been able to make use of credible data, produced through other means such as small

scale qualitative research, to create a longstanding dialogue with other institutions challenging maternal mortality rates produced nationally such as the one performed by the maternal mortality joint force led by the WHO. This seems to reflect the lack of political interest in challenging maternal mortality as a social issue and its importance for social equality. Moreover, it also denounces the instrumentalisation of maternal mortality issues by government only seeking to acquire political leverage internationally.

Additionally, maternal mortality cases in Brazil are, such as in other parts of the globe, not as common as other high-burden disorders such as HIV/AIDS. The smaller size of the burden of the problem in relation to others reflects on its limits in achieving political leverage internally. However, the low incidence of cases does not explain the reason why reformist health strategies have been more effective at reducing other indicators such as child mortality, while maternal deaths continue to be reduced at an incredibly slow pace. Furthermore, due to the small absolute number of maternal deaths, the issue is often repudiated by the conservative opposition as if it were not a public health concern.

In sum, in Brazil, health sector reform designs were constructed as a means of putting new measures in place to promote interventions that were clear, simple, cheap, cost-effective and based on scientific data. What the blueprints do not recognise is that the use of scientific data is also very subjective. It fails to deconstruct the idealised concept of 'technicality' and its effects over strategies that are not perceived as 'technical' or 'technical' enough. Moreover, these blueprints afford value to neoliberal discourses that reject the role of the State as a promoter of health and/or defend the failure of the State as a justification for incremented private sector participation in health care. This is coupled with the implementation of two strategies as political dogmas: fiscal retrenchment and decentralisation ('the magic bullet'). However, this mistaken promotion of austerity measures fails to acknowledge that the problem is not the absence of financial resources but the fact that public sector resources are being drained in favour of private companies' interests. Understanding the importance of maintaining this cycle of privilege and inequality, the Brazilian government advanced decentralisation (now properly co-opted and transformed the favour of neoliberalism) which unintentionally and internationally was diverted as a way to pulverise political activism and depoliticise the right to health.

Conclusion

This work attempted to present accounts that have otherwise been silenced by mainstream accounts of social policy reform in Brazil. It deconstructs women's rights discourses as a way to generate a discussion on the possibility of a radical feminist reaction that effectively resists conforming to mainstream maternal mortality initiatives, strategies and discourses. It challenges human rights praxis, development discourse and health sector reform design by asking what social justice strategies are supposed to be about. Is it about helping others to help themselves? Serving as enablers or catalysts of change? Would that not be too presumptuous? Should we not be more focused on removing the obstacles put in place which prevent people from being catalysts of change themselves? Rather than fixing this world should we not go back to the radical politics of actually transforming it?

This thesis's findings established that, in reality, there is no prioritisation of maternal health as an intrinsic value. Maternal health is clearly defined as a development issue and therefore not treated as a public health problem as envisaged by the progressive agenda promoting the right to the highest attainable health. In addition, as all spaces are socially constructed, they are prone to replicating existing power inequalities. This is no different for health sector reforms which are responsible for the multiplication of policy spaces that then become populated by conservative policy networks (neoliberal and/or religious) which make use of jargon (originally created or appropriated and transformed) to further exclude already marginalised policy networks. In this sense, the neoliberal design of health sector reforms is particularly responsible for leading to the further exclusion of reproductive health needs from the mainstream policy making and implementation agenda.

These findings established that hegemonic human-rights based approaches and human rights language were in fact appropriated by the mainstream neoliberal policy networks and transformed in order to suit market-driven interests. This appropriation, transformation and re-appropriation have not occurred in a transparent or even visible manner. The lack of transparency, coupled with the effects of excessive targeting and use of technical jargon and methods, actually harmed feminist political activism by considerably depoliticising the

women's rights agenda and impairing progressive strategies for the promotion of maternal health.

These research findings have confirmed and expanded what has already been established in previous literature that argues that language matters. Indeed, the language used in policy making - and certainly in development - dictates the ruling culture through the persuasive mainstream of values as facts, or 'truths', which in short initiates and installs support for interventions based on a particular set of interests or political position. As soon as new concepts are developed, they are appropriated by particular policy networks, becoming intelligible to others. Words are awarded with an arguably 'scientific' and 'technocratic' status in discourse which shields it from any questioning or unpacking. This literature, in which I also classify my own, calls for more research exploring discourse analyses of women's rights movements' strategies as a way of understanding health policy making and/or implementation failures and successes.

In this sense, by attending to this particular call for an expansion of discourse analysis to the study of women's rights strategies and movements, I applied a feminist Foucauldian analysis of discourse to health sector reforms and maternal mortality in Brazil. This research, the first one of its kind in terms of its context and theme, used this innovative methodology and, because of that, was capable of reaching very surprising conclusions. The most important conclusion is precisely linked to the use of discourse in praxis. More clearly, this thesis concludes that the use of social justice discourses in mainstream policy debates and by women's rights policy networks contributed to the marginalisation of reproductive health and impaired the implementation of maternal mortality reduction strategies in Brazil in the last three decades.

In conclusion, social justice discourses are not only in themselves incapable of promoting change, but also, and most alarmingly, they can have serious and negative consequences reversing or impeding progress in social equality. This is because social justice discourses, inserted into the context of neoliberalism, are vulnerable to change and appropriation. Key concepts advanced by social justice discourses - such as human rights, decentralisation and efficiency - are often appropriated, transformed and re-inserted into the mainstream without any sort of transparency. These transformations in social justice discourses are usually made by public policy elites aimed at promoting market-led interests,

neoconservatism and/or averting social and structural change. These processes are dangerous because they undermine the capacity (or perceived capacity) of social justice discourses and social movements to promote any positive change. Furthermore, because the political elites - neoliberals and/or neoconservatives - usually use social justice discourses to acquire political legitimacy, social justice discourses are used to guarantee the maintenance of unequal power and/or to create more mechanisms that pose more obstacles to social change. For this reason, this research calls for more research using a feminist critical discourse analysis engaging with human rights and human rights-based discourses, ideas and their importance to policy change and to the wider social justice project. The tracing and analysis of the use of social justice concepts and the comparison of these concepts with their original social justice values, I think, is crucial for expanding women's rights and furthering a feminist agenda for change.

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Appendices

Information Sheet

Department of Geography, Environment and Development
BIRKBECK
University of London
Malet Street,
London WC1E 7HX
020 7631 6000

Title of Study: From Rhetoric to Reality in Improve Maternal Health Outcomes in Urban Southeast Brazil

Name of researcher: Marianna Vargas de Freitas Cruz Leite

The study is being done as part of my PhD degree in the Department of Geography, Environment and Development, Birkbeck, University of London. The study has received ethical approval.

This study wants to explore how decentralised public health policies and rights-based discourse have affected maternal health outcomes in the macro-meso-micro level in Brazil.

If you agree to participate you will agree a convenient time and place for me to interview you for about an hour. You are free to stop the interview and withdraw at any time.

A code will be attached to your data so it remains totally anonymous.

The analysis of our interview will be written up in a report of the study for my degree. You will not be identifiable in the write up or any publication which might ensue. The study is supervised by Dr. Jasmine Gideon who may be contacted at the above address and telephone number.

Consent Form

Department of Geography, Environment and Development
Birkbeck, University of London

Title of Study: From Rhetoric to Reality in Improve Maternal Health Outcomes in Urban Southeast Brazil

Name of researcher: Marianna Vargas de Freitas Cruz Leite

I have been informed about the nature of this study and willingly consent to take part in it.

I understand that the content of the interview will be kept confidential.

I understand that I may withdraw from the study at any time.

I am over 16 years of age.

Name _____

Signed _____

Date _____

There should be two signed copies, one for participant, one for researcher.

Questionnaire

1. What is your name?
2. What is your address?
3. How old are you?
4. How do you define yourself in terms of your identity and sexuality?
5. What is your profession?
6. How long have you been in this position?
7. Is this work permanent, temporary, fixed term, per item or service or other?
8. What are the activities and responsibilities involved in your current position?
9. Who do you have to respond to and oversee while in this position?
10. Could you talk a little about the following subjects:
 - i. Public health policy reform in the last three decades :
 - a. Do you think the Movement for Sanitary Reform was successful in achieving universal health?
 - ii. The inclusion of targeted health programmes in the 1990s health reform agenda (PSF and PAISM):
 - a. Why do you think Women's Health Rights were dealt with separately from wider Health Sector Reforms?
 - b. Have national health programs such as PSF and PAISM been effecting in guaranteeing access to quality care to all women?
 - iii. Decentralisation and recentralisation of health services:
 - a. Why do you think decentralisation was used as a model for Health Sector Reform in Brazil?
 - b. Do you think it has been effective?
 - c. Why do you think there was the recentralisation of certain responsibilities?
 - iv. Health budgeting:
 - a. Health budgeting has never been fully decentralised. Why would you explain that? And how has it affected the overall Health Sector Reform agenda?
 - v. Maternal mortality Rates:
 - a. How would you explain Brazil's inability to tackle high maternal mortality rates?

- vi. Maternal health services:
 - a. Do you think quality of care and access to it is equal across Brazil? Do you think maternal health services in particular are equal across Brazil? How would you explain that?
 - vii. Bureaucracy and policy change:
 - a. What were/are the obstacles for the full of implementation of the Movement for Sanitary Reform agenda? Do you think they have changed over the years? Why?
 - viii. Democratic participation and health conferences and councils:
 - a. Many academics mention health conferences and councils as an indicator of the success of decentralisation strategies. Do you think these have promoted more democratic participation and accountability?
11. Do have links or access to international and/or regional networks? Explain.
 12. Do you think international and/or regional networks influence (or are influenced by) public health policy and practice in Brazil? Explain.
 13. Have you been exposed to the 'rights' discourse in your daily routine? Explain.
 14. How would you describe the use of rights discourse in terms of public health policy making and implementation?
 15. Do you think the 'rights-based approach' is effective? Explain.
 16. Have you ever been exposed to the term 'reproductive rights'? If yes, when?
 17. Do you find the use of reproductive rights as a terminology and as discourse useful to the achievement of improved maternal health outcomes?
 18. In your opinion, what are the successes and failure of Brazil's public health policies targeting the reduction of maternal deaths?

List of Interviews

1. An academic that works on demographic transitions. Interview, 14.11.2012, Rio de Janeiro.
2. A feminist collective health academic. Interview, 30.10.2012, Salvador.
3. A member of an international feminist organisation. Interview, 28.09.2012, Bogotá.
4. A former manager at the Technical Area for Women's Health. Interview, 18.08.2012, São Paulo.
5. A member of the international feminist movement. 20.10.12, Porto Alegre.
6. Public policy maker at the state level. Interview, 15.11.2012, São José dos Campos.
7. A collective health scholar. Interview, 01.12.2012, Rio de Janeiro
8. A former manager at the Technical Area for Women's Health and a current manager at on of the departments of the Ministry of Health. 21.11.2012, Rio de Janeiro.
9. A member of the international feminist movement. Interview, 22.11.2012, Rio de Janeiro.
10. A specialist of maternal-child health and member of the movement for humanisation of birth. Interview, 28.09.2012, London.
11. An obstetrician at a public hospital. Interview, 07.11.2012, São Paulo.
12. An activist and birth attendant working with in the private sector. Interview, 28.11.2012, São Paulo.
13. A prominent political scientist that works at a private foundation. Interview, 14.11.2012, Rio de Janeiro.
14. A lawyer and member of the international feminist organisation. Interview, 23.10.2012, Rio de Janeiro.
15. A sexual and reproductive health scholar. Interview, 19.09.2012, Rio de Janeiro.
16. An obstetrician who provides legal abortion services at public and private hospitals. Interview, 19.11.2012, São Paulo.

17. A former bureaucrat at the Ministry of Health. Interview, 19.11.2012, São Paulo.
18. A paediatrician and local manager at the Municipal Health Secretariat. Interview, 01.11.2012, Belo Horizonte.
19. A health professional and abortion activist who responsible for the implementation of legal abortion services and correlated norms at national level. Interview, 22.11.2012, Recife.
20. An obstetrician at a public hospital. Interview 05.11.2012, Belo Horizonte.
21. A law professor and a judge. Interview, 09.11.2012, Porto Alegre.
22. A public health specialist and activist of the black women's movement. Interview, 17.09.2012, Curitiba.
23. A collective health scholar. Interview, 19.09.2012, Rio de Janeiro.
24. A specialist on public health and abortion. Interview, 20.08. 2012, Salvador.
25. A women's health expert and academic. Interview, 01.12.12, Rio de Janeiro.
26. A bureaucrat of the Secretariat for Special Policies on Women. Interview, 30.08.2012, Brasília.
27. A member of the Feminist Network for Health. Interview, 03.08.2012, Porto Alegre.
28. A physician and specialist on preventive health. Interview, 26.10.2012, São Paulo.
29. A collective health scholar. Interview, 22.11.2012, Campinas.
30. A congressman who previously worked as a local health manager. Interview, 09.11.2012, Brasília.
31. A health professional that assists victims of domestic violence. Interview, 29.10.2012, Santa Bárbara do Sul.
32. A feminist and former policy maker. Interview, 22.09.2012; 06.06.2012, Rio de Janeiro.
33. A feminist activist working on violence against women. Interview, 06.11.2012, Recife.
34. A former nun and reproductive rights activist. Interview, 04.10.2012, São Paulo.

35. A member of the National Health Council and a Municipal Health Secretariat. Interview, 15.11.2012, Rio de Janeiro.
36. A lawyer and public health specialist. Interview, 27.11.12, Rio de Janeiro.
37. A professor at a department of preventive medicine. Interview, 27.09.2012, São Paulo.
38. A former official at the Ministry of Health who is currently a manager at an international organisation. Interview, 01.11.2012, Montevideú.
39. A feminist activist and manager of a urban workers union. Interview, 14.12.2012, São Paulo.
40. A member of an international organisation. Interview, 16.11.2012, Geneva.
41. A public health specialist and academic who has been at the forefront of discussions on maternal health and human rights in Brazil. Interview, 24.10.2012, São Paulo.
42. A member of a maternal mortality committee. Interview, 29.11.2012, Recife.
44. An activist working at an organisation focused on women's rights. Interview, 07.11.2012, Recife.
45. A bureaucrat at the Ministry of Health working on health surveillance and the maternal mortality committees. Interview, 21.11.2012, Rio de Janeiro.
46. A specialist on maternal mortality rates, Interview, 28.11.12, São Paulo.
47. A feminist activist from the black women's movement. Interview, 22.07.2013, Curitiba.