



## Human Rights, decentralization and maternal health in Rio de Janeiro: An NGO perspective

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### Abstract

Brazil has one of the largest rates of maternal deaths in the world and it accounts for over a quarter of Latin America's maternal deaths. Notably, in spite of the influence of the feminist movements on reproductive public policy making, minority women are still disproportionately affected. The highest maternal mortality rates are among black, indigenous, and single women living in the poorest regions of Brazil. The objective of this paper is to examine the truth of this problem through the local perspective of a non-governmental organization in Deodoro. Although the data presented here is neither conclusive nor representative they show that the socioeconomic and demographic profiles of maternal deaths in the city of Rio de Janeiro reflect a vulnerable social situation. Yet, the government has remained unresponsive to the real needs of the women of Deodoro and their families, thus affirming the World Bank view that Brazil is disproportionately directing government spending for health to the affluent while the poor lack access to basic health services and receive low-quality care. There are also health sector fragmentation, loss of policy leadership, confusion of responsibilities and deterioration of services due to the adoption of top-down policies which in turn create further complications and discrepancies in health policies. This does not mean that in Deodoro the women have full control of all aspects of their reproductive life. It means that the official discourse of the modern Brazilian State was at times embraced, combined or rejected by informal local groups and individuals.

**Keywords:** Brazil, decentralization, health reform, maternal health, NGO, public policy

### Introduction

This paper was originally written and presented during the 2010 Hilary Term Seminar Series on Gender and the Struggle for Economic, Civil and Social Survival at the International Gender Studies Centre, University of Oxford. It draws on personal work developed with an NGO in a low income setting in the city of Rio de Janeiro, Brazil from mid-2008 to 2009. It started from a political standpoint and not as social science research. Therefore, even though it relies on social science methodologies, it does not analyse any type of formal/informal interviews or participatory observation. Here only a few accounts will be presented from many that have been observed. Given that no permissions were asked at the time these accounts were given, the real names of the people and organizations involved will be concealed. The article briefly introduces the Latin American context, the Brazilian Health System, the local setting, the organizations and then moves on to the concerns expressed by the local women and some examples of their experiences.

### *Background information*

Upholding international human rights obligations is particularly complicated in Latin America where '[h]ealthcare segmentation predominates and generates inequalities which erode social solidarity' (Mesa-Lago, 2010: 29). Health systems in Latin American have been undergoing profound neoliberal changes over the last several decades which 'have been encapsulated in the term health sector reform' (Standing, 2002:1). These reforms were associated with 'huge social and economic costs' (Gideon, 2006: 1270), particularly for women who require specific healthcare services due to their reproductive function such as family planning and pregnancy care (Mesa-Lago, 2010).

Latin American health care provision 'developed into systems that are highly individualized, curative and hospital oriented' (Atkinson, 2005:69). This leads to bad experiences of the health care system which can then be associated with poverty and powerlessness (Gideon, 2006). In this sense, '[a]n analysis of power relations is central to understanding the failure of states to guarantee an enabling environment for women's enjoyment of their social and economic rights, as many women remain excluded from decision-making processes within policy arenas' (Gideon, 2006:1269).

In 1980, '[h]ealthcare access decreased or stagnated in half of Latin American countries and increased in the other half while the segmented health systems predominant in the region contributed to the low coverage and its decrease' (Mesa-Lago, 2010:7). Social insurance covers only formal employees in urban zones, private sector insurance covers urban high income strata and the public sector 'legally protects the non-insured populations' - poor and low-income rural people as well as indigenous peoples (Mesa-Lago, 2010). This is worsened in countries with federal a organisation such as Brazil where 'several insurance schemes separate from the general system cover powerful groups - such as the armed forces, civil servants, oil workers - with more liberal entitlement conditions and benefits and superior quality of care, totally or partly financed with regressive fiscal subsidies' (Mesa-Lago, 2010:29).

The effects of health system reform policies can be analyzed 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).

This paper is mainly concerned with the effects that recent policy making has had on gender equality and the gendered aspects of political participation in terms of health policy making. By this means, one can observe the impact of the 1980s economic crisis on gender equality:

'Women were more affected than men for three reasons: 1) the incidence of unemployment was higher among women than men; 2) more women than men worked in the growing informal sector, which was not covered by social insurance; 3) real wages contracted thus reducing women's contribution amounts and future pension levels, given that women were usually paid lower salaries than men; and 4) several countries cut their health budgets and imposed user fees on public health services, which especially hurt women, who tend to use those services more than men' (Mesa-Lago 2010:11).

Health sector reforms 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 monitoring and accountability are essential to civil society. This explains why non-governmental organizations and other grassroots movements have become increasingly important (Bloom and Standing 2001). However, local organizations may perpetuate unequal power relations, especially because

'[u]nder neoliberalism the concept of civil society, and by extension the concept of participation, has been transformed. It has taken on new meaning and importance, as 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).'

Therefore, it is crucial to analyze the role of local organizations as well as the power relations embedded in the societies themselves in order to properly address the nature of current participatory mechanisms and decision-making regarding health care and health care reform.

### **The Brazilian health system**

Brazil's health-care system consists of two components, a public system with universal access and a private system with limited access, referred to as the supplementary system. The public system is known as the *Sistema Único de Saúde* (SUS) (Unified Health System) and was created to ensure the 'constitutional and universal right to health'. The SUS is the *sole source* of health care for 76 percent of Brazil's population. Since the 1980s, attempts to improve health indicators and existing service conditions (Rondinelli, 1981) have led to the decentralization of the provision of public health services so that the services are either provided directly by members of the public administration or indirectly by third parties (through legislation, contracts or agreements) (Meireles, 2002).

Brazil's Unified Health System is, in fact, highly segmented with significant inequalities. For example, it does not 'cover the armed forces and police, which have their own facilities; federal civil servants, as well as those in states and large municipalities, receive fiscal subsidies towards the purchase of private plans, which normally have better access and quality of care than in the SUS, without losing their right to SUS care' (Mesa-Lago, 2010:30). There are also great disparities in terms of regions, states and municipalities. The public system covers 72 per cent of the population in the northeast compared to nearly 99 per cent in the southern region (Mesa-Lago, 2010).

Decentralizing and strengthening municipal governments did bring significant benefits to the system however according to Lobato and Burlandy '[o]ne cannot say that the decentralization process itself guaranteed better health care' (2000:98). 'This was, among other reasons, because sometimes local governments passed on even more intensively the distortions that had occurred at the federal level, such as patronage' (Barros 1996 in Lobato and Burlandy, 2000:98). Decentralization to lower levels of government may also shift the burden of resource mobilization too far and too quickly, creating a problem of unfunded mandates. 'If populations are poor and local accountability mechanisms are too weak to ensure ringfencing of essential services, basic service provision is likely to suffer' (Standing, 2002:15). Indeed, the decentralizing of health places much greater burdens on municipalities which may not only suffer from unfunded mandates but also from duplication of resources and blurring of responsibilities (Standing, 2002).

During the 1980s, women's rights activists proposed several health initiatives to government (Turshen, 2007). As a result, Brazil created the Integrated Programme for Women's Health and incorporated the right to family planning in the Constitution of 1988 (Turshen, 2007). After 1989 the implementation of these programmes became rare. In 1995 several new programmes were introduced at the state level to improve delivery care for pregnant women and postpartum care for mothers and children (World Bank, 2002).

Programmes launched in São Paulo, Rio de Janeiro and other states seeking to accredit 'hospitals that provided quality maternity care, encouraged women to visit before they delivered' (World Bank 2002:44), allowed newborns to stay with their mothers at birth, and permitted mothers to feed their infants at their own schedules. At the municipal level, programs were created to identify and educate pregnant women about their rights (World Bank, 2002). In spite of their purpose, the initiatives addressed only economical and technical resources (DFID, 2005) and ignored wider political and social contexts such as unequal access among people from different classes (Hunter and Sugiyama, 2009).

At the time of the implementation of the initial reform strategies, Brazil's referral systems were purported by some studies to 'function so poorly, [that] pregnant women sometimes

scramble to find an available hospital bed when they enter labour' (World Bank, 2002:63). Additionally, they have been deemed ineffective because medical 'records on antenatal care are not linked to treatment at the time of delivery, thus compromising physicians' (Hunter and Sugiyama, 2009:44) ability to diagnose and rapidly treat patients in emergency situations (World Bank, 2002). Indeed, in terms of family planning and maternal care the situation is still not very satisfactory (Sugiyama, 2008). 'Most doctors keep one foot in the public system while maintaining a private practice'. 'It is an open secret that on the whole, they give less attention to their public responsibilities than to their work in private clinics, and even that they use public resources to help build up their private practices' (Hunter and Sugiyama, 2009:44).

Taking into account the context of Brazil's economy, distribution of wealth, and allocation of government resources is crucial here. While income levels for Brazil's poorest communities have increased under current government policies, income disparities throughout the country remain extremely high (UNCT, 2005). The wealthiest quintile receives 62.4 percent of the country's income, a share that is 20 percent larger than that of the poorest quintile (UN, 2007). Though many of the country's poor live in urban areas, the percentage of poor people living in rural areas (57 percent) is more than twice as large as the percentage of poor living in urban areas (27 percent) (UNCT, 2005). There are also significant regional variations in poverty levels and inequality. For example, in 2002, the proportion of people living in extreme poverty in the Northeast (25.2 percent, was almost five times higher than in the Southeast (5.2 percent) (IPEA, 2004). This context explains in part the present situation of health care.

In addition, experts question the distribution of Brazil's health funding. According to recent estimates, approximately 10 percent of government spending goes towards health (WHO, 2006). Brazil's inequitable expenditure patterns in health 'continue to favour the regions that are better off and healthier' (WHO, 2006: 53). There has also been criticism of the uneven expansion of the national Family Health Programme – an initiative created to restructure the delivery of primary health care within the universal health system (World Bank, 2002) -, which covers a small percentage of households in large urban areas (UNCT, 2005). Hunter and Sugiyama cite Corrales while noting that:

'most reformers pursue "access reforms," which expand existing services to excluded or underserved groups [...] Yet to produce more efficient or equitable outcomes with existing resources—the typical function of "quality-enhancing reforms"—it is often necessary to redistribute resources among groups, which invites serious political opposition from well-organized segments of society' (2009:44).

Critics have also identified problems with implementation of health programmes and distribution of resources at the local level. For example, the manner in which federal funds are transferred to states and municipalities appears problematic. Specifically, the transfers tend to favour richer states, to the detriment of poorer states with greater health care problems, because the transfers are generally dependent on existing infrastructure, as opposed to actual health needs (OECD, 2005).

Some local governments are also known to prioritize 'better off' communities and give incentives to the development of private health providers (OECD, 2005). Even though, there is not necessarily a clear distinction between public health sectors and private health sectors, this distinction becomes 'more evident when we consider hybrid institutions such as health centres, which provide both primary and secondary care' (Lobato and Burlandy, 2000:113). Lobato and Burlandy note:

'This kind of establishment fulfils the need for services in simple units with few beds to provide general care, minor surgery, and gynaecological and emergency services. In Brazil, such health centres are predominantly public and concentrated in the poorest regions. Emergency units, too, occur primarily in the public sector. The private sector owns the majority of small - and medium-sized health facilities, but it is particularly involved in hospital ownership' (2000:113).

Overall, 'the system still suffers from low levels of financing and investment; poor quality services; and a limited ability to solve problems' (Lobato and Burlandy, 2000:113). Today, 'a large segment of the population uses private health care services, which have increased and diversified to the point that their revenue nearly equals expenditure on the public health sector, although they serve only one-quarter of the population' (Lobato and Burlandy 2000:80). We see that '[p]repaid and private health insurance plans have been stimulated first by the reduction in public services and then by public subsidies in the form of income tax deductions on the part of companies and consumers' (Lobato and Burlandy, 2000:97). But structural adjustment measures are not the only cause for public health inefficiency. Lobato and Burlandy affirm that:

'...although [the momentum for public health reform] [is] no longer expressed through broad social movements as in the 1980s, [it] has expanded significantly and been expressed principally through government institutions. For this reason, proposals aimed at altering the process underway would have a high political cost' (2000:81).

Furthermore, a recent profile of health-care facilities conducted by the Brazilian Institute of Geography and Statistics revealed that the proportion of establishments with in-patient facilities, which are important for childbirth, has fallen in recent years (IBGE and PAHO, 2008). Specifically, 67 percent of health-care establishments lacked in-patient facilities in 1980, and by the year 2002, that figure had risen to 86 percent (PAHO, 2008). At the same time, '[f]ixed values are established according to the diagnosis and required procedures' (PAHO, 2008:14). Hospitals where highly complex procedures are carried out are paid extra to maintain their structures. Payment for ambulatory services is based on ambulatory care units, as well as a fixed amount for each service (Lobato and Burlandy, 2000).

The financing of Brazil's unified system is 'not linked to results, which in turn are not sufficiently evaluated' (UNCT, 2005:46). Moreover, because services covered by the SUS are provided universally and free of charge, high-income groups often rely on the public health system for more complicated and expensive procedures, not covered by private providers. While this has the beneficial effect of generally reducing the premiums of private plans for upper-income populations, it 'causes the costs to be extremely high for the poor and, consequently, limits the possibilities of expanding the coverage of regular services sponsored by the SUS for this segment of the population' (Medici, 2002:11). That way, the poor lack regular access to basic health-care services, while 'richer households enjoy access to costly services at public expense' (UNCT, 2005:15). Because, as Hunter and Sugiyama say, 'Brazil is still a socially segregated society, where groups at the bottom lack the means to influence their country's economic and political development' (Hunter and Sugiyama, 2009:31). The authors continue:

'High levels of inequality (a measure of distribution) impede the achievement of sustained economic prosperity [...] They are also thought to decrease the frequency with which people use existing institutions that are nominally open to them, ranging from formal legal rights to "universal" health care; if broadly utilized, these institutions would enhance citizens' own well-being and create further investment in the social welfare system' (2009:31).

In fact, '[d]ifficulties with public services have prompted people to contract with private companies that feature low prices and few guarantees' (Lobato and Burlandy, 2000:129). In Rio de Janeiro many voluntary subcontracting plans cover only office visits. And, in Lobato and Burlandy's words,

'...[w]ith the breakdown of the public system anyone who can afford to signs a contract with a voluntary private service. Segmentation occurs within the private system, as the offerings differ enormously from one company to another. It is based on the hierarchical position in the formal labour market. Thus, in the same company or sector of the economy, for example, there are different levels of private coverage' (2000:131).

Brazil has one of the highest rates of maternal deaths in the world and it accounts for over a quarter of Latin America's maternal deaths (World Bank, 2002). Specifically, while nationwide maternal deaths account for 2.9 percent of all registered deaths of women aged 10-49 years, in the

North and Northeast, this proportion increases to 4.8 percent and 4.2 percent, respectively (World Bank, 2002). Notably, 91.5 percent of childbirth takes place in public hospitals, and approximately 66 percent of women who die from pregnancy-related causes rely completely upon the public-health system when giving birth (World Bank, 2002). In spite of the influence of the feminist movement on reproductive public policy making, minority women are still disproportionately affected. There are higher maternal mortality rates among black, indigenous, and single women living in the poorest regions of Brazil (CLADEM). At the same time, the majority of maternal deaths occur in low-income families and families with low levels of education (TCU, 2003). The primary direct causes of maternal death in Brazil are eclampsia - a serious complication of pregnancy characterized by seizures in pregnant women usually preceded by symptoms such as high blood pressure and excess and rapid weight gain - , pre-eclampsia, haemorrhage, infection, and unsafe abortion (MoH, 2006). But the root causes are socio-economic and gender-based disparities in access to health care.

Essentially, strategies of power, resistance and negotiation may be perpetuated by the transplant of an international 'health belief model' which is premised upon the notion that behaviour is determined by 'rational' calculations of outcomes assuming that if people are educated and provided with accurate health information, they will change their behaviour accordingly' (Hawkins, 2001:66).

Even though, the management of reproductive life cannot be restricted to the analysis of formal systems of authority - since it is in fact a process intrinsically connected to biological, social, economic and political factors (Tremayne, 2004) - its study is crucial. Indeed, '[w]omen's discourses on reproductive health, sexuality and gender are embedded within the wider construction and negotiation of social identity and power relations in a society' (Hawkins, 2001:68). Reproductive health is not only restricted by a question of information and access; nor can it be restricted to international standards. It shifts according to one's perceptions of self as well as to social, economic, political and historical constructs that are intimately associated with power both within the community and within the marital relationship (Cook, 2003). The safeguarding of the right of women to determine their own reproductive future is also intrinsically linked to access to resources which reach far beyond those of reproductive health services (Hawkins, 2001). It has to do with marginality and power.

Women's lesser economic and social status as a whole can contribute to the lack of attention a state places on the protection of women's health and survival, and it also can contribute to the obstacles individual women face in accessing the health care necessary to secure their overall health and to avoid and treat complications relating to pregnancy. Obviously, this previous analysis is far too generic and quantitative but it gives us some ideas of what may be happening locally. Now, the article draw on a particular study undertaken in the urban outskirts of the municipality of Rio de Janeiro, southeast Brazil.

## **The setting**

The city of Rio de Janeiro is compartmentalized into a frenetic business area near the harbour, a working class zone to its north, a rapidly growing suburban zone to the west and a rich sea side zone in the south (Arias, 2006). The setting of this study, Deodoro, lies on the outskirts of the city, on the north-west edge of the municipality. Deodoro is located on a disused military site and grew out of pressure from the elite to transfer the poor and underprivileged from downtown to this area.

Deodoro is not a ghetto nor a squatter settlement. It is a residential community not socioeconomically homogeneous, that is partially integrated into Rio's urban society. It reproduces, in most ways, the dominant ideology in terms of social, political and economic structures. There is limited upward mobility and no rigid segregation. However, there is

separation into groups by gender, economic situation, status and 'race'. There are a few 'favelas' close by but Deodoro has different living conditions and is not a particularly violent community unlike most 'favelas'. Deodoro's population was served by one state hospital and one main municipal health centre.

In this locality, health is mostly provided by specialists thus confining it to the strait jacket of formal rules related to western bio-medicine. There are lay concepts of health and some practice of popular medicine. These consist of religious and supernatural services performed mostly in informal settings by older women who rely heavily on natural products (leaves, oils, flowers and roots). Traditional midwives (parteiras) 'independent [not formally educated] primary care providers during pregnancy, birth and postpartum [...] recognized as such by her community and jurisdiction' (RECALAHUPAN 2007:1) based on aboriginal heritage, spiritual beliefs or intuition - used to be common before the 1970s. Nowadays, this practice seems to be fading away.

According to the 2000 national census, Deodoro had a total population of 11.593 of which 6.310 were women and 5.283 men (IBGE, 2000). In 2006, 188 women gave birth. Out of this total 83 had natural births while 105 had caesarean-sections. There is no information the number of abortions. However, it is known that in this same year 37 women chose to pay to give birth in a private facility instead of using the public municipal hospital and 11 gave birth at home or at some other facility not part of the 'formal health system'. Out of the total, 43 died of unknown causes related to pregnancies or childbirth. Causes of death were rated as direct (resulting directly from an obstetrical event) or indirect (from illness or disease not directly related to an obstetric event, such as cardiac disease). Mortality from direct causes greatly exceeded that from indirect causes, due primarily to deaths related to abortion and - the next highest cause - toxemia (a condition associated with high blood pressure that can be called eclampsia or pre-eclampsia - in moderate cases). The women almost never receive prenatal care. Some NGOs such as the Maternal Mortality Initiative are trying to tackle this problem.

### **The Maternal Mortality Initiative**

The Maternal Mortality Initiative (MMI) is a women's rights NGO that instrumentalizes the bio-medical discourse of maternal health through education and self-empowerment techniques. Since its beginning in February 2005, MMI has been working for the skill building and strengthening of women's movements locally. It uses a human rights framework while running workshops, seminars, conferences and public manifestations on behalf of the implementation of international women's rights locally. Its purpose is to tackle gender discrimination, gender violence and social marginality through three main focal points: women's local leadership; capacity building and accessibility to public health services. MMI develops projects on sex education, family planning, economic empowerment and other minor social works. It aims at creating a sense of belonging and identity by forming small groups of like-minded women and serving as their intermediate and meeting space.

It is feminist by definition but it portrays several stereotypical gendered roles. For example, according to MMI, women are still supposed to 'connect' with women only while completely dissociating from the 'men's world'; women are always portrayed as victims while men are victimizers; family planning is only a woman's concern; and embroidery is a 'natural idea for a women's cooperative'.

MMI started from the desire of a low middle class retired woman to make sense of her life and to contribute in some way to society. She first instituted lace making courses, then a lace making cooperative and - only out of the need to gather external funding for sewing machines - a formal women's rights organization. The founder, now MMI's executive director, was not born in nor lives in the target community.

MMI's funds come mostly from personal donations, the Inter-American Foundation and the Ford Foundation. Some occasional smaller partnerships with the Brazilian National Service of Industrial Learning may be established for specific 'crash courses' on lace making, needlework and entrepreneurship. MMI's office has been moved many times. But today, MMI's office is located in Deodoro.

MMI is formally registered as a Civil Society Organization of Public Interest (OSCIP) which presupposes a General Assembly, an Executive Directorate, a Fiscal Council and an Advisory Council. But in reality, MMI has only seven staff members: one executive director, one administrative director, one organizational manager, one advocacy manager, one legal counsellor and one office assistant. I worked for MMI from October 2008 to September 2009 initially as its legal counsellor and later as its legal counsellor and organizational manager. Soon after I started working, MMI transferred its office from downtown Rio de Janeiro to Deodoro as an attempt to attain 'real engagement of the women'. Curiously enough, the key person in this transition process was a man, the president of the Deodoro Residents Association. He was the one who arranged the move to a new office space and called for more public engagement.

In general, the women targeted by MMI's projects showed particular interest in projects related to sex education and family planning. They expressed the community's need for equitable and easy access to contraceptives, good public reproductive health care and legal abortion. However, MMI's projects really only dealt with the reduction of HIV/AIDS and maternal mortality rates through educational strategies. It encompassed the free distribution of male and female condoms, sex education workshops, safe motherhood classes, informational sections concerning their right of access to health services, referral to other human rights organizations, the local health centre and hospital. MMI's services were also geographically restricted. The assistance was only provided in the community of Deodoro and for residents of Deodoro.

## The study

From October 2008 to September 2009, MMI's projects attracted fifty-two women. Their ages ranged from sixteen to seventy-one. Four were married. But most of them were either single or widows. They were mostly in charge of all domestic labour (house work) and could only work outside their homes informally. Some dedicated all their spare time to lace making, some worked in open markets selling handicrafts and produce while some sold homemade cookies and jams. With time women's participation was drastically reduced. By January 2009 only twenty-three women were still showing up to the workshops and seminars. And the lace making cooperative fell to only two women. The two eldest remaining women justified their persistence because of their lack of choice. Some of the youngest said they enjoyed taking part in the activities. Others affirmed that it was a good opportunity to socialize with other women and to escape from the loneliness of domestic work. The women that no longer took part in MMI's daily activities usually evasively justified their absence by numbering several commitments and promising they would come back when 'it got better'. But these were not the only accounts. Some women expressed other problems.

For example:

Teresa, a sixty eight year old widow, mentioning MMI's workshops and classes said:

*'I didn't forget about you [the organization], I haven't had time for nothing else, soon I will be in touch to get everyone together for a meeting of solidarity and economy. I miss them. I'll try to get a time to come and talk to you. We need to be more organized.'*

Ana, a forty year old single mother, mentioning her new cookie making business said:

*'I am sorry to inform that I will not be able to finish the project. There are too many requests for information [from the lace making cooperative]. I will put all my coins into one bowl. Would you be able to do both?'*



Debora, twenty two year old married woman - the last one to leave the lace making cooperative - explained her decision:

*'I have already said no to taking part in the 'Bazar' [clothes selling market]. I have little time to take care of her [her daughter], she gives me little time to be prepared, even more, the first week of the month is not good for selling my products, most people only get their salaries from the 10th day on. However, my friend asked us to take all the products there for us to arrange a table for a whole week. She asked so kindly. There was no way I could say no. You know how it is. We [the women] have to do everything, right?'*

Daniela, a fifteen year old girl, went on:

*'In the beginning I was told to be part of the project because many teenagers would also participate. I showed up for the 'sex-ed' classes for the initial period [three months] but then I was the youngest there...I was embarrassed. How could I ask my questions in front of the old ladies? People talk. I would never find a real boyfriend that way. I don't wanna be like them [single mothers].'*

Rose, the mother of Tania also one of the youngest girls of the initial group said:

*'I tried to convince her. I even put her name down. I filled up the paper work. But I really don't understand what children want nowadays. She says that Jesus will help her. Help her how? She decided to listen to those people in the church and now she is pregnant. I told her she should take the pills [contraceptives]. Many women in our projects are taking the pills. But now I know she cannot do it by herself [giving birth]. Now I have to help her but I did not chose it.'*

First women came to MMI to take part in the lace-making. They wanted to learn a new trade, wanted to earn money and do it all in a supportive environment. But with time this changed. In 2008, most of the younger women seemed to join MMI in order to avoid unwanted pregnancies. The older women though seemed to be attracted by the idea of being able to generate alternative income without having to leave the household for long periods of time. There are some mothers and grandmothers who bring their daughters and granddaughters on board. Some tend to get involved with more activities than just the one activity that attracted them in the first place. The reasons for continuing or interrupting participation varied. But usually it had to do with the struggle for economic survival. Two accounts revealed a growing interest in rigid religious life styles such as Catholic and evangelical. Four women expressed concerns related to approval by their husbands and their mothers. The younger girls were concerned with gossip. No one ever talked about abortions. Even though MMI's staff approved of the practice no real projects were designed in favour of abortion. It seemed to be a real taboo. There were a couple of cases of middle age women taking infusions to induce abortions and one case of a teenage girl who asked to be referred to an illegal abortion clinic. Some of the women seemed to find their own way of ensuring their own reproductive freedom and agency outside of formal systems of authority such as in private health clinics through paid services and at home with self-regulated contraceptive techniques. The community seemed very sceptical about MMI's work.. The heads of the nearby churches also appeared to be disapproving of MMI's presence. There were no class differences in the membership. But well-off women seemed more comfortable to speak up at meetings and tended to control the discussions.

### **The loss of the health centre**

In June 2009, a nearby municipal health birth centre closed its doors to the public. The centre was 'staffed by 18 obstetric nurses "with extensive experience" - according to a statement issued by the institution - eight nursing assistants, two social workers and a nutritionist' (Frayssinet 2009). It attempted to 'provide a more home-like environment during childbirth (natural birth only), along with specialised "integral" care for the expectant mother throughout the pregnancy and the

birth'. However, a 'health inspection [by the Ministry of Health concluded] that it lacked equipment considered necessary for attending childbirth, such as a fetal heart monitor, and that sterilisation was inadequate'. The president of the Brazilian Federation of Associations of Gynaecology and Obstetrics justified the closing by saying in a statement that:

*'the insistent and frequent attempts to remove childbirth from the sphere of the obstetrician/gynaecologist, the health professional with the greatest knowledge and skill in the process of assisting childbirth' is "unacceptable" and "reckless"' (Frayssinet, 2009)*

In response to its closure, MMI started a campaign for its re-opening. At that time, some of the women of Deodoro expressed their views. For example, Chris, a 39 year old mother of four, when asked to join MMI's campaign responded:

*'Thank you for asking. Not many people ask our opinion around here [in the community]. I think I will come yes. It looks super nice.'*

In the same occasion, Lilian, a fifty one year old mother, affirmed:

*'This thing with the health centre is resolved. The State committed this crime. Everyone is sad, not believing in what happened. The men [the way people in Deodoro usually refer to public officials] have decided and we just have to live with it. I gave birth to my two children there but now I will have to go to the hospital. May God help me'.*

Carmen, a sixty year old great grandmother, circulated an email soon after the closing and before the beginning of MMI's campaign:

*'...the violence is endless here. They want to end poverty by practicing genocide of the black population. This is paid by the State, by us. This Saturday we lost our health centre. I am very hurt. I am sorry. Yesterday I was here in Deodoro talking to the people of the community, to the President of the Resident's Association, everyone is still shocked. We worry about our children. Who knows what other sort of violence we will be subjected to. We know these people. There is no dialogue: what are you going to do? We are muted. That is the fact.'*

At the first public manifestation organized by MMI on behalf of the re-opening of the health centre one of the participants, Maria, joyfully said:

*'I am glad MMI came up with this. We always receive good news from MMI. We will have volunteers that will help here in our community. At least we can shout out. Shout out that we do not agree with this. We cannot lose this opportunity. The time is now!'*

On that same day, Ana, the mother of five expressed her view:

*'What did I think? I don't know what I think. I have too many things to worry about. My husband is drinking our money and he won't take care of the children so that I can work too. The little ones are going to school except for the baby who is still on formula [milk formula]. Politics is for rich people. I have no money so I have no politics.'*

Chris a twenty five year old single woman who had just finished training to become a nurse answered:

*'I am worried with all this noise. I am worried. The doctors explained to me that that place, the health centre you know, was no place for giving birth. The doctors know better. They are trained to know everything. I was trained to work with them and that's how I know. But these women don't understand. If it was closed it was for a good reason. It will be better for them. It was too dangerous a place.'*

Some of the concerns expressed above demonstrate that pregnancy and childbirth are seen by this specific community, as in most western societies, as extremely medicalized events. In 'such a mechanistic model of the body' the individual is treated 'as undergoing a temporary state of 'deviance', as a result of mechanical failure, but soon to be returned to normal functioning' (James and Hockey, 2007: 41). This derives 'from a root metaphor of 'production' which reflects a society organised around industrialisation under capitalism' (James and Hockey, 2007:41). '[M]edical knowledge both describes and constructs the body as an invariant biological reality' (Armstrong 1983 in James and Hockey, 2007:46). '[T]hese so-called 'objective' or 'scientific' ways of knowing the body are themselves a product of cultural and historical processes' and 'are

as much a *political* as a medical anatomy' (James and Hockey, 2007:47). Notwithstanding this model may also be permeated by lay understandings, as in Deodoro. Social constructionism of bodily processes or crises is not only bio-medically interpreted but also individually mediated and constructed (James and Hockey 2007). Embodiment theory explains:

'The body is a subject of (and subject to) social power. But it is not a passive recipient of society's mould, and therefore external to it. The human capacity for social agency, to collectively and individually contribute to making the social world, comes precisely from the person's lived experience of embodiment. Persons do not simply experience their bodies as external objects of their possession or even as an intermediate environment that surrounds their being. Persons experience themselves *in* and *as* their bodies' (Csordas 1994 in James and Hockey, 2007:54).

## Conclusion

Brazil's enormous regional wealth disparities have not been reduced by health care decentralization (World Bank, 1993). These initiatives have proven not to be able to strengthen provincial-level planning and alter the power relationship between the periphery and the central offices of the Ministry of Health (Bossert, 1998). Currently, the provincial and local level officials are still very dependent on central offices in Brasília, while at the same time there is still a very opaque and inefficient system of accountability (Sugiyama, 2008). 'The data suggest that despite [decentralization's] regulatory measures to increase efficiency and reduce inequalities, delivery of health care services remains extremely unequal across classes' (Almeida, 2000:129).

Indeed, considerable research indicates 'that greater levels of health services are provided in urban areas, richer areas, and areas with greater income inequality' (World Bank 2002:134). They also show that 'decentralized municipalities provide more services only if good governance accompanies decentralization' and that 'there are strong neighbourhood and spatial autocorrelation effects' (World Bank, 2002:134).

Typically, maternal and child health services overemphasize the synergy between the health of women and their children while overlooking the nonreproductive health needs of poor women, as well as the broader range of gender-related factors that determine health status and care and this failure to value women lies at the core of women's health problems (Turshen, 2007).

'Neoliberal health policies call for the commercialization of clinics, hospitals, doctors' practices and the distribution of drugs. Cutbacks in public health and the privatization of education result in the training of fewer doctors, nurses, and health workers. Budget reductions and the privatization of water supplies also affect environmental health conditions, raising the incidence of cholera and diarrheal diseases. The principle is that users must pay for services; the problem is that women rarely control cash and cannot pay. So, fewer women turn to trained personnel for assistance in childbirth and maternal death rates rise...' (Turshen, 2007:43)

Even more:

'Most practitioners of medicine and public health are pragmatists, not theoretical purists, and they select whatever response seems useful in a particular situation. Not all are aware of or interested in the distant determinants of disease, the ideological implications of their diagnosis, or the economic, social, or political consequences of their treatment decisions' (Turshen, 2007:49).

Bio-medical campaigns seldom change people's living and working conditions but at the same time race, gender and class inequality largely determine health outcomes (Turshen, 2007). Several studies supporting the 'social production' of illness note that women's health and women's medical care should not only be taken out of biological and behavioural realms but also of economic, social, and political determinants (Turshen, 2007). Women and men do not

participate equally in health care services and care yet most health service systems neglect the differences or use unresponsive male-only perspectives (Turshen, 2007).

‘Decisions about how many children to have and when to have them are family decisions, not individual choices, in many communities. The decisions to seek trained help when complications arise is not a woman’s to take, and in any case she would rarely have her own money to pay the bill at the clinic, pharmacy, or hospital. Nor does she have the information to estimate the seriousness of her situation, as she is often illiterate. Lack of income and lack of education are related reflections of her dependent status. Unequal power relations reverberate through her life, dictating marriage (including polygamy), childbearing, and work. To introduce biomedical obstetric technology into this situation can lead to the consolidation of power relations in which women are the losers’ (Turshen, 2007: 54 citing De Konick 1998).

The socioeconomic and demographic profiles of maternal deaths in the city of Rio de Janeiro reflect a vulnerable social situation. But the government has remained unresponsive to the real needs of the women of Deodoro and their families. Brazil is disproportionately directing government spending for health to the affluent while ‘the poor lack access to basic health services and receive low-quality care’ (World Bank, 1993:4). There is also health sector fragmentation, loss of policy leadership, confusion of responsibilities and deterioration of services due to the adoption of top-down policies which in turn create further complications and discrepancies in health policies’ (Tremayne, 2004:182).

This does not mean that in Deodoro the women have full control of all aspects of their reproductive life. It means that the official discourse of the modern Brazilian State was at times embraced, combined or rejected by informal local groups and individuals.

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