**Putting Maternal Health at the Centre of Public Health Policies**

**Colocando Saúde Materna no centro das Políticas de Saúde Pública**

**Abstract:**

Drawing on a process of historical and policy analysis, this article considers the extent to which reproductive health services have been marginalized by the reform processes in Brazil’s health sector over the past three decades. This marginalization has had significant implications that are reflected in the country’s continued failure to tackle high maternal mortality rates despite renewed emphasis placed on these goals, for example via the Millennium Development Goals. Moreover, discourses surrounding the capacity of a rights-based approach to fulfil these goals through strategies such as decentralisation continue to ignore underlying social structures that influence power, agency and context grounding the notion of rights.

**Resumo:**

Baseando-se num processo de análise histórica e de políticas, esse artigo trata da extensa marginalização dos serviços de saúde reprodutiva dos processos de reforma de saúde pública do Brasil nas últimas três decadas. Essa marginalização tem tido implicações significantes que se refletem na incapacidade do país lidar com as altas taxas de mortalidade materna apesar de contínua ênfase dada à esses objetivos como por exemplo via MDGs. Ademais, discursos relativos à capacidade da abordagem baseada em direitos de produzir resultados através de estratégias como a descentralização continuam a ignorar profundas estruturas sociais que influenciam poder, ‘agency’ e contexto nas quais a noção de direitos se baseia.

**Key Words:** health sector reforms; decentralisation of services; maternal mortality; Brazil.

**Palavras-chave:** reforma do setor de saúde; decentralização de serviços; mortalidade maternal; Brasil.

**Introduction:**

Drawing on a process of historical and policy analysis, this article seeks to determine why reproductive health services have not benefited from the supposed advantages of decentralisation. The Brazilian case study will be situated within wider debates of health sector reforms in Latin America, inequalities of access to health care and its implications on women’s health and gender equity. It explores how transnational policy legacies and internal policy networks may have influenced the use of a reproductive rights discourse while in fact perpetuating a neoliberal population control agenda.

**The MDGs and Maternal Health Outcomes:**

Global progress in terms of achieving Millennium Development Goal 5 of reducing 75 per cent of the maternal mortality ratio of 1990 by 2015 is crucial for the effective integration of gender perspectives to health policy making and monitoring (VICTORA et al. 2011). 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). Nevertheless, according to 2008 estimates, over 350.000 women still die every year of treatable or preventable complications of pregnancy and childbirth annually (WHO et al. 2010). A total of an astonishing 99% of these deaths occur in developing countries (WHO et al. 2010).

The importance of these numbers cannot be underestimated. The 2010 Human Development Report asserts that the maternal mortality data is a “dramatic” aspect of well-being (UNDP 2010). Well-being meaning surviving, leading a long and healthy life, being well nourished, “living decently” and having the ability of fulfilling life plans (SEN 2002, ALKIRE 2005). It is an indicator of status in society and part of people’s basic entitlements to live life with dignity and according to every person’s limitations and capabilities (NUSSBAUM 2001). Therefore, yielding insights on health policy gender gaps may help overcome systemic disadvantages in well-being and empowerment (NUSSBAUM 2001).

The 2010 Human Development Report indicates that Latin America and the Caribbean reproductive health country systems are one of the largest contributors to gender inequality in the world (UNDP 2010). Brazil is reported as the most flagrant paradox of the region (UNDP 2010; WHO 2004). 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 (VICTORA et al. 2011). Brazil’s Unified Health System should guarantee equal access and quality of services to everyone (VICTORA et al. 2011). However, people in vulnerable and lower income groups’ experience more difficulties in getting access to quality care and women are still disproportionately affected (VICTORA et al. 2011; ALMEIDA et al. 2000).

Brazil has made significant progress in tackling challenges in other areas of the health sector and some indicators have improved and benchmark standards met (VICTORA et al. 2011). In particular, successful policies have been identified in areas dedicated to programs such as HIV/AIDS, immunizations and child mortality (WHO 2004). Nevertheless, despite broader economic growth Brazil reproductive health indicators have remained poor (VICTORA et al. 2011). 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 et al. 2010), Brazil’s rate only decreased by 3.9 per cent (HOGAN et al. 2010).

**Rights-Based Approaches and Maternal Health:**

The use of the language of rights has grown rapidly amongst development policy and practice (CORNWALL AND MOLYNEUX 2006). Nevertheless, formal rights as advocated by international development bodies have not always proven to improve the everyday reality of women (CORNWALL AND MOLYNEUX 2006; CORNWALL AND NYAMU-MUSEMBI 2004; 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).

In addition, structures of gender inequality within society profoundly condition attitudes towards the rights-based discourse and initiatives related to it (UNTERHALTER 2003). The wider conditions of gender injustice associated with masculine and feminine identities such as negotiations between partners and family members may make change particularly challenging (GREANY 2008; UNTERHALTER 2010).

Health care organizational policy implementation is particularly restricted by the conservative wing of the Catholic Church which contests all advances in the area of sexual and reproductive rights (DOYAL 1995; CORRÊA 2010). And with the growing stages of religious pluralism in Latin America, opposition to sexual and reproductive rights also comes from other fronts including the Evangelical and Baptist Churches (HARTH 2006).

Gender equity in health policy may only be achieved when similarities and differences in women’s and men’s health needs are identified (DOYAL 2000). Furthermore, policies must ensure equal access by guaranteeing women’s ability to realize their full potential for health (DOYAL 2000). This must be done through equitable resource allocation that acknowledges the differential constraints current modes of social organization poses on each gender, in particular on women (UNTERHALTER 2003; GREANY 2008; DOYAL 2000).

**Health Sector Reform as a Case Study:**

Health sector reform understood as a set of processes incurring in changes in the organization and functioning of health services is aimed at “*improving the performance of existing systems and of assuring efficient and equitable responses to future changes*” (KOIVUSALO AND OLLILA 1997). Health sector reform encompasses the context, the content and the process by which these changes are made (KOIVUSALO AND OLLILA 1997; WALT AND GILSON 1994). Therefore, health sector reforms incorporate and replicate built-in values characteristic of health sectors and institutions such as gender bias (STANDING 1997; ELSON AND EVERS 1998; GIDEON 2000). Albeit the creation and implementation of gender-sensitive policies, health sector reforms 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 (ELSON AND EVERS 1998; GIDEON 2000).

Social exclusion and vulnerability occurs in different levels depending on groups and individuals (ABEL AND LLOYD-SHERLOCK 2000). These 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 (ABEL AND LLOYD-SHERLOCK 2000). All of the factors above play into the various health status pertained to individuals and groups of a society.

Women’s greater exposure to vulnerabilities such as poverty, socioeconomic and political discrimination may incur in a lower health status than those of men (MURTHY AND BHATTACHARYA 2010). Lack of adequate or no coverage for sexual and reproductive health services is one of the main factors leading to women’s “negative” health status (MURTHY AND BHATTACHARYA 2010). Critics have argued that the duality of the health care systems may go some way to explaining inequalities and inefficiencies reflected in maternal health services (VICTORA et al. 2011).

“*Health systems have a key role in ensuring safe pregnancy and childbirth because there is clear evidence that when adjusting for country income level – provision of and access to maternal health care services, particularly emergency obstetric care, are associated with a reduction in maternal mortality*” (RUIZ-RODRÍGUEZ 2009, p.150).

An attempt of improving existing conditions and the basic women’s reproductive health indicators – i.e. maternal mortality ratio and adolescent fertility rate - has been shown through the decentralisation of public health systems throughout Latin American countries (MESA-LAGO, 2010). This occurred in the 1980s and the 1990s as part of the health sector reform rhetoric pertained to structural adjustment programmes advocated by the World Bank and the International Monetary Fund and backed by the largely feminist United Nations International Conference on Population and Development held in Cairo in 1994 (MAYHEW 2003).

In the period of health sector reform between the 1980s and the 1990s welfare state practices oriented by solidarity principles were replaced by neoliberal theories emphasizing individual interests (KOIVUSALO AND OLLILA 1997). 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 (KOIVUSALO AND OLLILA 1997; MESA-LAGO 2008).

**Policy Analysis and Health Sector Reforms:**

Since the mid-nineteenth century social policy in Latin America has been targeting motherhood as the object of state regulation through efforts of women’s movements and social hygiene movement aimed at modernizing childrearing practices (MOLYNEUX 2007). Policy then became more clearly the response or the pursuit of the interest of certain policy networks by political institutions staffed by self-seeking individuals (LIPSKY 1980). The complex design of institutions and the use of expert persuasion by networks became therefore crucial to design and implementation (MACKINTOSH 1992).

The field of health policy making is not different. Health policy is inherently subjected to conflict in terms of solidarity vis-à-vis individualistic concepts as well as in terms of the appropriate policy choice (WALT AND GILSON 1994). In this case, the content of the reform 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 1994; WALT et al. 2008). That is because the “*[f]ocus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge*” (WALT AND GILSON 1994).

Values and evidence of the determinants and consequences of health and illness (or lack of it) orient every policy decision related to health reforms (WALT AND GILSON 1994). These may be used to influence policy implementation in reality or as part of a wider governmental rhetoric (KOIVUSALO AND OLLILA 1997). The fundamental variation lies in qualifying 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).

This is where human rights and human-rights based approaches come in place. Human rights as intrinsic value or rhetoric identify the pursuit of health as a fundamental social value indispensable to equity and distributive justice (KOIVUSALO AND OLLILA 1997; HUNT AND SHELDON 2010).

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 recipients part of its implementation (MAYHEW 2003; MCINTYRE AND KLUGMAN 2003). Often times, internationally idealized health strategies fail to acknowledge that there are also huge gaps in bureaucratic cultures, political structures and discretionary decision-making at the time of local implementation of reform policies (WALT AND GILSON 1994; LIPSKY 1980).

In this case, to understand the factors influencing the effectiveness or ineffectiveness of health policy change, one must understand the policy process (WALT AND GILSON 1994; MACKINTOSH 1992; WALT et al. 2008; GILSON AND THOMAS 2002). This means to position the policy environment in terms of internal, transnational (or cross-border) and international networks and the relationship between them (WALT et al. 2008). This politicizes 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). It explores the relationship between global political rhetoric, power and the realisation of the rights-based discourse (WALT et al. 2008). The use of a policy analysis approach is directed towards the questions of reasonsand manners to whichchange came about, as well as how that linked to the reform itself (GIDEON 2000; GILSON AND THOMAS 2002).

**The 1980s and 1990s Health Sector Reforms:**

The reform of public health systems differ considerably from country to country. A myriad of approaches has been used in different settings (MESA-LAGO 2007). These range from sweeping reforms or narrower changes and can be grouped into financing changes, organizational changes, or policy changes (MESA-LAGO 2007). However, it can be said that most Latin American countries implemented, at some point throughout the 1980s and the 1990s, some sort of sweeping public health reform strategy based on organizational changes (MESA-LAGO 2007).

These reforms can promote greater flexibility, efficiency, accountability in resource use and community participation and involvement (MESA-LAGO 2007; 2008). But, 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).

Health sector reforms in Latin America have produced diverse outcomes. Reforms were either positive and/or negative to reproductive health (MESA-LAGO, 2010). But given that general health reform analysts usually do not share the values of reproductive health reform advocates, negative effects seem to be appalling (LUBBEN 2002). Most, if not all, all Latin America countries have reported to have overall negative experiences in terms of achievement effective reproductive rights and well-being (MEIER 2010). That is because reforms normally aim at overcoming weak management structures and lack of performance incentives, leaving reproductive status alongside (MESA-LAGO, 2010).

The failure to reduce maternal deaths in Brazil in spite of great economic growth and extensive health reforms is a particularly interesting piece of this puzzle. During the 1980s and 1990s, some interest groups were in particularly strong: the Catholic Church, the neoliberal market-oriented elite and the Malthusian and neo-Malthusian population control movement (CORRÊA 1993). All the same, family planning and reproductive rights were strong demands in the realm the feminist movement as early as late 1970 (ÁLVAREZ 1990). The feminist movement managed - through the activism of key players - to influence the 1988 constitution making process, to push for the institution of the National Council for Women’s Rights and the creation of the Program for Integrated Women’s Health Care (ÁLVAREZ 1990). Nonetheless, feminist constituencies did not manage to gain political legitimacy as to effectively influence the aftermath of the democratic transition enough as to strongly shape the implementation of health sector reform in the 1990s (ÁLVAREZ 1990).

**Policy Networks and Decentralisation of Services:**

Health sector reforms are particularly difficult because they affect a great number of people, their benefits are immediate, provision of services is complex, the clientele is diverse and the health market is highly imperfect and unequal (MESA-LAGO 2008). In all cases, policy makers engage in some form of decision-making when engaging with policy choices (HAAS 1992). And, considering the complex policy problems generated by health sector reform, policy makers tend to reach for clear and tested solution often accessible from models used in neighbouring countries (WEYLAND 1996; EWIG 2010).

Supranational and global actors have been increasingly important in changing policy outcomes (DEACON et al. 1997). In the case of welfare state and social policy, international institutions like the International Labour Organization, the World Health Organization, the International Monetary Fund 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 (DEACON et al. 1997).

Even though, a strong a rights-based approach informing World Health Organization’s policies date to its creation, this broad and positive definition of the right to health was left aside during a dramatic shift to World Health Organization’s paradigm from 1953 to 1973 (MESA-LAGO 2008; MEIER 2010). Global health then became infiltrated with biomedical jargon and targets as a result of post-World War science advances (WALT AND GILSON 1994; MEIER 2010). This conceivably came in large detriment to the development and implementation of the right to health and its inclusion into health sector reform policies (KOIVUSALO AND OLLILA 1997; WALT AND GILSON 1994).

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 - was particularly important to this phenomenon (MESA-LAGO 2008). In fact, the main characteristics of the 1990s Latin American social policy were 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 (MESA-LAGO 2008). In this way, privatisation and decentralisation were introduced as a conditional of loan agreements between Latin American countries and the World Bank and the International Monetary Fund (MESA-LAGO 2008).

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 democratize health systems (HOMEDES AND UGALDE 2005). This was 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*” (HOMEDES AND UGALDE 2005).

Brazil’s health system was only decentralized in the 1980s as a result of a broad movement for social and economic justice originated in the medicine academic circleentitled the Movement for the Sanitary Reform (COHN 2008). The movement pressed for a comprehensive preventive care and access to basic services to everyone, but with special attention to the poor (COHN 2008).

Health sector reform was far from the movement’s initial goal (WEYLAND 1996). Its beginning focused at local and distributive demands rather than larger reformist quests. This was due to strong links with clientelist networks which represented business-oriented interests and resisted any changes to the *status quo* and to a divide conflicting interests between the Ministry of Health and the National Institute for Medical Assistance and Social Security (WEYLAND 1996; COHN 2008). Different from most Latin American countries, Brazil’s reforms were - at least until the mid-1990s - majorly influenced by the internal leftist medical movement. However, there are accounts that point to the Alma-Ata Declaration and to World Health Organization’s Health for All strategies as a source of inspiration and reinforcement (WEYLAND 1996).

The reform was 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 and the National Institute for Medical Assistance and Social Security to states and municipalities, called the 1983 Integrated Health Action (COHN 2008). And the second phase occurred in 1987 and 1988 with the creation of the Unified and Decentralized Health Systems which furthered administrative decentralisation by transferring staff and facility control to state and municipal health secretariats (COHN 2008). Subsequently, as part of the transition to democracy, the 1988 Constitution incorporated the ideals of the Constitutional Health Charter and created the Unified Health System (COHN 2008). Article 196 of the 1988 Constitution recognized health as a right and individual and collective right to access health services (COHN 2008).

In 1990, the Unified Health System was regulated by the Health Organization Law comprised of Organic Laws 8.080/90 and 8.142/90 (LOBATO AND BURLANDY 2000). The Health Organization Law sub-divided the Unified Health System 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 and also included private profit and non-profit providers under contract to the public system (LOBATO AND BURLANDY 2000; BUSS AND GADELHA 1996).

In spite of this intricate three-pronged structure, ideals of taking health policy making closer to communities was far from effective. Indeed, the Health Organization Law partially recentralized several measures back to federal government giving it the right to define norms for contracting private providers and to control the fiscal transfer of federal revenues to states and municipalities for Unified Health System’s initiatives (WEYLAND 1996). Moreover, the fight for political, economic and institutional power divided the post-1988 health movement compromising in this sense the very principles and reasons that unified these divisions in the first place (BAPTISTA 1996).

The new political formations of the diluted left wing polarized further the reformist health movement leaving little space for feminist initiatives (BAPTISTA 1996). The only organisational guideline of the Unified Health System that was widely supported for it did not collide with neoliberalism was decentralisation (BAPTISTA 1996). This was later escalated in the 2000s with the diffuse opposition from the new conservative wing of Catholic Church and evangelical Christian churches which moved away from framing public debates on issues of personal morality towards a rights-based discourse which had previously been only within the realm of the oppositional left wing (MACAULAY 2010).

Today, the Unified Health System is characterized by a decentralisation that is fiercely reliant on municipalities and which is simultaneously dependent on the federal government’s power over the transfer of financial resources and key policy-making areas (BAPTISTA 1996). Oddly enough, the non delegation of significant roles to states lead up to the weakening of the bargaining power of municipalities’ *vis-à-vis* the federal government generating conflict of responsibilities and political links (BAPTISTA 1996). The health system is defined as a highly technical sector and is therefore governed by operational rules leaving little room for feminist constituencies pushing for maternal health as an intrinsic value (BAPTISTA 1996).

**Conclusion:**

In the 1980s and the 1990s, public health reforms have been widely implemented in Latin America. However, the results coming out of the reforms have been mixed. The Brazilian initiatives introduced in the late 1980s were aimed at providing holistic and equitable access to health services, but 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.

While policy makers are pressed for taking part and contributing to governments’ reform agenda focused on financial and efficiency issues, reproductive health concerns are usually left aside in favour of more politically established issues, such as cost analysis and population control. In this sense, decentralisation does not guarantee a democratic character to the decision-making process and for this reason it marginalises networks and actors that have been historically disadvantaged. This does little or nothing to improve the astonishing case of high maternal mortality rates in Brazil.

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