

## Health Deficits and (the Absence of) Popular Mobilization in Brazil

Madhvi Gupta<sup>1</sup>

[P]rotest movements among the economically and politically weak are especially likely to occur when [communities] with social and cultural bonds experience sudden economic deprivation, when they lack attractive alternatives to 'exit' and seek individual solutions to their plight, and when they have the support of 'better situated' individuals and groups (Eckstein 1990: 294).

The roots of the problem and the conditions that lead Brazilians to doubt their capacity are systemwide. On the one hand, there is little or no accountability of elected officials to their constituents; on the other hand, there are no peoples' movements sufficiently powerful for the urban poor to make demands on the state (Perlman 2008: 273).

The objective of the article is to explain why Brazil's popular sectors<sup>2</sup> participated in health movements during the mid-1970s and why they did not do so during the 1990s. I show that the active engagement of left-wing doctors, medical students and the Catholic Church with a wide range of social justice issues—including the health predicament of the urban poor—brought about the emergence of a relatively brief but significant period of health movements—as distinct from the sanitary movement<sup>3</sup>—in some Brazilian cities

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<sup>1</sup>Madhvi Gupta is joining the Department of Humanities and Management, Birla Institute of Technology and Science (BITS) Pilani-K.K. Birla Campus, Goa, in April 2013. She previously taught at McGill University and Concordia University in Montréal (Canada). The article is based on the author's PhD dissertation *When Democracy is not Enough: Political Freedoms and Democratic Deepening in Brazil and India* (McGill University, 2006). Thanks are due to Philip Oxhorn and David Lehmann for their feedback and comments on the dissertation and to Pushkar and an anonymous reviewer for their suggestions to earlier versions of the article. Field research grants for the study came from the International Development Research Centre, Ottawa (Canada) and the Faculty of Graduate Studies and Research, McGill University

<sup>2</sup>The popular sectors consist of the urban and rural lower class and the lower middle class (Collier and Collier 2002). Traditionally, labour unions and peasant organizations constituted two of the most important popular sector actors in Latin America but have become less so with the growth of the informal sector.

<sup>3</sup>It is important to make a distinction between popular health movements and the sanitary movement. Health movements—which emerged in several poorer neighbourhoods in cities such as São Paulo—were primarily

during the mid-1970s. Given the incidence of health movements at a time when the military was in power (1964-1985) and political freedoms were at best limited and tenuous,<sup>4</sup> the absence of popular mobilization after the transition to democracy in 1985—when widespread health deficits persisted for the poor and the lower classes in the urban periphery—is quite puzzling.<sup>5</sup> While a history of health movements is hardly a reliable predictor of popular mobilization in the present or the future, it does point to a tradition and culture where health is considered an issue worth fighting for. Furthermore, poorer Brazilians considered health care as one of their main rights (Perlman 2008: 268-9). They also expressed high levels of concern with health. For example, in early 1995, Brazilians health ranked second only to jobs as a source of anxiety (Hugh-Jones 1995). Why didn't they then make demands for better health and related services?

Drawing from the academic literature on “external actors”—individuals, social groups, and organizations such as middle-class professionals including university teachers, doctors, lawyers, and students and the Catholic Church who are better situated than common people—in the making of social movements in Brazil (Alvarez 1990;

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concerned with issues that needed immediate attention, such as the establishment of health posts and hospitals in specific localities. The sanitary movement was limited to doctors and medical professionals whose main goal was to reform Brazil's health system. The two ‘movements’ shared some common goals and were connected by the active participation of health experts. However, popular struggles for health merged with other need-based struggles—such as demands for employment and housing—and eventually with the broader pro-democracy movement over the course of time. The sanitary movement, which was inspired by the Italian sanitary movement and especially the ideas of Giovanni Berlinguer (Fleury and Mendonça 1989), began in the early years of military rule. Its key figures developed their ideas in university departments of preventive medicine, the institutional networks of these departments and state and municipal secretariats of health. During the 1980s, it was absorbed by the bureaucratic apparatus of the state and played a central role in health sector reforms that followed (van Stralen 1996; Weyland 1996; Escorel 1999).

<sup>4</sup>Under President Ernesto Geisel (1974-1979), the military regime initiated a process of political liberalization (*abertura*) which provided some space for political activity (Skidmore 1988).

<sup>5</sup>While Brazil's overall health situation certainly improved between the 1970s and the 1990s, there remained widespread health deficits and new health challenges—notably violence and HIV/AIDS—surfaced. For a recent overview and discussion of health challenges in Brazil, see Schmid et al (2011) and Reichenheim et al (2011).

Assies 1999; Cardoso 1983; Jacobi 1989; Machado 1995), the article argues that the role of external actors is crucial since—unlike the popular sectors—they have the skills and resources to challenge dominant ideas, formulate competing discourses and construct potent mobilization frames. The ability of the popular sectors to perform the same tasks is in doubt since the lower-classes lack similar skills and resources. Further, as Perlman (2008: 269-70) puts it, “the ‘view from below’ [in Brazil] lacks potency” so that there is a “belief-behaviour disconnect”: even those who believe in the value of political participation doubt their capacity to bring about any meaningful change. Under such conditions, external actors are also needed to activate the agency of the popular sectors by nudging them to believe that their actions can bring about social change.

During the 1970s, cities such as São Paulo witnessed widespread popular struggles for a variety of social justice issues. The economic policies of the military regime had wreaked havoc on the lives of the urban poor and led to a dramatic worsening of their living (including health) conditions. Health movements emerged at this time when doctors, medical students and Church officials took up the cause of the popular sectors. With the arrival of democracy in 1985, the relationship between external actors and the popular sectors changed. The physical and social segregation between the popular sectors and the middle-classes—which had reduced somewhat during the heyday of popular struggles for democracy—was re-established. A related development was the disengagement of the Catholic Church and health professionals from the politics of the social as they turned to more routine activities. As a result, the popular sectors were left to their own to fashion their struggles for social justice. In sum, I make the argument—based on prior research on Brazil during the 1970s and the New Republic era<sup>6</sup> as well as field research in Sapopemba (2001), in the eastern region of São

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<sup>6</sup>There is an enormous amount of academic literature on social movements, the Catholic Church, democratization and related themes both in Portuguese and English. It was impossible to cite more of them in a journal-length article.

Paulo—that the retreat of the external actors explains why health movements did not take place during the 1990s.

In the first section, I explain why external actors matter for popular mobilization. The second section reviews prior research on popular health movements in the 1970s to highlight the role played by doctors, medical students and the Catholic Church. The third section draws on my field research and on other writings on democratic Brazil to identify probable reasons for the absence of health movements in the 1990s. In conclusion, I argue that the retreat of health professionals and the Catholic Church left the popular sectors to fight their own battles so that they were caught in a “cognitive trap” and did not believe that their actions would be successful.

### **Why External Actors Matter**

Karl Marx (1978: 172) famously wrote in “The German Ideology”: “The ideas of the ruling class are in every epoch the ruling ideas: i.e., the class which is the ruling *material* force of society, is at the same time its ruling *intellectual* force.” Marx’s ruling ideas refer to the wide range of public discourses produced by dominant social groups to secure the legitimacy of existing political and socio-economic relations. Such dominant discourses have clear ideological goals: to maintain existing patterns of domination and subordination without widespread conflict. The success of these discourses lies in their acceptance among subordinate social groups so that they begin “to consider their subordination as ‘normal’, a naturalizing view of social hierarchy predominates, and the relationship with the state is expressed more often in terms of clientelism or paternalism than in terms of citizenship, rights and obligations” (Jelin 1996: 107). Under such conditions, the impulse for popular mobilization can only come about when subordinate

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groups counter the legitimacy of prevailing discourses with progressive ideas about democracy, social justice and citizenship and the nature of social relations between different classes, ethnic groups and men and women.

The scholarship on social movements, Alvarez (1990: 58) argues, tends “to underplay the importance of social discourses for awakening critical political consciousness and sometimes inspiring protest actions” even though they “play a crucial role in shaping the *subjective possibilities* for protest by interpellating oppressive conditions for subordinate social groups and classes, fashioning new social and political identities, and providing moral or ethical rationales for engaging in anti-status quo behaviour and political action.” In deeply hierarchical societies like Brazil, the initial impulse for popular sector mobilization can only come from the rejection of everyday discourses, followed by the fashioning of progressive competing discourses. For example, the women’s movement emerged due to the “new discourses about liberation and democracy developed by the church, the militant Left, and the bourgeois opposition [which] provided the grounds” for women to assert their “natural” rights (as wives and mothers) or claiming new rights” (ibid).

The emergence of competing discourses is crucial because it provides a starting point for the construction of mobilization frames which relate to the grievances of subordinate groups. The creation of mobilization frames involves “conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action” (McAdam et al 1996: 6). Thus, a “social justice” frame derives from new ideas about democracy, political and socio-economic equality and welfare. The extent of popular support for issues adopted in mobilization frames depends on whether or not that particular issue is part of public discourse. A potent mobilization frame—one which applies to issues that have saliency for large numbers of people—has the potential to overcome the passivity of the popular

sectors. However, much still depends on “persuasive communication” (Klandermans 1992) by those in the business of frames-making. It is possible that there is a happy alignment between the views of large sections of the population and the issues that are being framed; however, such alignment is not a given. Often, individuals have to be convinced of this alignment through a process of “frame-bridging” (Snow et al 1986). Crucially, individuals and social groups must also undergo a process of “cognitive liberation” (McAdam 1982: 51) so that they develop a collective definition of their situation as “unjust and subject to change through collective action.”

This is where external actors come into the picture. Cardoso (1983) and others (Jacobi 1989; Alvarez 1990; Machado 1995; Assies 1999) identify them as individuals, social groups, and organizations that belong to civil society but are ‘external’ to the popular sectors.<sup>7</sup> In Brazil, these external actors challenged the dominant discourses of the military-authoritarian regime—particularly its discourse of development—and reinterpreted it in the context of growing socioeconomic inequalities in the country. In doing so, they reached out and connected to the popular sectors, and successfully constructed a mobilization frame of “opposition to authoritarian rule” / “return to democracy” that brought to the fore issues such as human rights, democracy and social justice.

In multi-ethnic and unequal societies like Brazil, external actors also play a key role in bridging social divides across ethnicity, class and gender divisions. Brazil is a country characterized by marked social distance between blacks and whites, men and women, rich and poor and the poor and the poorest. Such divisions tend to have

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<sup>7</sup>The distinction between civil society and the popular sectors is an important one. I subscribe to Chatterjee’s (2004: 38) view on ordinary people in India—that they are “not proper members of civil society” because they “are not regarded as such by the institutions of the state”—for the popular sectors in Brazil. Perlman (2008) refers to the urban poor in Brazil as “pseudo-citizens” (p. 262) because a majority of them have neither experienced nor perceive any significant improvement in their lives despite the end of military rule and the transition to democracy (pp. 262-3).

negative effects on social capital: those “norms and networks that enable people to act collectively” (Woolcock and Narayan 2000: 226). This is because countries with “huge social distances entailed by deep inequality” typically witness “manifold patterns of authoritarian relations in various encounters between the privileged and the others” (O’Donnell 1999: 322-3) which are not conducive for building high levels of trust and solidarity essential for pursuing a common cause as citizens. During the 1970s and the 1980s, when middle-class professionals and the Catholic Church reached out to the popular sectors and propagated a common discourse about their aspiration for democratic rule, social justice and human dignity, they helped to create bonds “between groups who in other settings were antagonists” (Stepan 1988: 5) or simply indifferent to each other.<sup>8</sup> The creation of such solidarities was important because it increased the levels of trust between different social groups and promised a better future *for all Brazilians*.

The importance of external actors to the emergence and success of social movements is not given due credit (Foweraker 1995). For Foweraker (ibid: 83), “outsiders often hold the key to collective action, since they are able to advise on organization, the law, and the political landscape, as well as supporting movements in their negotiations with political authorities.” It is when the social deficits experienced by the popular sectors are vocalized by public intellectuals, political activists and other influential actors that they begin to be really heard. The ‘outsiders’ also play a key role in identifying and defining the issues over which popular struggles take place. They play the role of framing specialists: those “who develop, borrow, adapt, and rework

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<sup>8</sup>The solidarities between the popular sectors and the middle classes during the 1970s and the 1980s should not be exaggerated. While urban popular movements involved different social classes, only on occasions did they come together (Mainwaring 1987).

interpretive frames that promote collective action and that define collective interests and identities, rights, and claims” (Baud and Rutten 2004: 7).

### **Health Movements in 1970s Brazil**

After it seized power in 1964, the military regime took decisive steps to deepen industrialization and speed up economic growth. Subscribing to the merits of trickle-down growth, the regime emphasized technocratic planning, capital accumulation, foreign investment and labour repression. There was no consideration given to issues of equity. These efforts were quite successful. The economy grew at an average of 10.9 percent between 1968 and 1974 (Skidmore 1999: 177). However, the so-called “economic miracle” benefited only a small minority and increased poverty and income inequalities in an already unequal society. By 1974, 30 per cent of Brazilians lived in absolute poverty (Alvarez 1990: 45). The urban poor were increasingly marginalized and pushed into the periphery which was severely lacking in basic necessities: adequate housing, water supply and garbage removal. The “urban spoliation” (Kowarick 1980) was part of a dual process of exploitation at the workplace and the place of residence.

The period of Brazil’s economic miracle was one when social development indicators touched rock bottom (personal interview with Lúcio Kowarick, São Paulo, 21 August, 2001). According to Atwood (1990: 155), “the antagonism between economic development and social welfare” became quite apparent and this was especially the case with health. Falling incomes and lack of basic amenities intensified the burden of disease. The health system was ill-equipped to deal with the emerging contradictions of growth-centred policies. The number of public and private health facilities was relatively low and unevenly spread across the country. Further, the military regime emphasized curative medical services “as the ‘modern’ way to social development” to

the detriment of preventive and public health care (Horn 1985: 51). The reorganization of the health system led to the emergence of two subsystems: the public collective-preventive subsystem and the largely privatized individual-curative subsystem (Atwood 1990). The latter was prioritized so that “the health system acquired a two-tiered character, with an essentially privately funded and provided system offering high quality health care, contrasting with a publicly funded, impoverished lower level system” (van Stralen 1996: 90).

The results were disastrous. Infant mortality began to increase from the mid-1960s onwards and reached alarming levels in the periphery during the early 1970s. The overall situation improved somewhat from the mid-1970s due to health and infrastructural investments but the “regionalization of deprivations” remained a serious problem (Jacobi 1989: 42). In 1975, infant mortality in São Paulo’s eastern zone was 122.23 per 1,000 births and even higher in some pockets of both the eastern and the southern zones, whereas the wealthy district of Jardim Paulista registered a rate of 44.6 per 1,000 (Jacobi 1989: 43-4; Caldeira 2000: 228). Life expectancy dropped from 62.3 years for 1959-67 to 60.8 years for 1969-71 (Caldeira *ibid*). The city experienced a frightening rise in epidemics, notably the meningitis epidemic in 1974, and the incidence of other diseases had a particularly severe impact on infant mortality (Jacobi 1989; Atwood 1990). The deficits in health care services were particularly acute in the urban periphery. For example, only 46 per cent of the population in the periphery had access to health posts compared to 76 per cent in the central zone (Jacobi 1989: 43). Thus, after 1974, as the economic miracle came to an end, the military regime experienced a further erosion of its legitimacy.

It was under such conditions that “the drama of the periphery” unfolded in São Paulo (Jacobi 1989: 32) despite military rule. Though the Ernesto Geisel (1974-1979) administration had initiated political liberalization, the fear of repression remained a

deterrent to popular mobilization (Mainwaring 1989; Weyland 1996). Thus, the emergence of health movements was not inevitable. It required the intervention of doctors and progressive Church officials to transform the political consciousness of the popular sectors so that they could begin to search for collective solutions.

At the height of Brazil's social crisis, left-wing medical students and doctors, often together with progressive Church officials, began to work in poor urban neighbourhoods. They raised health awareness by explaining "the relation between conditions of life and spread of diseases" and between politics and health (Machado 1995: 171) and transformed popular perceptions about health issues. They also "contributed to the organization of popular movements such as neighbourhood associations, health groups, and other grassroots movements, and helped to channel the steadily broadening sphere of social and political protest" (van Stralen 1996: 133-4). As Jacobi (1989) notes, without the active involvement of health professionals, the movement for better health conditions would not have emerged or gathered momentum.<sup>9</sup>

Progressive Church officials constituted the second important group of external actors. In 1970, after Cardinal Paulo Evaristo Arns was appointed Archbishop of São Paulo, he and his collaborators launched "Operation Periphery" to target the Church's resources to "where the people were": mainly the *favelas* that had emerged in the city's outskirts (Berryman 1996). Subsequently, the 1977 *Conferência Nacional dos Bispos do Brasil* (CNNB) endorsed organizing activities by its members that made the Brazilian Church stand out as the most progressive in Latin America (Burdick 2004). In his study of popular movements in São Paulo's eastern region, Jacobi (1989: 129) observed:

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<sup>9</sup>Similarly, in his study of the Movement of the Friends of the Neighbourhood (MAB) in the city of Nova Iguaçu, Mainwaring (1989) traced the origins of the movement to two doctors who began to work with the poor in one of the city's outlying neighbourhoods.

The strength that the Church gave to the popular movements is unquestionable, principally through the work of the agents of the Health Pastoral....Following this work, the population began to establish the relation between their inadequate conditions of life, the health question, social injustice and the necessity to find collective solutions.

The influence of the Church and Christian (specifically Catholic) faith and experience was apparent in the ethical language of struggle employed by the popular movements (Alvarez 1990; Doimo 1995).

The activism of Church officials had a particularly profound impact on the lives and the attitudes of women in poor neighbourhoods. Alvarez (1990: 43) has drawn attention to “the fact that the overwhelming majority of the participants of urban social movement organizations [were] women.” As she explains (ibid: 46):

The lack of adequate social services and the deficient urban infrastructure found in the peripheral neighbourhoods directly affects women and their ability to perform their ascribed feminine roles....If a neighbourhood does not have adequate sewage, it is women who must care for family members who fall prey to infectious diseases contracted from open sewers. If a community has no public health facilities, it is usually women who must travel long distances to seek medical attention for their children.

Women’s traditional role of caregivers galvanized them into public action in the context of the health catastrophes that occurred almost on a daily basis in the periphery.

In Jardim Nordeste—a *bairro* in the eastern zone of São Paulo—where the health movement flourished in the mid-1970s, its leaders, commonly women, acknowledged the influence of the Catholic Church and progressive nuns (Machado 1995). The Church upheld the notion of equal rights for women and encouraged them to work with men in improving the conditions of life in the *bairro* even though at the same time it emphasized the care-giving role of women. While it did not propose a structural transformation of the patriarchal order of family or society and maintained the traditional notion of womanhood, it preached respect for women both in the private and public spheres, and “in this sense, its influence on the development of political consciousness of women of the Jardim Nordeste was significant” (ibid: 179). The Church provided an acceptable and safe space—the physical space for meetings and discussions—as well as intellectual stimulation from progressive priests and nuns for political activity (Doimo 1995; Sader 1988). Citing Durham (1984), Machado (1995: 174) argues that “what induced the organization [of women] was not so much the actual situation of poverty, but the development of the consciousness of this poverty.” After they recognized the precariousness of their living conditions, they came to comprehend “that the same conditions affect everyone...and, finally and most important, that they had the right to access to health services that were being denied to them” (ibid: 175). The next logical step was making “the connection between those ideas and the solution of the problems” (ibid).

In sum, Church officials and medical professionals helped the popular sectors develop a critical consciousness about their lived conditions. They successfully propagated a discourse that challenged the legitimacy of existing social relations and showed the ways in which the urban poor could search for collective solutions to their

problems. They lent their organizational skills and leadership and were instrumental in the emergence of health movements in the eastern zone of São Paulo.

### **Brazil in the 1990s: The View from Sapopemba**

Among the most significant developments of the post-transition years was the creation of *Sistema Único de Saúde* (SUS) consisting of the Health Organization Laws, the 1988 Constitution, the state constitutions of 1989 and the municipal organization laws (Almeida et al 2000; Lobato 2000; Paim et al 2011; van Stralen 1996; Weyland 1996). With the introduction of universal health care, Brazil entered a new era of health. However, the country's health conditions were also shaped by the economic conditions of the 1980s—"a decade worse than lost" (Kowarick and Campanário 1988: 65)—when the country experienced a "deepening of its chronic social contradictions" (Souza and Minayo 1995: 103). Economic growth stalled—GDP growth was 1.6 per cent for the period 1980-1990 and per capita incomes actually declined during the same period (ECLAC 2003: 68, 69)—and there was massive government retrenchment from social services. Unemployment and poverty levels rose, bringing about a familiar combination of economic and social woes for the poor as well as the middle-classes. Public health declined or stagnated through the 1990s. In 1990-1991, per capital spending on health was \$156, rising to \$158 in 1994-1995, and it inched upwards to \$163 in 1998-1999 (ECLAC 2002: 271). The overall health situation, however, improved through the 1980s and the 1990s. Infant mortality declined from 64.4 per 1,000 during 1980-1985 to 47.2 per 1,000 for 1995-2000 and life expectancy increased from 63.4 to 67.9 years during the same period (ECLAC 2004: 241). These numbers were still high for a middle-income country so that even two decades later, Hunter and Sugiyama (2009: 45) concluded that while the new health system "definitely increased poor people's ability to receive medical care,

the degree of effective access and the quality of services they enjoy are at times questionable.” On the ground, in a study conducted by Perlman (2008) in Rio de Janeiro between 1999 and 2005, 55 per cent of respondents expressed the view that their health situation had worsened (44 per cent) or had not changed (11 per cent) from the time of military rule.

Brazil’s health woes deepened due to its emerging epidemiological profile. While chronic-degenerative diseases came to account for a growing number of deaths, they co-existed with infectious and parasitic diseases (Baer et al 2001). Thus, the country experienced an “epidemiological accumulation” (Franco Agudelo 1988) due to the persistence of social and economic inequalities. Further, a new health problem that is only partially captured by the label “external causes” appeared. While external causes refer to death by physical violence, they arose from a “sharpening of the social question” (Souza and Minayo 1995: 111) and became the second leading cause of death after cardiovascular diseases. And it was the poor and blacks who were the main victims of violence (Alves and Evanson 2011; Arias 2006; Caldeira 2000; Chevigny 1995; Reichenheim et al 2011).<sup>10</sup>

Why didn’t the poor and lower classes in Brazilian cities, especially São Paulo, make claims for health in the 1990s even though they enjoyed political freedoms and their living conditions remained precarious? In 2001, I spent several months meeting with a large number of residents (primarily women) in Sapopemba, approximately two hours east by bus from the city’s core, to understand the nature of health problems—especially health issues—faced by the urban poor and lower classes.<sup>11</sup> Sapopemba was

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<sup>10</sup>Homicide-related mortality rose from 26.8 per 100,000 people in 1991 to 31.8 per 100,000 in 2001 (Reichenheim et al 2011: 1963). Municipal level data for São Paulo in 1998 indicates that the incidence of homicide was 64.09 per 10,000 inhabitants in the less affluent Southern zone and 28.98 in the Central zone (PMSP 1999: 66, 69).

<sup>11</sup>I did my field research in several *bairros* including Parque Santa Madalena, Jardim Alba, Jata, Vila Bancaria, Vila Primavera, and Jardim Colorado between April and September 2001. More than 50 interviews were conducted and

in the 1970s one of the poorest areas of the city. In 2001, it also had substantial middle- and lower middle-class housing that coexisted with *favelas* built on steep hills covered with trash. In all, the eastern zone was one of the less developed and crime-ridden areas and it was here that health movements emerged during the 1970s.

The residents of Sapopemba were exposed to a variety of social deficits emerging from Brazil's economic woes and disappointing human development performance. They expressed deep concern with the various forms of inequalities, their humiliating exclusion, the violence that devoured their children, the lack of good public schools that forced their children out on the street and exposed to its depravities and the lack of decent quality health care. They spoke about racism and the lack of dignity. They repeatedly expressed their dissatisfaction with democracy, describing it as 'betrayal' of its basic ideals.<sup>12</sup> Many constantly referred to their 'marginality' and 'exclusion' and expressed anger and frustration about their social conditions. According to Carmen, a nurse, Brazil had "failed the [common people] in a social sense." These and similar statements conveyed a disappointing story for Brazil's bottom half or more of the population. Through my meetings with residents of Sapopemba over several months and based on prior research on social movements in the 1970s, I identified five probable factors which inhibited popular mobilization for health.

1. Survival first: For most residents, everyday survival, beginning with employment and a place to live, was a first priority during what one interviewee described as "a time of

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recorded. However, more than a dozen other interviews, especially during the later months, were informal and I took down handwritten notes. The statements of respondents cited in the article are translated from the Portuguese and edited for clarity (where necessary). I have deliberately left out the specific dates for the cited statements since they were all recorded during a six month period.

<sup>12</sup>This is consistent with opinion polls in 2000 in which less than one-fourth of Brazilians expressed satisfaction with democracy (Lagos 2001).

war.” Residents were certainly concerned about health issues. They recognized that health expenses were a big drain on their income. Many complained about the lack of resources in the public health system and the high cost of private care. However, providing basic necessities for their families was an enormous burden and took up considerable time and effort. Teresa, a health post volunteer, described the many kinds of challenges people confronted in everyday life:

Our health today is a portrait of many crises, of many things that are just out of place in this country. We do not have employment and we cannot have money, we do not have education, and we do not have health care.

Given these multiple challenges, it was to be expected that people were largely preoccupied with everyday struggles for survival. It required “hard work” to mobilize and protest for public services like health care. Others felt that, in the face of such challenges, people simply lacked the will to mobilize for health or other services.

2. Our lives have improved: After the transition to democracy, access to public health improved, even though it was often of poor quality. However, for many residents, the health situation was at least an improvement over the past. Since they had few expectations from the state, many were content with whatever health facilities had become available. As Lucia pointed out:

In my neighbourhood, only a few years ago, the health post was established. All this is new to us, piped water, drains, paved roads. I

think, in my opinion, people are simply grateful they have all this. The quality of services is not something people are thinking about.

Lucia added that “it is very common and very easy for people to accept and live with what they have.” Therefore, it appeared that while residents were not satisfied with the public health system or with their living conditions in general, they also felt that their situation had improved somewhat and would perhaps continue to improve.

3. Nothing is going to change: According to Teresa, people did not have “any expectations from life” and felt “marginalized and abandoned.” This meant that many residents, even though they spoke the language of rights, perceived themselves to be victims of processes beyond their control. According to Celia:

A big part of the population believes that nothing is going to change, even that it is the will of God. And this part of the population is bigger than the one with consciousness of its rights, a political consciousness for change. This part of our population is so battered and bruised that *despite all the talk of rights they no longer believe in the possibility of change* (emphasis added).

The pointlessness of social struggles and a loss of hope undermined people’s belief in their agency.

While the latent promise of democracy was recognized by several residents, overall, the extent of pessimism was discouraging. Most residents felt excluded from any meaningful political participation. To them, democratic politics was simply an arena for elites and political parties to make their deals. There was also widespread perception

that elected representatives simply did not listen to the voices of common people. According to Olivia, a PT (*Partido dos Trabalhadores* or Workers' Party) supporter:

We thought that democracy would bring equality and freedom. Yes, we have freedom to talk back, to scold, to go on the street if we feel like it, and I think it is important. But is that the only thing we fought for? When we open our mouths and scold somebody should also listen. I think we remain excluded, even though we have freedoms. Democracy has changed things, it has opened political spaces for us, but we are not managing to reach into them.

Others blamed the lack of political consciousness as the reason for the absence of popular struggles but simultaneously acknowledged that it was difficult to get results. According to Carlos, an activist in his 40s:

People will have consciousness when they have information. People lack information on health issues. Those who do have consciousness know and realize how difficult it is to get anything from the government....It is so common to struggle for the smallest things and you end up mostly with no results. The activists in the community, the ones you are meeting today, we have consciousness. We seek for it. But the majority of people are not like us.

As Maria put it: "Even if some people have political consciousness, most of us believe that nothing is going to change." It was evident that residents of Sapopemba were

caught in what may be called a “cognitive trap” where they recognized their situation as unjust but did not believe that their actions could bring about any change.

4. Growing violence and social distance: The arrival of democracy barely scratched the surface of social relations in the country. Democratic Brazil remained a country characterized by social and physical distance between the rich and the poor, the black and the white and the poor and the poorest (Caldeira 2000; Frugoli Jr. 1995; Reichmann 1999; Sheriff 2001; Silva and Hasenbalg 1992; Telles 2005). While the 1988 Constitution finally gave political equality to all Brazilians (in allowing illiterates to vote), São Paulo and the rest of the country continued to become more unequal and separate in social and physical terms.

The emergence of a new discourse on health in which violence was defined as the preeminent disease in the country contributed to growing social and physical separation between the popular sectors and the rest of society. The ‘health question’ became less about adverse urban conditions—whether sanitation, water supply, poor housing conditions—and focused on physical violence. The growing concern with violence was understandable. While communicable diseases were the main cause of death for the lower classes in the past, violence became the primary source of threat to life, especially for young Afro-Brazilians and the poor. State violence increased dramatically, as did drugs and gang-related violence, claiming the lives of the urban poor, street children, indigenous peoples, poor peasants and homosexuals (Alves and Evanson 2011; Caldeira 2000; Pereira 2000). Because the root causes of deprivation and disease—poverty, inequality, racism or broadly-speaking *condições de vida*—were not systematically addressed, crime and violence peaked, coexisting with democracy, and perhaps even magnified by what appeared to be a hollow discourse of freedom and equality.

The issue is not whether violence as a health issue was more or less relevant than the persistence of older health problems. Rather, while the poor were the main victims of violence, it was the middle-classes and the rich who were most fearful of it. On the face of it, since the popular sectors were the main victims, and the middle-class was worried about violence, they appeared to have a common interest in combating violence. However, the discourse on violence, while seemingly sympathetic to the popular sectors, also marked them as the perpetrators of violence. The upsurge of violence, rather than push key political actors to support pro-poor public policies which may have helped reduce growing crime and violence, identified the popular sectors as the problem. The larger tendency was to see them as 'enemies' and 'aggressors' who were by nature given to violent acts or chose the path of crime and violence. In effect, the discourse on violence fractured the relatively cordial social relations of the authoritarian era. At the least, as Hochstetler (2000: 169) notes: "The middle-class sectors waver between seeing *favela* dwellers as common victims of urban violence or as perpetrators of it." Thus, even in a vibrant anti-violence movement such as Viva Rio coalition in Rio de Janeiro, middle-class and popular sector participants found "limits to their shared language of citizenship" (ibid).

The awareness among low-income groups about how they were perceived by elites, middle-classes and the state heightened their antipathy and exclusion. The residents of Sapopemba were well aware of the discrimination practiced by privileged social groups and the state. As Luiz explained:

You will not get a job or you will be needlessly arrested by the police if you are poor and dark, compared to a white and rich person. If a rich person commits crime, he will not be caught but instead a poor person

and a black person will be caught. He will be tortured and even killed only because poor people are simply suspicious.

Social distance is not restricted to relations between the rich and the poor or blacks and whites. While everyone who lived in the periphery, especially those who 'look poor', faces discrimination from the middle- and upper-classes and the police, there is a further distancing and separation from those considered inferior even within that particular social world. According to Caldeira (2000: 90):

The paradox of the working poor's attempts to separate themselves from the stereotype of the criminal is that this is achieved by using the same strategies against one's neighbours that have been used against oneself. As a consequence, the category of the criminal and its repertoire of prejudices and derogations are rarely contested. Rather the category is continuously legitimated, and prejudices and stereotypes against poor people...are re-enacted on a daily basis.

In Sapopemba too, my interviewees saw themselves as unfortunate vis-à-vis the rich but they also separated themselves from the *favelados* whom they saw as the "true wretched."<sup>13</sup> In sum, Brazil experienced "decreasing social solidarity" (Pereira 2000: 230) which was hardly conducive for collective action.

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<sup>13</sup>It is not surprising that opinion polls in 1996 indicated that only 11 per cent of Brazilians trusted others most of the time and by 2000, the number had fallen to 4 per cent (Lagos 2001). Brazil displayed one of the lowest levels of trust in the region.

5. The Retreat of the External Actors: When I asked Adriano Diogo, a local PT leader and municipal councillor, why popular movements had declined in democratic Brazil, he replied that:

Social movements have not diminished...they were never all that spontaneous and autonomous to begin with. They emerged with the emergence and consolidation of PT and have accordingly now taken another form, that of party politics (personal interview, São Paulo, June 20, 2001).

While there is more than a hint of exaggeration in Diogo's statement,<sup>14</sup> there is little doubt that external actors took up routine roles in democratic Brazil. The return to democracy opened up new opportunities for middle-class professionals so that their interests diverged from that of the popular sectors. As members of more privileged social groups, they no longer shared the same political or social concerns as the popular sectors. Even when the two did share similar concerns, members of more privileged social groups took up more institutionalized and routine forms of public action through their positions in the bureaucracy, the academia, political parties and NGOs (Costa, 1995) and abstained from the activist role they had played in the past. Overall, the close ties that existed between the popular sectors and middle-class professionals weakened by the 1990s.

Other key external actors such as the Catholic Church also retreated to the background. During the "golden age" of the progressive phase of the Church, the

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<sup>14</sup>The PT was certainly a key actor in the emergence and staying power of popular movements. Further, many doctors and middle-class professionals who were active in the periphery during the 1970s did subsequently join the PT or other pro-democracy parties. However, the emergence of health movements predated the formation of the PT (see Machado 1995, especially pp. 263-274).

thousands of *comunidade eclesiais de base* (CEBs) were at the frontline of a variety of urban popular movements (Burdick 1993; Doimo 1995; Mainwaring 1986). After the democratic transition, several factors conspired to tame this activism. The Vatican took an increasingly aggressive position under Pope John Paul to marginalize progressives and propped up conservative officials. The new institutional environment also prompted changes. As Burdick (2004: 7) notes: "Brazil's return to electoral democracy...drew many of its best leaders from the progressive Church, and bequeathed to those who remained uncertainty about their political role." Since the Church was not a substitute for political parties, Church leaders encouraged social groups that they had nurtured and supported during the period of military rule to take up political tasks (Bruneau and Hewitt 1992). Political parties, unions and social movements with a more secular orientation were perceived to be better equipped to deal with political and social issues (Berryman 1996).

Finally, the Church no longer enjoyed its former pre-eminence in Brazilian society. The country experienced a Pentecostal boom so that Protestant ministers already outnumbered Catholic priests by the mid-1980s (Berryman 1996; Stoll 1990). In a country where religion is seen to offer a way to cope with poverty and illness (Mariz 1994), it is not surprising that Pentecostalism appealed to the poor and those suffering from illness (Chesnut 1997). The Pentecostal challenge forced the Church focus on its institutional interests (Gill 1998). The real downside to the growing influence of Pentecostals is that they do not aim to mobilize their followers to bring about changes in the social and economic conditions of the poor but merely to help them adapt to their situation (Serbin 2000). Thus, while Pentecostalism "offered a way for the poor to seek economic betterment, social dignity, and political participation," it did so "in a conservative manner" (ibid: 153) and helped to legitimize the status quo.

## Conclusion

Popular movements for health are not commonplace. To some extent, the absence of claims-making for social services like health is to be expected because it is not essential for immediate survival except under specific conditions. At any given time, matters of life and death affect people only at the individual or family level rather than at the community level. It is only when epidemics occur and there is substantial loss of human lives within a short period of time that we can expect affected communities to express their discontent and demand remedial measures. Further, except for the very poor, there are exit options in the private sector. Therefore, health deficits are tolerated even when the importance of health is recognized. Finally, in Brazil as in many other developing countries, since people have low expectations from the state and political leaders, they do not see any reason in making claims which are unlikely to be addressed.

However, health movements did occur in Brazil during the mid-1970s under unfavourable political conditions. In contrast, even though the living conditions of the popular sectors stagnated or improved only marginally through the 1990s, and they enjoyed political freedoms, they did not make claims on the state for better health services. Why did they not?<sup>15</sup>

One could argue that the urban poor and lower-classes expected their living conditions to improve over time so that, rather than make claims on the state, they waited patiently for democracy's benefits to reach them. However, there was little evidence of such thinking among the residents of Sapopemba or in opinion polls (Lagos 2001). At the dawn of the 21<sup>st</sup> century, ordinary Brazilians were clearly disillusioned with democracy and had few expectations that their lives or that of their children would

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<sup>15</sup>Democratic Brazil witnessed civil society activism on newer health concerns such as HIV/AIDS (Parker et al 1999) and violence but not on old health concerns which still affected large numbers of the lower classes.

improve. Brazil-observers have expressed surprise over the human development and other gains the country has made over the past decade (Kingstone and Power 2008).<sup>16</sup>

Health movements emerged in mid-1970s Brazil with the intervention of a specific group of external actors—middle-class health professionals and progressive Church officials—who 1) questioned the military regime’s discourse of economic development in the light of widespread social deficits; 2) propagated ideas about democracy and social justice and more importantly, linked them to health and living conditions; 3) with their progressive ideas and practice, narrowed the social distance between the middle-classes and popular groups, thus imparting greater strength to the cause of the popular sectors; 4) created mobilization frames around the issues of democracy, social justice and health; and 5) activated the agency of the popular sectors by giving them a sense of belief in their actions. During the 1990s, these external actors largely retreated from their activist role of the past, certainly from health and related areas. With their exit, and due to the shift in the nature of public discourse on health, the popular sectors were left to their own to fashion their struggles for social justice in matters of health. That did not happen because members of the popular sectors were caught in a “cognitive trap” where they did not believe themselves as capable of bringing about social change.

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<sup>16</sup>The lives of ordinary Brazilians have improved over the past decade due to the progressive social policies implemented by successive social democratic and PT administrations (Melo 2008; Ravailon 2011) but question marks remain over the extent of improvements (CEBRAP 2012; Perlman 2008). Similarly, while there have been marked improvements in the health situation, several challenges remain (Hunter and Sugiyama 2009; McGuire 2010; Paim et al 2011).

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