Beyond a conventional analysis of supply and demand: the Ecuadorian process of universal healthcare, the development of an 'intercultural project', and its gaps in maternal health

A Research Paper presented by:

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(Ecuador)

in partial fulfillment of the requirements for obtaining the degree of
MASTER OF ARTS IN DEVELOPMENT STUDIES

Major:

Social Policy for Development
(SPD)

Specialization:

Public Policy and Management

Members of the Examining Committee:

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The Hague, The Netherlands
December 2013

Disclaimer:

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List of Acronyms

CSO	Civil Society Organization
ENIPLA	Estrategia Intersectorial de Prevención del Embarazo Adolescente y Planificación Familiar (Intersectoral Strategy for Adolescent Pregnancy Prevention and Family Planning)
ENSAMYN	Establecimientos de Salud Amigos de la Madre y el niño (Friendly Mother and Child Health Establishments)
HR	Human Rights
ICPD	International Conference on Population and Development
JBG	Junta de Beneficencia de Guayaquil (Guayaquil Welfare Board)
INEC	Instituto Nacional de Estadísticas y Censos (National Institute of Statistics and Census)
MCDS	Ministerio Coordinador de Desarrollo Social (Coordinating Ministry of Social Development)
MAIS	Modelo de Atención Integral del Sistema Nacional de Salud Familiar, Comunitario e Intercultural (Family, Community and Intercultural National System Model of Integral Attention of Healthcare)
MEF	Ministerio de Economía y Finanzas (Ministry of Economics and Finance)
MSP	Ministerio de Salud Pública (Ministry of Public Health)
MDG	Millennium Development Goals
PNBV	Plan Nacional del Buen Vivir (Buen Vivir National Plan)
PAHO	Pan American Health Organisation
UN	United Nations
UNRISD	United Nations Research Institute for Social Development

Abstract

The research aimed to identify and seek an explanation for the gaps between the state provisioning of maternal healthcare and the needs of the female population from various ethnic groups, in a context of both health universalism and the development of an intercultural project for 2007-2017. Taking an innovative approach of mixed methods and using primary data from interviews of ethnic minority users, health practitioners, and the CSO, and secondary data from national statistics, budget information, and data set surveys, it shows that despite investment and legal reforms, there remain vital unaddressed aspects that jeopardise access to the public system. The gaps include the lack of coverage of hidden and opportunity costs, legal reforms, and concrete provision issues that make women choose between their ancestral practices and the public free of charge services. It concludes that both universalism and intercultural processes are fragmented and limited, shaped by the interactions of economic, cultural, and structural factors, and follow historical paths resulting in constraining the use of public facilities and thus, it is proposed to re-think the policy and call for future research.

Relevance to Development Studies

There is plenty of evidence supporting the fact that maternal death is a social injustice affecting mainly rural women in developing countries, as well as portraying the state as incapable of guaranteeing their safety. This study goes beyond this, focusing on addressing the access to public healthcare in Ecuador, in order to contribute to the debates about how to improve the system with an innovative approach to research. It highlights the gaps for an inclusive safe motherhood experience and suggests small steps to improve it.

Keywords

Universalism, de-commodification, intercultural project, maternal healthcare, Ecuador.

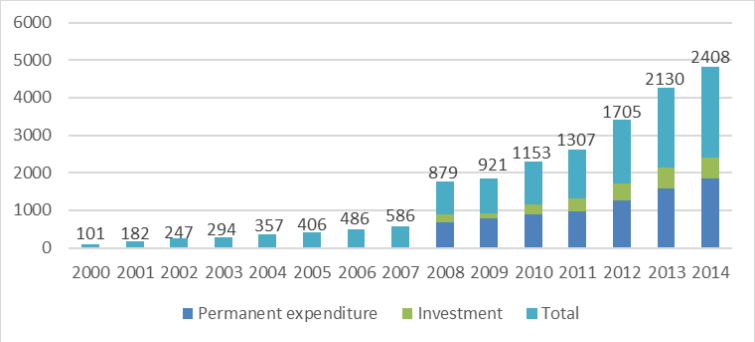
Introduction:
Background of the topic and contextualisation

In 1990-2006, Ecuador experienced a period of political instability and a limited role of the state in the public provision of the traditionally so-called 'social sectors'. However, this appeared to come to an end in 2006 when Correa was elected president promising shifts in the country, including a change of the Constitution. Particularly relevant for this study are the process of universalism of the healthcare system and the formal recognition and effort to approach the ethnic diversity, inherited part and vital characteristic of the Ecuadorian context.

Firstly, the health reforms between 2007 and 2014 are divided into two (Naranjo et al. 2014): the urgent investment and the implementation of the MAIS.

In 2007 Correa declared the health sector as an emergency which allowed the government to allocate a greater proportion of the public budget (figure 0.1) to the MSP (Naranjo et al. 2014) where the breaking point was 2007. This led to the massive building of infrastructure, the increase of health personnel in the public sector, the improvement of equipment and others in order to increase the scope of the provision of health services (Naranjo et al. 2014).

Figure 0.1
General executed budget of the state allocated to health 2000-2014
(US dollars in millions)



My elaboration based on MSP (2014)

Also, in 2008 the country changed its Constitution with important results in the health sphere (table 0.1), part of the *Buen Vivir*[1]. Nonetheless, one of the most important warnings that comes from policies oriented to this kind of universalism is that "(they have) been used to create a false sense of unity, which conceals the fact that it discriminates against certain social groups on grounds of gender and race and, through tutelage, it imposes on new grounds standards set by the dominant group" (Mkandawire 2005:5). Thus, attention should be placed not only on a 'general' provision, but also on 'what' is publicly provided because 'what' is called universal is not necessarily meant for all. The relevance here is that, if there is no provision addressing minorities' needs, it is not only an injustice, but it could also affect their use of services resulting in problematic health outcomes and jeopardising their life as well as that of future generations.

[1] This was a corner stone in the policy sphere during the period of analysis that aimed to build a fair society where the human wellbeing is the core of public actions (PNBV 2013).

Table 0.1
Changes and implications of the 2008 Constitution related to health

• Establishment of health as a right linked to the exercise of others (water, food, education) (art. 32), and therefore a protagonist role of the state as its direct guarantor and provider of healthcare services.
• Free of charge good and services delivered in any of the public levels of attention (art. 362), different from the previous Constitution where this was only for those with no spending capacity [MSP 2009].
• Public policy focus on guaranteeing access to the actions and services of attention for integral health, including sexual and reproductive health, through principles of universality, interculturality, gender, generation, etc. (art. 32)
• Establishment of the MSP as the national sanitary authority (art. 361)helping to maintain its monetary allocation as well as its service provision.

My elaboration based on the Constitution (2008) and the MSP [2009]

Second, and in this context there was a reevaluation of the ethnic groups by recognising people's diversity and the right to their own traditions. It established Ecuador as an intercultural, pluri-national and lay unit in the first article of the Constitution. Particularly related to health, the Constitution also stated the role of the state in guaranteeing the practices of ancestral heath by recognising and promoting its use (art. 363). As a result, as argued by Ayala (2008), the view of Ecuador as a homogenous nation has been overcome in this century removing the idea of integrating indigenous and black into the dominant society through the homogenisation of social aspects, including traditions and languages historically seen as primitive. A policy example of this is the MAIS that concentrated on working on primary health care[2] in order to reorient health services to promotion, prevention, rehabilitation, and palliative care, respecting people's cultural diversity (Naranjo et al. 2014).

However, despite the investment, the changes in the legal framework, and the implementation of the MAIS, such efforts has not translated into better outcomes where the maternal mortality rate does not present a constant reduction. In fact, it is one of the most MDGs lagged targets reported in 2014 (Carvajal 2016) where most of the cases in 2006 (MSP 2008:15) and 2011 (MSP 2012:9) occurred in the health unit for deficiency of an adequate health care facility including lack of 24-hour health personnel, equipment and/or medical supplies. The particularity of such deaths is that they are avoidable and that the risk of experience is not equally distributed among women, with rural women in developing countries most vulnerable to suffer this [WHO 2019a]. This is a social injustice and portrays the state as incapable of guaranteeing their safety.

Therefore, this research focuses on addressing the access to public maternal healthcare, analyzing the universalism/de-commodification process and highlighting the gaps for an inclusive safe motherhood experience in a country with an intercultural project. It explores some of the 'factors' that satisfy the needs of the indigenous and if they are provided by the state and on what grounds, in order to establish if there is a universal healthcare for *all*.

[2] The WHO (2019b) define it as "a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities (…) (ensuring) people receive comprehensive care (…) as close as feasible to (their) everyday environment".

1.1 Methodology

1.1.1 Research objective

Identify through an innovative research approach, and seek an explanation for the gaps between the State provisioning of maternal healthcare in the period 2007-2017 and the needs of the female population from various ethnic groups in the context of both processes health de-commodification/universalism and the development of an intercultural project in order to contribute to the decisions and policy making debates about how to improve the system to ensure the right to comprehensive maternal healthcare.

1.1.2 Research question

How has the Ecuadorian State, in both policy and practice, approached maternal healthcare in the period 2007-2017 in the context of health de-commodification/universalism and the development of an intercultural project?

Research sub questions

1. What aspects of the public provision of maternal healthcare were promoted and supplied by the State in the period 2007-2017, passing (or not) through a de-commodification in a context of universal and intercultural development projects?
2. What is needed/experienced/demanded/wanted by female populations from various ethnic groups that experienced a pregnancy in such a period?
3. What are the gaps between the state provisioning of maternal healthcare and the needs of the female population from various ethnic groups that need to be addressed to ensure an inclusive and safe motherhood experience?

1.2 Research Positionality

My motivation and proposal to work on this issue is established based on three important aspects. First, the lack of a constant reduction of the indicator of maternal mortality[3] despite the improvements in healthcare. Second, the social injustice of such deaths where minorities, whose identities intersect with groups historically discriminated against mainly based on class, gender, and ethnicity, have a high risk as a consequence of a historically stratified system that perpetuates inequality. Third, my previous experience in the field of healthcare and closeness to indigenous groups in terms of affinity as well as solidarity with their struggles. Hence, the results of this research have also tried to have an instrumental use hoping to find 'right now' measures to improve the healthcare system, considering that its access is part of what everyone in Ecuador is entitled to.

The structure of this research and the way the information and data were collected, analyzed and presented have followed an approach of mixed methods. This is a consequence of my ontological position as a pragmatist. I accept the existence of singular and multiple realties and therefore, believe it is relevant to use all available means to gather such data without limiting myself to either qualitative or quantitative techniques. Therefore, I follow an approach that offers to end the "unproductive debates discussing the advantages and

[3] This was noted and used when pursuing my BA in Economics. The full document can be read at http://repositorio.puce.edu.ec/handle/22000/2636/browse?value=Carvajal+Cisneros%2C+Ana%C3%ADs+Isabel&type=author

disadvantages of quantitative versus qualitative research" (Feilzer 2010: 6) avoiding getting lost in them, and devote more space to the research itself. This is used to incorporate indigenous women's voices and knowledge on principle grounds, to explore their truth, and to suggest where the health system could be improved, considering that their vision could offer stronger objectivity because of their interest "in producing knowledge for use as well as in revealing the relations of power hidden in traditional knowledge production processes" (Naples 2017: no page)

My background as an economist inherited from a positivist school and my current exposure to critical Development Studies provide the way the research is developed. I believed in the need to use numbers to show part of what is "out there", but my closeness to non-academicians had led to my questioning about how positivists consider not only that the 'knowledge that matters' is the one resulting from the scientific method, but also their constant search for 'unbiased' methods (including natural science techniques) for social studies to keep the idea that a separation between the subject and the object of study exists. This has contributed to deny that researchers are already embedded in their own beliefs and realities that affect their interpretation of others' truths, and therefore, I do not believe in the existence of value free research[4]. In fact, in practical matters to encourage research from 'the desk', meaning as far as possible from the 'object' of study, not only misses all the opportunity to talk with others and try to understand their reality, which is a fundamental lack when researching about these 'others', but also as argued by Harding (1995), contribute to a moral detachment allowing scientists to work with indifference to the human consequences of their research. Finally, during this MA process, I have also explored and experienced how the first step of measuring whatever can be easily measured has led to the disregard of things that cannot be quantitatively measured (Smith 1972: 290 in Agarwal 1997). Particularly by reading Elson, Mkandawire and Foucault and re-reading Polanyi, Stiglitz and Duflo, I realised that this common bias amongst scientists (including health economists) results in 'half-truths' which are misleading and could result in suggesting that such (unmeasurable) things are not only not important, but they actually do not exist which, as argued by Smith (1972: 290 in Agarwal 1997), is suicide. Therefore, the approach I take is rather interpretative instead of purely positivist with only quantitative data.

1.3 Research strategy, sources and methods applied in this journey

This paper proposes to follow an approach of mixed methods using quantitative and qualitative techniques, as a result of my positionality and the nature of the questions, both previously discussed.

In relation to the data gathering, I worked with primary and secondary data. Firstly, sixteen online semi-structured interviews were organized with four indigenous women that gave birth in the last decade, nine health practitioners, including traditional midwives and public health workers, and three people working on maternal health in CSO (appendix 1). The interviews, conducted from the Hague between June and October 2019, were recorded for my better interpretation, analysis, interaction and development of follow-up questions when needed, and they were erased once used. The selection of interviewees followed, in the first instance, a convenient sampling strategy based on my relationship of trust with some of the key interviewees in an effort to actually know what is, in reality, going on, and, in the second instance, it took a snowball sampling technique from this point onwards until a

[4] This even less in Economics where we have historically been the power theorists contributing to build the idea of the existence of an hegemonic truth.

saturation point. This process was to try to avoid having only one side of the story, a common risk of such a technique. Also, the participants were informed broadly about the research topic and guaranteed anonymity in order to create a safe space and also to avoid any unwanted consequences as a result of their opinions in the context of this research. In return for their participation, all were offered a presentation of the research findings as well as any other knowledge exchange I could offer[5]. There was no monetary compensation for any participant because I considered it unethical as well as to avoid any complex dynamics this could create.

For secondary data gathering, I also used information from official sites, including mainly the INEC and the MSP data sets, the official government budgets, and the published policy documents, including strategies, projects, and manuals, all available online and referred to in the text and references.

In relation to the development of the research itself, I started by developing the chapters in the order followed here. Initially, to develop my conceptual and analytical framework(chapter 1), and to do the macro analysis of the Ecuadorian state (chapter 2), I read and analysed relevant literature in English and Spanish, for developing countries with particular attention on Latin America, as well as state official documentation, including national statistics and financial documents. The information was compared, contrasted, supported and pointed out with interviews when needed. For chapter 3, I first conducted the interviews, then transcribed, translated, and grouped them into groups based on the individual participant's perspective, as reported later in that section.

Finally, the challenges and limits of this research are inherited from the data collection method and 'my location 'as researcher. Firstly, while the numerical population data can be generalised because it is taken from national census and predictions, the qualitative data could not. However, this is not its aim. Its significance lies in the intimate understanding of people lived experiences and standpoints. In fact, the qualitative approach itself allows the researcher to immerse into people's reality (O'Leary 2017) that cannot be broadly understood with numbers only, nor with interviews alone, and therefore the numbers show a larger picture and the interviews a specific one. Nonetheless, they both offer a complementary perspective and therefore this is precisely the value of research of mixed methods in a world of scarce time and infinite information. Additionally, while working with semi-structured interviews offers a guide to the interviewee and the interviewer, they could limit the findings to those parts of the questions asked. Despite this, they were chosen because, at the same time, they are flexible in the case the conversation flow changes, allowing one to gather more details when needed (O'Leary 2017). Secondly, 'my location' refers to two facts: a) I conducted all the interviews via WhatsApp and Facebook from the Hague which constrained the interaction and in some interviews experiencing connectivity issues that required me to re-establish the conversation flow and also the view of the body language of the interviewee, and b) while my relationship of trust with some participants could help me to have access to them, my inherited 'location' as a mestizo, part of the historically privileged groups interfere in this process. Thus, the information could be biased reflecting what the interviewees thought I wanted to hear. This is part of who I am, and it is in every researcher, and it could not be changed, but one should be aware of it in order to learn to work . In my case, listening to their stories without pretending I have experienced them helped me to connect with their reality; nevertheless, my previous closeness with this indigenous group was paramount for this.

[5] I made available my knowledge and experience because even though the research topic is of their interest, they may have other more important needs where I can be useful.

Chapter 1 Conceptual and analytical framework

> (In order to use social policies to) enhance social capabilities, (it is required to) rethinking social policy away from its conception as a residual category of 'safety nets' that merely counteract policy failures or developmental disasters.
>
> (Mkandawire 2001: 6)

This research aims to analyse the Ecuadorian public healthcare system between 2007-2017, characterised by the strong appearance of the role of the state as a provider of healthcare, with an emphasis on identifying the gaps of maternal health provisioning in the context of two processes: the intercultural project and the universalism/de-commodification of healthcare, both central parts of the policy agenda in the period of analysis. Therefore, I focus on four key concepts and their linkage, that are developed in this section and are used as the basis of the analysis of the subsequent chapters: 1) universalism -and targeting-, 2) human, reproductive, and maternal health rights, 3) de-commodification -of welfare- and the role of the state in the process, and 4) multiculturality and *Interculturalidad Crítica* -as ways to address diversity in the public policy sphere.

1.1 Universalism and targeting in public policies and provision

Since the 1990s there has been a reappearance of the dimension of 'social' in the development discourse and in policymaking at a supranational level. For the UNRISD (2010), it was the result of the failure of the neoliberal model to promote economic growth and declining poverty. However, the central debate about social policy,[6] and particularly about provisioning, continues to be the discussion between the universalism and target approaches. It considered the challenges of treating people the same and the need to differentiate among them to address discrimination and redistribution issues (Fisher 2018). In neoliberal discourses this has been framed as an issue of efficiency and a dilemma of cost effectiveness, both part of their hegemonic concern mainly in limited budgetary environments (Devereux 1999)[7].

On one hand, universalism could be understood as when "the entire population is the beneficiary of social benefits as a basic right" (Mkandawire 2005: iii). However, the idea of universal coverage has put aside what kind of provision is actually being given; this has been reinforced by strong positions, for example, the World Bank that defines a system as universal as long as all have access to whatever is provided, including private provision or low quality services (Fisher 2018). Additionally, such limited understanding has also promoted the anticipated celebration of 'universal' healthcare in countries with rudimentary and low-quality public health systems (ibid). On the other hand, the target approach is based on the "eligibility to social benefits (involving) some kind of means-testing to determine the 'truly deserving' (of such provision)" where the criteria is in fact a social construct (Mkandawire 2005: iii). However, the challenge in this approach is figuring out how to treat the selective beneficiaries as equal to everybody and avoid stigmatization at the same time of

[6] I understand social policy as the "(…) interventions directly affecting transformation in social welfare, social institutions and social relations" that can be embedded in economic policies or are more explicit in provision of social welfare (Mkandawire 2001: 6).

[7] In fact, Kabeer and Cook (2000) highlight that most countries with universal forms of social provision are mainly located in the north in contexts of high per capita income, low rates of absolute poverty, stable financing and an efficient tax system with strong regulatory frameworks.

generating redistribution of wealth from the privileged to the underprivileged classes (Fisher 2018) which implies that there is an issue of social justice behind it.

The problematic aspects about targeting are not with selectivity *per se* but with the current increase of selective approaches in policy making that result in actually being segregationist by threatening the people in a disadvantaged position in a low-quality manner (Fisher 2018) leading to their exclusion. In fact, Sen (1995: 14) states "benefits meant exclusively for the poor often end up being poor benefits" considering that the targeted groups tend to be weak politically constraining their capacity to exercise their rights. Also, one of the central arguments against selective approaches is that they have higher per capita costs, including both monetary and political (Devereux 1999). The per capita monetary cost is higher than untargeted interventions because administrative and monitoring expenditure are needed for a restricted number of people, and the political cost comes from the withdrawal of support from the elite and other non-beneficiaries (ibid).

Even though both approaches are presented as one against each other, they work under different logistics that are not necessarily antagonistic. The target perspective assumes that resources are scarce, which is part of the assumption of the classical economy, and thus, they have to be focused on the people who need the most. The universal approach follows the position that all people have equal entitlements, so all should have access to such provision. Consequently, even though all people in principle should have the same rights, there are people who are in need more than others and therefore, further assistance is justifiable under a social justice principle.

In practice, there is no pure policy regimes, but for Mkandawire (2005) the choice depends highly on the ideological predisposition of the regime. However, despite political ideology possibly being an important precondition, it alone cannot explain how policies are shaped during time (Franzoni and Sánchez-Ancochea 2016). In fact, extraordinary universal health systems exist in different politically orientated countries, for example, Costa Rica, South Korea and Uruguay- (ibid). Therefore, there could be different levels of universalism as a consequence of the combination of many policy instruments and thus, Franzoni and Sánchez-Ancochea (2016) call one to pay attention to the following criteria:

Table 1.1
Policy Architecture

Criteria	Details
Eligibility	What are the eligibility criteria to get access to the system?
Funding	Who pays for the service and how?
Benefits	What is the provision that it includes /which provisions are included?
Outside option	What is the role of the government in the alternative provisioning?

My elaboration based on the Constitution (2008) and the MSP [2009]

Nevertheless, two aspects need to be emphasised notably in the healthcare provisioning. When it relates to service provisioning, a target approach could compromise the quality of the delivery creating a dual system: one for those that can afford it and another for those who cannot. Therefore, a universal approach should be encouraged framing it as a goal to achieve in order to guarantee the quality of services for *all* people. This could be supported by taking as a basis a rights-based approach where everyone is entitled and has access to comprehensive health care. This is elaborated in the following section in a profound manner, with a focus on reproductive and maternal rights and health.

1.2 Human, reproductive and maternal health rights in the development discourse

The HR framework officially started with its declaration in the UN Assembly in 1948 and one of its major new ways of thinking was to shift and build together with the idea of human development in the international arena, resulting in the 2000's MDG agenda (Hamm 2001). This section explores this with an emphasis on reproductive and maternal health rights and thus, the key role of the state in guaranteeing them.

In the 1980's reproductive health was part of the key symbols used by activists working on women's rights taking as a premise that:

> Every women has a right to reproductive health, that is, to regulate her fertility safely and effectively; to understand and enjoy her own sexuality; to remain free of disease, disability, or death associated with her sexuality and reproduction; and to bear and rear healthy children
>
> (Dixon-Mueller 1993: 269)

In the ICPD in 1994, important debates took place addressing issues of population, demography concerns, and fertility regulations on one hand, and women's rights about their life and body on the other. This promoted a shift in international debates related to policy advice; from reduction of fertility-centered policies to sexual and reproductive health and rights for all (Ravindran 2005). Therefore, it was a turning point in the field of sexual and reproductive health, repositioning development programs in terms of "reproductive rights, gender equity, and women's empowerment" (Thomas et al. 2014: S32).

However, one of the endless debates was *who* controls the ability to conceive or not (the woman, husband, family, community, or state) and if it is in fact a right or if it should be condemned. In supranational environments, that they were talking about living women and not only wombs was put aside. This point was raised by feminist movements who had mentioned the need to reclaim women's own bodies as a whole with not simply a medical visualisation; therefore, in their agenda this right is highlighted together with rights to information, confidentiality and choice (Ravindran 2005). This was partially in the ICPD's Plan of Action that called for commitments to promote universal access to reproductive health services, but the lack of political support and programmatic changes limited its results (ibid).

This back and forth process finally lead to important promises at the time: the MDGs Agenda. It was the largest international agreement in 2000 that attempted to show the existence of global concerns for health, gender, and poverty for example, and tried to push countries to address them (Todaro and Smith 2012 in Carvajal 2016). However, even though it was an important achievement in terms of cooperation (Carvajal 2016), passing, at least in discourse, from capital-centred to a 'more' people-centred approach, paramount issues were left out. One of them was universal access to reproductive health care (Ravindran 2005), challenged by the Vatican and conservative Islamic states (Hulme and King 2017). This was part of a major strategy in the agenda setting phase, to have the most support possible for the MDGs (ibid). This included ensuring 'human development' matches economic growth to be acceptable for decision making in powerful countries, and avoiding recipes on how to achieve the goals to reduce the chance of political debates that limit universal support (ibid). Thus, the HR and human development approaches have to be as ambiguous as possible to have more countries involved, but as clear as needed in order to at least have common ground in terms of morals and values. In fact "the concept (of HR) is one of the few moral visions ascribed to internationally" (Bunch 1990: 488), but the universality of rights had to look for universal applicability and the setup of "universal conditions under which (they) can be realised"(Hamm 2001: 1008).

As argued by Ravindran (2005: 9) the MDG not only excludes this, but also avoids the 'full package' of services for a more comprehensive view for maternal health, although it does highlight birth assistance as a key indicator. This includes education, communication, and services about family planning, prenatal care, safe delivery and postnatal care, prevention and appropriate treatment of infertility, abortion, including its prevention and the management of complications, treatment of sexually transmitted infections and other reproductive health conditions, and counselling on sexuality, reproductive health and responsible parenthood (ibid). Zooming in on maternal healthcare, understanding maternal health as a state of complete wellbeing in physical, mental and social aspects and not only the lack of pain or diseases (WHO 1946 in Carvajal 2016: 19) during pregnancy, birth and postnatal period [WHO 2019c], a comprehensive package should have at least three perspectives:

Table 1.2
Comprehensive maternal healthcare

Criteria	Perspective
Rights	A legal framework that allows women to decide about their bodies and future, as part of a basic human right
Provision	Services for prenatal care, birth assistance, and postnatal care that are safe, warm, and cultural appropriate
Access	Coverage of opportunity costs (addressing hidden costs of transportation and social constrains that limit women's access to healthcare)

My elaboration

The notion of *access* has been widely problematize in development studies and public policy analysis, considering it is a dynamic and reinforcing process of interplay between the service users (and their social contexts) and macro level decision makers (Dixon-Woods 2006). In practical terms, the access to maternal healthcare could be analysed as a vector of:

Table 1.3
Access to (maternal) healthcare

Criteria	Perspective
Service availability	What is the provision?
Adequacy	What are the implications of getting the service?
Accessibility	What is the relevance in terms of the needs of cultural settings?
Affordability	Is the supply continuous?
Appropriateness	Is the supply utilised?

My elaboration based on Patient Access Partnership (n.d.)

Moreover, the delay or the lack of access to maternal services had been classified into three according to the World Bank (2006 in Carvajal 2016: 85): 1) the delay in deciding to look for attention, 2) to identify and reach the health centre, and 3) to receive treatment. However, as pointed out by Sundari (1994) those that are called 'patient factors' (1 and 2), are in fact 'inaccessible health services'.

Finally, the limiting understanding of maternal and reproductive health in the MDGs, does not imply that they are not useful. In fact, the importance of the MDGs (and the HR framework) lies in the protagonist role attributed to the state as guarantor of rights and in the position of developing policies to achieve the MDG targets. This means that "adequate health (and others) are no longer a matter of charity" and therefore, there are duty bearers that are responsible for this (Hamm 2001: 1014). Nevertheless, it is paramount to consider a warning point. While both the MDG and the human development idea could be themselves a shift beyond exclusive focus on economic growth in international arenas, it does not imply that it actually occurred at national levels. In fact, in Latin America, this change was, at the most, a discourse alteration, considering that the neo-liberal economic globalization and the structural adjustment programs challenged the idea of a legitimate strong state in the 1990's and 2000's, restricting some of its important responsibilities. Nevertheless, the exact degree of state interference has always being up for debate and Esping-Anderson's (1989) typology, discussed in the following section, is one the most important contributions related to how societies provide themselves with welfare goods and what are its results in terms of stratification outcome.

1.3 The welfare provisioning, its de-commodification and how it is shaped in countries of the South

Following the HR approach and the principle of universalism, policies require states to assume important responsibilities, that according to the UNRISD (2010) include provision, financing, and regulation. This has been part of the debates about "the optimal division of responsibilities between the market and the state" that comes from classical political economists (Esping-Andersen 1989: 11). In this context, there are two dominant approaches of welfare regimes[8]: the structuralist suggesting the need for social policies because institutions (such as family and solidarity) will be destroyed with the rise of individualism, and the institutional approach highlighting the fact that social policies become necessary in order to maintain the economy integrated and the social and political institutions, and therefore to avoid the destruction of human society (ibid). In particular, the state intervention is vital when dealing with what Polanyi call 'fictitious commodities' that are not produced in order to be sold on the market, such as health (Fisher 2018), because they do not follow market laws[9] placing society in a constant state of risk. Complementary, Stiglitz (2000) also supported the regulation of the healthcare sector because of its particular market imperfections that lead to excessive expenditure of households. This including imperfect information, limited competency, the presence of agents with risky behavior and moral hazard issues, for example, health insurances, for profit entities, non-governmental organizations, etcetera (ibid).

Moreover, the definition of a basic welfare state makes it also responsible for securing some basic welfare benefits for its citizens, but in practice its commitment has been only to asses by the level of social expenditure (Esping-Andersen 1989). However, this at most shows the degree of expenditure,[10] which could be related to monetary resources allocated to provision, and availability, but it does not mention anything about population access to

[8] Regimes could be understood as the way in which the production of welfare could be divided between the state, the market, the household and the family (Esping-Andersen 2001)

[9] The production of fictitious commodities is not controlled by its prices meaning that their prices are inelastic (Polanyi 1944). However, the main implication is that the profit made as a result of the exchange of such commodities in the market is not controlled either, implying that their owner could set up any price as a consequence of this non-self-regulated market.

[10] Esping-Andersen (1989: 19) highlights it is "epiphenomenal to the theoretical substance of welfare" and thus, scoring of welfare states using it, assumes, all spending is equally important.

such provision. In fact, the distinction between aggregate availability (supply) and individual access or ownership was Sen's departure point for the entitlement approach later developed (Devereux 1993) and used in the Human Development framework and MDG. It mentions an individual possesses rights and opportunities to have access to a set of alternatives which is part of the moral and legal context in which the person exists (Devereux 1993). A similar perspective is argued by Esping-Andersen (1989) through the principle of social citizenship, a core concept in the welfare regime typology that implies that a person is entailed to a de-commodification status in order to not force it to be *vis a vis* with the market. This occurs in the context of an interface of the state, market, and family (ibid), and in countries in the south, the 'community', paramount in social provisioning and implies adding to the analysis institutional practices of hierarchy, reciprocity, inequality and power (Gough et al. 2004).

De-commodification implies that a person can leave aside intersectional status and categories and/or its' wage (resulting from selling its labor in a transaction in the market), in order to have access to welfare provisions[11]. Then, there is a de-commodification of welfare, understood as "the degree to which distribution (particularly of welfare goods) is detached from the market mechanisms", which should imply an emancipation of the market (Esping-Andersen 1989: 21). In this context, it means that the access to welfare provision is no longer a benefit but a right that all are entitled to. Consequently, de-commodification "denotes the ways in which (the providers) interact in the provision of welfare to produce or reproduce the stratification outcomes" (Gough et al. 2004: 4), but economic, cultural, and structural factors also shapes this process and its effects, replicating particular social inequalities and overturning others, such as disparities in access and quality (Timmermans and Almeling 2009).This is particularly relevant when dealing with minorities, such as indigenous women, because its access could be shaped by gender roles, poverty, language and other cultural barriers. Nevertheless, a minimalist definition of de-commodifying welfare implies that:

> Citizens can freely and without potential losses of job, income or general welfare, opt out of work under conditions when they themselves consider it necessary for reasons of health, family, age or even educational self-improvement.
>
> (Esping Andersen 1989: 22)

Using this criteria Esping-Andersen (1989) defined three welfare regimes (appendix 2) where the main critics have come from gender perspectives and visions of the south. Under such work, women's contribution is ignored as dominant providers of welfare and the gendered criteria historically applied to have access to social provisioning (Lewis 1997). Particularly linked to the principle of de-commodification, Lewis (1997) states that the definition of work and its relationship with welfare do not pay attention to unpaid work that generally women undertake at the household level. This implies that the de-commodification substantially varies between men and women despite the reduction of the gender gap in the labor market that maybe allows women to have more access to commodify social provisioning because there is no strong reduction of the women's workload in reproductive work which could be an additional constrain they face to have access to provisioning. Therefore, "de-commodification has a gender meaning" where for women, it may imply greater independence in caregiving work (Lewis 1997: 162). As an answer to this, Esping Andersen (2001) incorporated the notion of de-familization.

[11]It could be derived from Marx's (1889) definition of commodification as the process of producing use value and sell it in the market for its exchange value. But, this is limited considering that its focus was on the production of commodities and the relationship capitalists and workers. Thus, the status of worker to have access to welfare provision was not part of it, which was attached to the able- and non-able bodied criteria in the Britain Poor Laws (Block and Somers 2003). Nonetheless, Marx mentioned "worker sinks to the level of a commodity and becomes indeed the most wretched of commodities"(1964: 106 in Timmermans and Almeling 2009: 22)

In the academic debate issues have been pointed out that may affect the welfare regimes typology application in contexts of the south. Although this is beyond this research, it is worth mentioning that policy and service delivery require a strong state[12] (for example), but in developing countries domain monopolised states (by the local elite), minimal level of provision, and unequal distribution of resources[13], and therefore assumptions about independent policy decisions, law and order, and the ability to tax are only acceptable in OECD countries (Kabeer and Cook 2000). Thus, the issue there is not to defend what is provided, but to actually build structures of provision promoting the state capacity (ibid), avoiding a patronage relationship, and creating a framework of exercise of rights. This criticisms are in fact a call to consider the larger picture of the forms of the state itself in different contexts, including its projects of reforms. Consequently, the withdrawal of such a set of assumptions is needed when making an analysis in such contexts. Particularly for this research, one of these projects is the nation state building, part of the dominant discourses of the XX century in Latin American, and its multiple critics coming from its historically ethnic diversity. This is addressed in the following section by exploring the idea of multiculturalism and *Interculturalidad Crítica*, both criteria for policy implementation.

Finally, an important aspect to highlight for healthcare is that its commodification could bring benefits to the recipient through improvements and product innovation that otherwise could not exist in these countries (Timmermans and Almeling 2009). But, this raises the question of who has access to this commodity and thus, it is beyond this research.

1.4 Multiculturalism, a way of addressing cultural difference versus *Interculturalidad Crítica*, a new political framework

This section addresses first the idea of 'multiculturalism' as the nation-state predetermined reply to address cultural diversity in its public policies during the XX century in countries in the south and particularly in Latin America. Second, it focuses on the conceptualisation of *Interculturalidad Crítica* and its differences depending on its context.

The idea of cultural pluralism, as an inseparable element of the modern states of the last century, brought to the academic debate how states approach and operationalise "diversity" (Meer and Modood 2011). Modern nation-states, in their effort to consolidate a national project, encounter a range of identities and cultures that resist it (Tubino 2004). Therefore, such a process implies a re-making of the state and thus, the idea of citizenship, dealing not only with rights but also with symbols and political equality to include the 'difference' (Meer et al. 2016). In this context, the nationalist liberals establish culture as an important aspect of the countries and thus, the need to redefine the state to establish a fair citizenship that "transcends cultural differences" and negotiate the national identity (Gagnon and Iacovino 2016: 107). Consequently, multiculturalism as a political project of the modern nation-state, acquires importance in the academic and political space. For Barabas (2014: 3), it is defined as "the recognition of the coexistence of different cultural groups within the same nation-state" in a publicly established and recognized cultural rights approach[14]. Thus, in the doctrine of

[12] In Esping-Andersen's work "the state is seen as the only institution capable of raising private interests and private limitations to ensure these goals are met"(Kabeer and Cook 2000: 6-7), but as argued it can come from different providers.

[13] Even though Kabeer and Cook (2000) mention the problems faced in northern and southern countries, this research focuses only on the second case considering the context of its' topic.

[14] Nevertheless, this can also be understood as a way of addressing cultural diversity as well as a form to conceive postmodern public policy implying new paradigms in it.

liberalism "particular cultural expressions" acquired greater importance under the argument that their repression is a "denial of the ideal of liberal democracy" jeopardizing individual self-realisation and engagement with a long and diverse society (Gagnon and Iacovino 2016: 106-107). However, the ideal of national liberalism has been based on the development of an undifferentiated citizenship and in this way, cultural diversity has been denied since the integrating discourses of "shared civic identity" (Kymlicka 1995 in ibid: 107).

In Latin America, multiculturalist policies were aligned with the hegemonic conceptions of the north aiming to promote the 'social inclusion' of groups of people established as 'targeted' in the so-called 'minority' policies, as part of the growing interest in the topic (Wade 2006 in Solano and Campos 2016: 188). But, this idea frames the understanding of cultural diversity as a synonym of ethnic minorities in the national territory. In practical matters, this has lead the different native groups which "found their rights in historical ancestry and millenary territorial ties" to be placed into the group of 'ethnic minorities' (Barabas 2014: 3) and migrants (for example), assuming no difference between them in the policy design and implementation (Vertovec 2003 in Barbas 2014). Thus, multiculturalism as a sum of diversities is susceptible to segregation and marginalization between cultures (Barabas 2014).

Despite the preferences for interculturalism over multiculturalism in political and policy frameworks, such concepts are complementary rather than opposite. Multiculturalism promotes the inclusion from a power-sharing perspective implying a redefinition of the state: the multicultural state, involving the inclusion of cultural diversity in its the institutional construction (De Waal 2018). While interculturality is inserted into that project focusing on "virtues, attitudes, dispositions, and knowledge that individuals need to possess in order to be 'intercultural citizens'" and get into contact with each other to increase social bounds in a diverse citizen contexts (ibid: 2). In other words, multiculturalism implies a de-concentration of power with attention to the inclusion of cultural diversity, while interculturalism involves internal relations between different cultures from a qualitative and transformative perspective (Levrau and Loobuyck 2013 in De Waal 2018). But, multiculturalism fails when rejecting the idea of a dynamic culture that is susceptible to 'intrinsic cultural change' through comparison and communication with other cultures (Barabas 2014).

Therefore, the concept of interculturality has been analysed referring to the study of the synthesis, hybridisations, dialogues and conflicts that occur in the different cultures that coexist in a given space (Tubino 2004), which is descriptive and an intrinsic quality of all societies in general. In contrast, a 'normative' conceptualisation of interculturality, refers to the political proposals that are framed as national projects to strengthen or transform power relations between different cultures aiming to create spaces for dialogue and thus, generate appropriate solutions to common problems (Tubino 2004). Particularly in healthcare, interculturality has been developed in response to claims of indigenous populations to their right to cultural identities (Salaverry 2010) aiming to include traditional knowledge and practices to transform the healthcare system.

Nevertheless, interculturalism acquires new meanings according to its appropriation by different political actors (Tubino 2004), implying that "it is an empty signifier" (Portocarrero 2004 in Bazán 2014: 13). This is aggravated by the fact that such a concept in particularly is in constant construction of its meaning and currently in debate (ibid). Additionally, Bazán (2014: 13) argues that interculturality is a "signifier that, far from being understood as an absolute value, acquires multiple meanings in relation to the social perspective from which it is defined and of the subjects that build it". However, it is possible to state that interculturality is strongly different in two particular contexts: the north and the south. The first is based on a discourse of cultural interrelation derived from migratory processes, and the second redefined it in order to promote the "revaluation and strengthening of ethnic identities" that characterised the claims of the *Indigenistas* movements (Tubino 2004: 4)

Interculturality as a political framework is presented following a vindicating speech of the dominant cultures' discourses. This is part of the features and challenges of such a concept in the policy sphere where it could not be understood as a framework for the development of merely inclusion policies (Earl 2017), historically part of the dominant discourses that address culture, particularly in the nation state project, which raises the question on whose inclusion and under which terms. These inclusion policies make the "structures of asymmetry and hegemony that are characteristic of colonial societies and not of peoples in the process of emancipation and self-determination" invisible (Esternnman 2014: 6). In this regard, Esternman (2014) and Cirese (1972 in Tubino 2004) highlight that the inclusion and dialogue discourses that are part of the interculturalism as a political framework had replaced the main asymmetry structure commonly addressed in the policy discourse, poverty, with cultural discourses, as the central issue ignoring "the distributive injustices, the economic inequalities, and power relations"(Tubino 2004: 5). In this sense, Sortello (2009: 78) refers to 'functional interculturality' as a model derived from the neoliberal nation-state whose welfare policies seek the "subordinated integration of groups traditionally excluded from the public policies of the state". This is done by using the common ideas of the construction of the national project following a neoliberal perspective, such as 'development', 'participation', and 'empowerment' (Estermann 2014: 8).

Therefore, an *Interculturalidad Crítica* is needed that breaks with its functional conceptions (Sartorello 2009). It will posses a right to cultural reproduction of national minorities through the transformation of colonial structures that generate an equitable convergence of "diverse cultural logic, practices and modes of thinking, acting and living" (Walsh 2008: 140-141,). Additionally, the academic debate on critical interculturalism also covers the demand for local and non-modern knowledge against universal and non-temporal western knowledge (Walsh 2005). Therefore, interculturalism is established as a proposal where the "equitable contribution of knowledge to universal knowledge" is recognised and established as a national project (Zárate 2014: 104). As a result *Interculturalidad Crítica* aims to challenge the dichotomous relationship between homogenous nationalism and ethnic particularities by disarticulating the hegemonic strategies of nation-states (Dietz 2017). It aims to transform the interactions between groups that were generated by defining the national and sub-national spaces as antagonistic, and the idea of static and immutable national monoculture, (Dietz 2017), calling for local participatory perspectives.

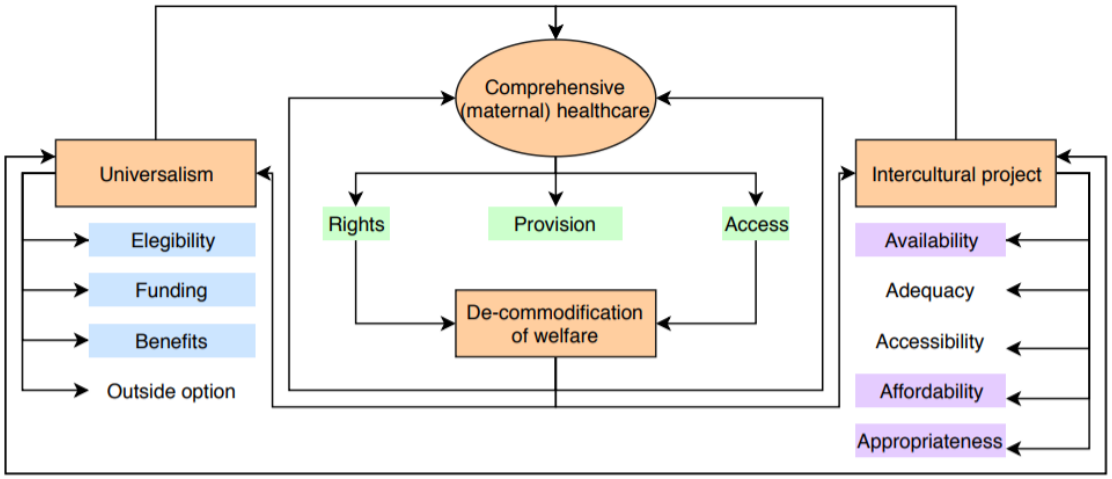
1.5 Construction of the framework of analysis

In this section, I have focused on four conceptual tools that are the basis for my analysis in the subsequent chapters in order to identify and seek explanations for the gaps between the state provisioning of maternal healthcare and the needs of the female population from various ethnic groups. Two of them, universalism and interculturality-, key parts of the Ecuadorian context during 2007-2017, are addressed in the form of chapters and the others, comprehensive maternal healthcare and de-commodification are discussed transversally as shown in the following figure[15]. As examined, the universalism and the targeting approaches are not necessarily against each other and in practice there is no pure regime. Therefore, Franzoni and Sanchez-Ancochea's (2016) propose a set of criteria to analyze this topic, which is how I have structured the chapter about this process in Ecuador. Moreover, as mentioned, the role of the state as duty bearer of healthcare, under the HR approach and the MDG, is paramount to the de-commodification result, which is understood as a basic entitlement for

[15] The text without highlight is not a direct part of the analysis in the following chapters to avoid repetition and overlapping findings in the universalism and intercultural chapters, but is part of the figure because it was discussed in the framework.

a person to not be *vis a vis* with the market in order to have access to public provisioning. I have applied this notion critically in both subsequent chapters considering that economic, cultural and structural factors shape this process. Also, the comprehensive package of maternal health I proposed in this section, considering its limited understanding in the MDG and the need to go beyond purely medical aspects of healthcare, is applied in the following chapters addressing the supply side by including social and cultural dimensions to analyse the access to the public system. Finally, in this chapter the 'common' form, used by Latin American 'nation-states', was also addressed to deal with cultural diversity in public policies and the appearance of a possible vindictive political framework (*Interculturalidad Crítica*). The implications include re-making the state policies promoting a transformative dialogue that rebuilds the idea of citizenship. I operationalise this in chapter 3 applying the criteria of availability, affordability, and appropriateness discussed.

Figure 1.1
Conceptual and theoretical framework application



My elaboration

Chapter 2 Macro level analysis of the Ecuadorian State in the process of universal healthcare, as guarantor of the right to health, agent of supervision of the sector, and provider of comprehensive (maternal) healthcare

Around 190 countries signed the MDG to show their commitment to policies orientated to directly improve people's wellbeing, as part of the supranational shift from the neoliberal growth to the inclusion of 'social dimensions' in development practices and policies (Hulme and King 2017). In 2015, the progress of targets such as the reduction of maternal mortality proved to be very difficult. Implying that despite the MDG's limited understanding of reproductive health and a minimalistic view of maternal healthcare, its' improvement was at most, incipient. Ecuador was not the exception despite the efforts already mentioned.

However, an important aspect to highlight is that it presented an increase of births attended by skilled health personnel,[16] a cornerstone in reducing the risk of maternal deaths (UN 2015 and World Bank 2006 in Carvajal 2016), arriving at almost 94% in 2014 (figure 2.1)[17] Nevertheless, one of the main problems with such indicators is that they hide important differences inside the country. In terms of income, women in the lowest quintile are the ones with less births attended by skilled health personnel, but at the same time, they are the ones who present the strongest increase in 2006 to 2014. In terms of region, the Andean and the Amazon areas are the ones with less birth assistance with both regions characterised for having rural and indigenous populations. This is not new and even though there is no current quantitative data about the professional assistance during birth in indigenous women, in 2004 only 30% of them received such (MSP 2005). This does not imply that they have not had any attention, considering that traditionally they have been assisted by midwives[18].

It is in this context that this section presents a critical analysis of the process of universalism in Ecuador in the period 2007-2017, from a general overview to the case of reproductive and maternal health. In order to do so, I follow an adaptation of Franzoni and Sánchez-Ancochea's (2016) components of policy architectures previously discussed[19], focusing on 'what is provided', or the state supply side of healthcare. It is also addresses the side of beneficiaries, but this is developed in a more profound manner in the final chapter that zooms in on the demand.

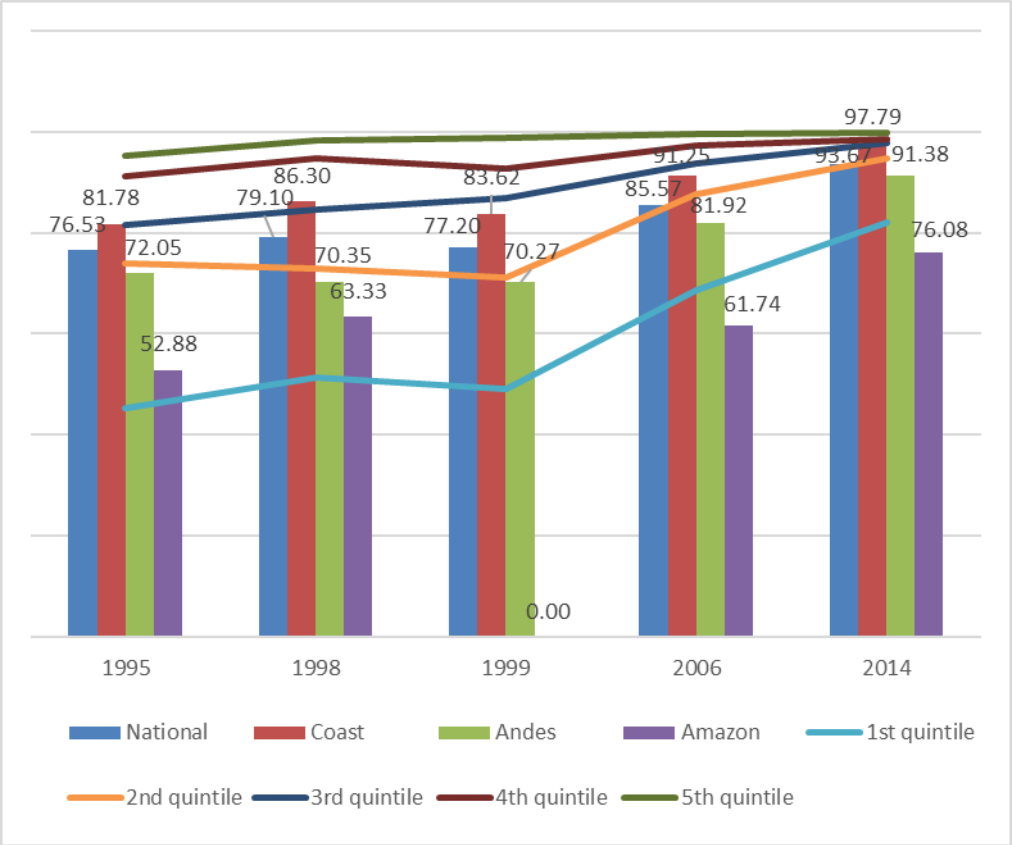
[16] This could affect the indicator of maternal mortality because more births are registered. However, it does not mean there is an actual increment of deaths, but an increase of their registrations.

[17] More details are in appendix 3

[18] According to the SIISE [2019], midwives are considered as trained health practitioners, but not professionals excluding them from this measurement.

[19] The 'outside option' has been left aside considering that parallel to this the role of the government has been addressed for being the paramount importance of this research.

Figure 2.1
Professional assistance during the delivery by regions and income quintiles 1995-2014 (Percentage of women who had a delivery in the last 5 years)



My elaboration based on MSP (2014)

Who benefits? Eligibility criteria for access

It could be said that the Ecuadorian healthcare system followed an entitlement basis or in Esping-Andersen's (1989) terminology, a social citizen approach where all have the right to benefit from the public health provisioning. In fact, health and healthcare are presented in the country's Constitution as entitlements where a person can leave aside intersectional status and/or its wage, in order to have access to public provision which could be understood as having passed to a process of formal healthcare de-commodification and universalism which is part of the principle of social citizenship. Additionally, considering that the Constitution (2008) also states that all healthcare activities will be regulated and controlled by the MSP (art. 361), there is a process of detachment from the market which could be the base for an emancipation process. However, there are already two main contradictions that should be highlighted when it is grasped more deeply.

First, the public system is itself fragmented where the access to part of it requires a contribution criterion. The public provision is divided into two groups: One is the central state including the MSP, MIES, and the municipalities (PAHO 2008), that offers services for the entire population[20] (Lucio et al. 2011); and the other is the social security systems, such as IESS, that covers only formal workers and their minor family members, and the ISSFA

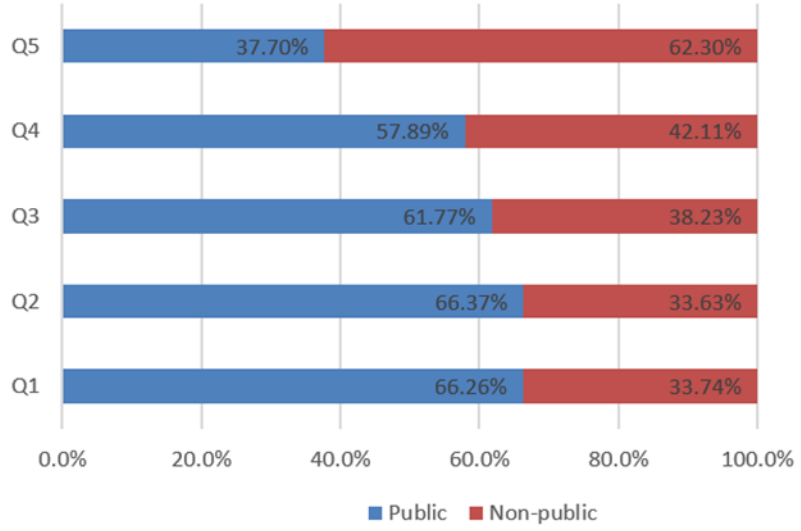
[20] All of these entities also have the competency to create additional schemes for promoting access to the vulnerable population.

and the ISSPOL for the army and the members of the police and their families (ibid). Therefore, citizenship is no longer enough, but people depend on an intersectional category (formal workers)[21] to have access to a part of the public supply, meaning that the public healthcare system has not fully passed through a de-commodification process. In fact, in terms of maternal healthcare, for example, in birth, its use declines with income increases (figure 2.2), compromising the quality of the service.

Second, with this process of the re-appearance of the role of the state in the Constitution, which as argued by Malo and Malo (2014) implied inclusion of historical social demands that were neglected in the neoliberalism era, the question is raised of the actual capacity of the state[22] in a highly concentrated market and one difficult to regulate. Iturralde (2015:18-19) emphasized that in Ecuador there is an increase of income concentration between private health providers, where 1% of them controlled 21% of the income in 2011 and 40% in 2012, which constrains the regulatory role of the state. In fact, their income climbed from 145 million US dollars to 298 million in these years (ibid).

Figure 2.2

Professional assistance during the delivery in the public sector by income quintiles 2014 (Percentage of women who had a delivery in the last 5 years)



My elaboration based on INEC (2014)

Who pays? Funding scheme

The 2008 Constitution implied a major shift in the financing of all the public health sector in qualitative and quantitative terms, in a context of an economic bonanza with not only a constant GDP increase mainly due to the increase of oil prices, but also the state income and its expenditure in key sectors traditionally related to development and wellbeing[23]. First, different from the Constitution of 1998 where charging a tariff was mentioned as a source of funding for those with payment capacity (art. 46), the 2008 Constitution in article 286 states

[21] On average during the period 2007-2017, only 45% of the population of working age has formal employment [INEC 2018] in a bonanza period.

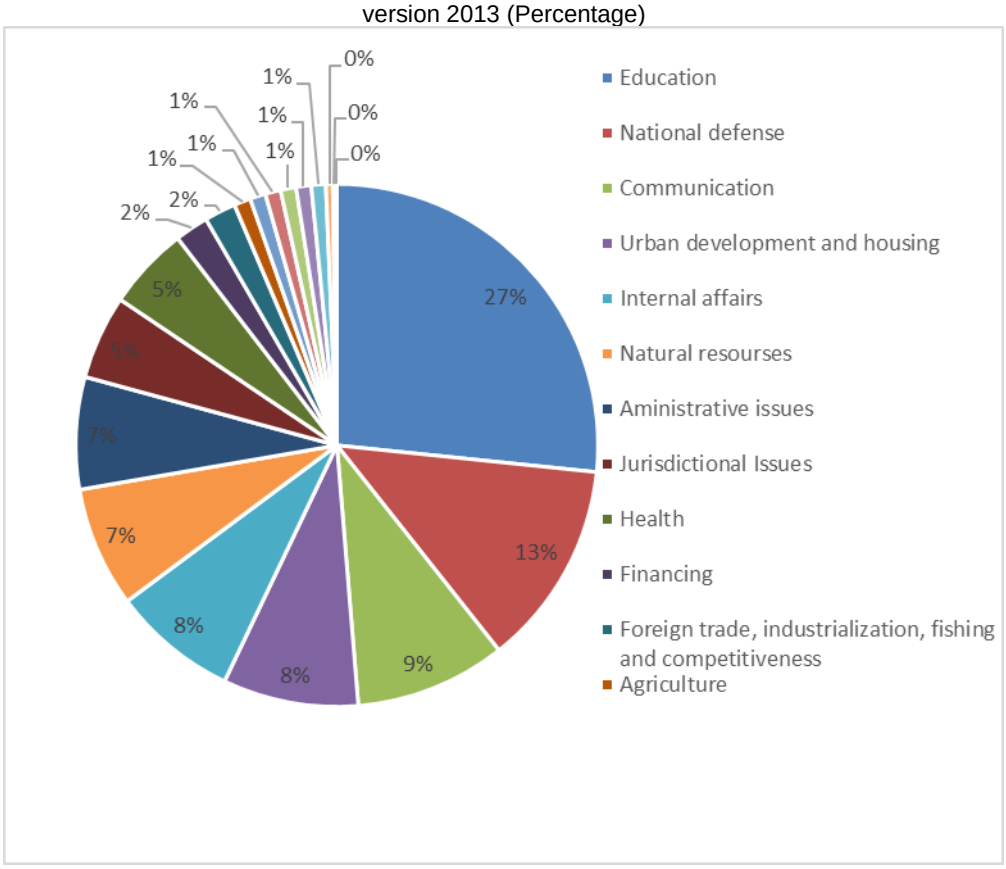
[22] Ortiz-Prado et al. (2014:61) state there is one pharmacy per every 2,303 people, the highest proportion in Latin American countries. However, only 10% are in the rural area (ibid)

[23]Contributing to the reduction of extreme poverty and child malnutrition (Carvajal 2016).

that the permanent expenses have to be financed with permanent income[24] from the General Budget of the State. Therefore, all services in the public sector are free of charge, reducing what the MSP [2009:7] mentions as "the contradiction with rights and universal access with no barriers". Furthermore, and particularly for the permanent expenses for health and education, there is an exception that allows for their financing through no permanent income to guarantee their priority (ibid). Second, in quantitative terms, as presented in figure 0.1, there is a constant increase in the general executed budget of the State allocated to health in the period 2000-2014. However, this does not necessarily imply that health has been a fiscal priority. As could be corroborated in the figure 2.3, the expenditure on health represents 5% of the total State spending with more allocation to national defense for example (13%)[25].

Figure 2.3

Codified general executed budget of the State classified according to expenditure sectors, summarized version 2013 (Percentage)



My elaboration based on INEC (2016)

For reproductive and maternal health in 2013, the State spent around 1.5% of its budget allocated directly to health (table 2.1). Most of this went to maternal health (1.24%)[26] and a residual part (0.15%) to reproductive health through ENIPLA, the main strategy for family planning and teen pregnancy prevention since 2011. This situation shows the priorities of the government with more budget allocated to *Mi Emergencia,* for example, (4.63%). It aimed to support the Integrated Security System (Sistema Integrado de Seguridad in Spanish) in cases of accidents, heart attacks, and normal deliveries [MSP 2013]; however, its focus was

[24] The permanent expenditure occurs in a continuous basis to provide goods and services to the society without directly generating capital accumulation, and the permanent income follows the same path, periodically and in a predictable manner, without the sale of any assets(MEF n.d.).

[25] The 5% is paramount but its priority is questionable. Nevertheless, it is vital to highlight if comparing in time, previous to 2007 most of the budget was allocated to debt services instead health and education.

[26] There is no desegregated data and thus it is not possible to mention what it includes.

on the first two considering that they were the main causes of death among men in 2014 with 14.6% (INEC 2014a: no page), which implies that the programme has more probability to benefit men *ceteris paribus*.

Table 2.1
Codified general executed budget of the State classified according to health activities, summarized version 2013 (Percentage)

Activities	%
Administration, human resources, pharmacy, laboratory, x ray, laundry, transportation, food, and other services	52.52%
Administration, management, services and support to health services	15.11%
Mi Emergencia	4.63%
Social Protection Network Programme	4.14%
Sustainability of the operations of the MSP units	3.04%
Hospitals (expenses of prevention, treatment, recovery, and rehabilitation)	2.58%
Infrastructure, equipment and maintenance	2.55%
Reform of the health sector and reconstruction of the MSP	1.82%
Emergency health status	1.34%
Free Maternity	1.24%
ENIPLA	0.15%
Free Maternity Law	0.05%
Prevention, control, and treatment of HIV	0.02%
Traditional medicine supply	0.02%
Administrative expenses related to the Free Maternity Law	0.02%
Health promotion	0.02%
Ecuador's response to HIV from a multisectoral approach	0.01%
Intercultural health	0.00%
Other	0.01%

My elaboration based on INEC (2016)

What are the benefits?

Zooming in on maternal health, the state guaranties the rights in table 2.2. Nevertheless, two rights have been continuously denied: abortion and family planning methods. In the first case, according to the Integral Penal Code 2014 (Código Integral Penal in Spanish), the person performing the abortion and/or the woman causing or allowing it will be sanctioned

with prison (art. 149), unless there are two exceptions: to avoid a health or life risk of the pregnant women or when the pregnancy is the result of a rape of a mentally disabled person (art. 150). Considering that the progress related to abortion has been minimal, not to say none existent,[27] it is evident that it is not part of the 'universal health' package. In fact, in order to have the right to such provisions, a particular set of intersections is needed: a) to be a woman with an evident health risk or life threatening situation, which excludes mental health , for example, when not feeling ready or not wanting to have a delivery or become a mother, or b) to have been a woman in a life threatening situation exposed to one of the most historically visible forms of gender violence (rape) as long as she is mentally disabled.

Table 2.2

Rights of pregnant women and women during the breastfeeding period

- No discrimination in education, labor, and social spheres,
- Free services for maternal health,
- Priority protection and care of their integral health and life during pregnancy, delivery and postnatal periods,
- Provision of the needed facilities for recovery after them and during the breastfeeding period,
- Free attention during their pregnancy, birth, and postnatal periods, and in sexual and reproductive health programs
- All expenditure for medicines, supplies, basic and complementary laboratory exams for her and the child, birth assistance, caesarean section and any obstetric emergency, blood supply, detection of cervical cancer, and access to fertility regulation methods.

My elaboration based on the Constitution (2008) and the Free Maternity Law (Ley de Maternidad Gratuita in Spanish).

These intersections, supposedly non-existent for having access to health provisions, show that when dealing with women's needs and rights, they are in fact present (even formally) as requirements resulting in a commodified access. Going further, the main question arising from here is why the intersections are present here? Is this maybe because a mentally disabled woman is 'the only irrefutable woman' that cannot defend herself from her perpetrator? Or maybe is it because only in such cases are women truthfully seen as not in any way causing such an offensive act?[28]. Nevertheless, abortion continues to be among the ten top causes of morbidity (table 2.3). Additionally, if summing the percentages associated with maternity (*) all together constitutes 4.5%, the top morbidity cause, this results in being women specific.

[27] The previous Integral Penal Code 1997 (110) in its' article 447 stated that abortion will not be punished only when the pregnancy is the result of a rape of an "idiot or demented women".

[28] This is not my position. A victim of any form of violence is never responsible for it. However, in the Ecuadorian context the debates about decriminalisation of abortion are centred in assuming pregnancy prevention as only a woman's issue, even in cases of rape, and the consequences of raising children their duty.

Table 2.3
Top ten causes of morbidity in 2014 (Percentage and rate per 10,000 people)

Causes of Morbidity	%	Rate per 10,000 people
Cholelithiasis	3.03%	22.55
Acute appendicitis	2.98%	22.19
Diarrhea and infectious gastroenteritis	2.54%	18.89
Pneumonia and unspecified organism	2.51%	18.71
Other disorders of the urinary system	1.44%	10.72
*Not specified abortion	1.32%	9.85
Inguinal hernia	1.27%	9.48
*Genito-urinary tract infection in pregnancy	1.09%	8.08
*False labour	1.06%	7.85
* Maternal care for known or suspected abnormalities of the mother's pelvic organs	1.03%	7.64

My elaboration based on INEC [2015]

In the second case, in relation to family planning methods, the Constitution (2008: 29-30) recognized and guaranteed the following right (art. 66) that has been approached with two antagonistic policies: ENIPLA launched in 2011 and *Plan Familia* in 2015 addressed in the following section:

> The right to make free, informed, voluntary, and responsible decisions related to a person's own sexuality and sexual orientation. Also, the state will encourage access to the means to promote these decisions taking place in safe contexts.
>
> Constitution 2008

At the same time, the government has worked on reducing mortalities with two main key policies since 2008: the National Plan for the Accelerated Reduction of Maternal and Neonatal Mortality (Plan de Reducción Acelerada de Mortalidad Maternal y Neonatal in Spanish) and the Technical Guide for Culturally Adequate Birth (Guía Técnica para el Parto Culturalmente Adecuado in Spanish), to reduce the risk of death mainly in indigenous.

- Firstly, the Plan's aim is to develop guidelines to act to reduce mortality based on lessons learnt from previous actions following a cost-effectiveness approach (MSP 2008). It emphasises that "most of the gaps in the access to reproductive health services are in indigenous women with no formal instruction and living in the rural area" and it pays particular attention to the assumption that women who give birth in their own houses choose it due to economic constrains (52%) or as part of their "cultural and ancestral habits" (48%) where routine and lack of trust are the main factors , and thus looks to increase the 'institutionalized delivery' in health centres (ibid: 32-33).

While economic constraints could have been *partially* worked on by establishing all health services free of charge the second factors had been addressed by making the health centre more 'trustworthy', assuming that this will increase the attendance instead of enabling the possibility of births at home for women who historically have *done* so. Here, it is not

stated as a 'preference' considering that the lack of access for indigenous women to the health centres is not necessarily a choice resulting from their preferences, but the only option they can afford or the only way to not face discrimination. Therefore, poverty should not be left aside from the analysis as Esternman's (2014) warning in cultural discourses where they had contribute to ignore economic inequalities and power relations. In addition, as mentioned by an interviewee of *El Parto es Nuestro*, shame and maltreatment are factors limiting indigenous access to public healthcare. Thus, the fact that births at home are part of what they historically have done, does not mean they have to continue to do the same, but that they can freely and safely choose; otherwise, problematic practices and conditions could be justified following this path (for example, gender issues and poverty).

Additionally, it is vital to highlight that the direct payment of the service is not the only economic cost that could affect women's decisions to visit the health centre. The hidden costs include transportation which is a paramount barrier that constrains the access to health centre facilities according to rural healthcare users interviewed (that established it as something they pay directly) and practitioners also interviewed in this research, as well as the high opportunity cost of daily (productive and reproductive) activities performed almost exclusively by women inside their household. According to the INEC (2019: 20-26), in the period 2007-2015, not only were most of the non-paid activities performed by women, but also their contribution was always higher (compared to men) despite their income level and ethnic self-identification. In the first case, women's contribution to reproductive labor reduces with the increase in income with a minimal difference of 5% between the highest and lowest quintile; and in the second case, afro-Ecuadorians are the ones with higher workload of reproductive labor (80%) compared to mestizo (78%) and indigenous women (76%) (ibid).

In relationship to the development of trustworthy health centres, this situation is clearly a policy choice congruent with the historical path of the national projects that implies the state effort has been in changing the habits of those different from the mestizo group trying to include them in the project following a functional interculturalism approach, a main characteristic of what Echeveria (2008) mentions as the modernising and civilising state.

However, the main question is if in fact the country and the State could actually supervise homebirths guaranteeing women's safety. This considering its processes have been characterised by the reappearance of the role of the State in a centralised manner in the case of health and education and whose state, usually coopted by its current government, is already difficult to manage in practise due to its present duties. Or in contrast, if the State cannot do so, then perhaps the deregulation and decentralisation of health could promote women safety or encourage the appearance of informal clinics putting women in riskier positions.

- Secondly, looking for the encouragement of 'trustworthy' health centres, Technical Guide for Culturally Adequate Birth taken by the MSP focuses on increasing the demand for health services by indigenous women by allowing certain cultural practises in the delivery (MSP 2008a) They include choosing the delivery position, having a family member close during the birth, keeping traditional clothes on, have a limb light and a warm temperature, drinking special beverages, and having the placenta incinerated or buried after the birth The importance of these is that despite not being necessarily respected in practise, they can and are used as a basis to claim rights, as mentioned by an interviewed activist from *El Parto es Nuestro*.

What is provided?

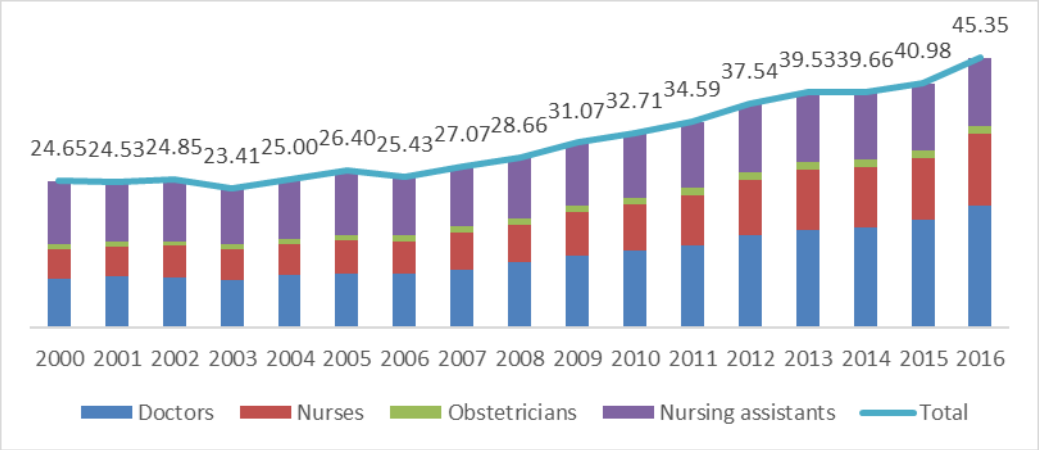
According to the Constitution (2008), healthcare services will be provided by the State, private centres, and autonomous and community organisations that provide ancestral and

alternative medicines (art. 362). Moreover, for provisioning purposes, the document highlights that the state can give financial support to private entities with no profit interest that guarantee free services, and they will be controlled and regulated by it (art. 366).

In the period of analysis, the MSP and the IESS were the two main entities in charge of provisioning in the public sphere (Chang 2017), although organisations, such as the JBG and the Ecuadorian Red Cross, also receive public financing (PAHO 2008). Nonetheless, the role of the private sector has been paramount in provisioning. Iturralde (2015) highlighted the fact that the government has encouraged the dependency of the entire health sector (private and public) on state revenue in two ways: by the number of private entities as a result of the public-private alliances and by the policies aiming to increase consumption that lead to the appearance of new private units[29]. In fact, private clinics and hospitals have been some of the key actors increasing the health coverage where there has been a "transfer of treatment to private providers" (ibid: 9). In this context, IESS decreased its number of establishments, but its expenses increased together with the increase of the public-private alliances by 1,000% in four years (ibid). This implies that most of the expenditure was allocated to them and not to self-improvement (for example, infrastructure, personnel, equipment, etcetera).

In the case of health practitioners, there is an increase of approximately 60% between 2003 and 2012 where gynaecologists and obstetricians are in the top five of the increased health personnel (appendix 4). However, the rate of gynaecologists does not present a major increase (appendix 5) and its proportion remains static between 2000-2016 (figure 2.4). But there is a strong increase of health personnel from 2007 with the declaration of emergency in the sector, arriving at 45 health professionals per 10,000 inhabitants in 2016 which is two times higher than the WHO [2019d] advises for minimal maternal and child health attention.

Figure 2.4
Health professionals 2000-2016 (rate per 10,000 inhabitants)



My elaboration based on INEC (2016a)

Additionally, particularly addressing maternal and reproductive health, ENIPLA and *Plan Familia* have been the main programmes executed by the government in the period of analysis with the following aims.

[29] Iturralde (2015: 13) pointed out the large number of new health centres (367 in the period 2007-2013) compared to 99 in the same period before.

Table 2.4
ENIPLA versus. Plan Familia

ENIPLA	Plan Familia
Increase permanently the effective access of citizens to information, education, counseling, inclusion, protection and health services for making free and responsible decisions about sexuality and reproduction, and the full exercise of their sexual and reproductive rights" (MCDS 2011: 38).	Prevent teen pregnancy through the strengthening of the protagonist role of the family and empower the adolescents to make free, informed and responsible decisions" (PNFF 2015: 33). According to ex-president Correa (Enlace Ciudadano 413) the new programme needed to include a set of values that highlight family as the centre of society.

My elaboration based on INEC [2015]

On one hand, the logic behind ENIPLA was to provide services to its beneficiaries, mainly adolescents, through the Health Centres. As a result, according to two interviewed public health personnel working in rural settings, the health team had to organise sexuality talks in grammar schools and provide contraceptives in the health unit by only requesting a student card, which contributed to the increase of women asking for family planning methods. However, ENIPLA was stopped by the former president Correa in 2014 because he believed that it encouraged 'hedonistic practises' and the irresponsible exercise of sexuality. On the other hand, the National Plan of Family Strengthening or *Plan Familia*, its replacement established in 2015, planned a waterfall effect where the main trainers will train community leaders, tutors, and parents following an approach to delay the initiation of sexual activity in adolescents (PNFF 2015: 45-50). Thus, according to the health personnel interviews in this research, the practitioners were required to stop their visits to grammar schools because sexual education was now understood as only a parental duty. The logic in this programme was to encourage the relationship inside the family in order to promote the idea that adolescents talk with their parents about sexuality. It was highly contested because of its emphasis on sexual abstinence, as ENIPLA was contested because of the lack of such an option, but the main issue was in fact the 'protagonist role of the family'. While looking for the encouragement of a dialogue about sexuality inside the family is not incorrect, because it could help bring about a collective empowerment about the topic, it is questionable that many adolescents and their families will actually engage in this[30]. Additionally, when conducting the interviews with the indigenous women and addressing family planning methods, they were never explicit about the practices they engaged in to avoid pregnancy. They only mentioned that they prevent it *así,* translated into English as "like that" and only one of them, the closest to me, stated that it means *coitus interruptus*. This shows that a free dialogue about sexuality is yet but a dream and policies based on such an idea trying to deal with current issues, such as teen pregnancy, will be ineffective for the time being.

[30] For example,. one urban adolescent stated (in an informal conversation) that even though her parents were very open to talk about sex, she did not feel comfortable asking questions about intercourse and birth control.

Chapter 3 The application of interculturality at a macro level project for comprehensive healthcare: the situation of maternal health

This section presents a critical analysis of the process of the development of an intercultural project in Ecuador, occurring at the same time as the universal process already addressed, using the criteria of appropriateness, availability, and affordability for the maternal health provision. It excludes the criteria of adequacy and accessibility that were part of the conceptual and theoretical framework because they are addressed in a transversal manner.

Appropriateness

The appearance of interculturality corresponds to a global tendency to incorporate the right to be different, which distinguishes and promotes the coexistence between different cultural groups in the same territory (Salaverry 2010).In the Latin American context, intercultural polices have been developed aimed at encompassing traditional and western medicine to promote the access to service provision of ethnic minorities during the last ten years (Llamas and Mayhew 2018). The Ecuadorian process started to materialise with the 2008 Constitution that finally mentions both that the health system will guarantee the promotion of ancestral medicine as complementary measures (art. 360) and that the State will guarantee practices of ancestral health by recognizing and promoting its use (art. 363). However, in practice the only visual progress of interculturality is in maternal health through the strategy of 'vertical delivery', according to the health personnel interviewed for this research.

'Vertical delivery' is the Technical Guide for Cultural Adequate Birth (Guía Técnica para el Parto Culturalmente Adecuado in Spanish) developed by the MSP (2008a: 16) that worked on "the recognition, reevaluation, and recuperation of ancestral knowledge and cultural practices" in order to develop appropriate policies in terms of local contexts (including the diversity of the population and their traditions). The document mentions the implication of intercultural polices by questioning how the western system of medicine had excluded the knowledge of other health systems, as a result of the lack of policies addressing historically marginalised social sectors (ibid). Therefore, it aims to improve the quality of healthcare of sexual and reproductive healthcare by adapting health services to cultural diversity to contribute to the reduction of maternal and neonatal mortality (ibid). Also, it highlighted that scientific knowledge had been seen as the only knowledge and categorizing other forms as "primitive", and the need to incorporate local health practices into the public system (ibid).

However, in practice this has translated only in allowing women to give birth vertically and not in the position they choose because it assumes all indigenous are the same as the women of Otavalo according to the members of *Amupakin* interviewed. Additionally, during this research two further points were made. First, when asking questions about 'intercultural health', the health practitioners interviewed immediately referred to vertical birth for the indigenous population. It was never framed as an option for other women nor was there and discussion about other positions. Second, when interviewing the indigenous women, they mentioned that they knew they had the right to give birth "in the way their mothers did", but that the doctors advise them not to. Also, one of the interviewees highlighted the fact that the women with whom she worked believe they can only decide between horizontal or vertical birth in a squatting position, while in her community in the Amazonian region most of them historically give birth with the assistance of a hanging rope which is "not allowed because of the MSP idea that all the indigenous are just the same".

While there is a call to take a local participatory approach to address diversity needs, it is also problematical because intercultural polices could be required to deal with the infinite diversity and as pointed out by Mkandawire (2005: 5), in the most extreme formulations it will "make any society incoherent because it sanctions something tantamount to unlimited relativism". In fact,

> It not only risks anarchy of competing claims from a variety of combinations of subject positions while offering no means of deciding among them, but also raises questions about how one can deal with those who seek to maintain (…) distribution outcomes at the expense of others.
>
> (Ellison 1999: 70 in Mkandawire 2005: 5)

However, this research tried to go beyond this and find 'right now' measures in order to improve the health system discussed later.

Availability

In terms of availability, two important strategies were identified related directly to intercultural maternal health based on the interviews of this research: the ENSAMYN (2015) and the Articulation of Practices and Midwives Ancestral Knowledge' in the National System of Health (2016) (Articulación de prácticas y saberes de las parteras ancestrales en el Sistema Nacional de Salud in Spanish), both part of the Technical Guide previously mentioned.

In the first case, the regulation establishes guidelines for the care of the mother and the new-born ensuring compliance with constitutional and MAIS mandates [MSP 2016]. It includes four components where two are of primary concern for this research. The Prenatal component highlights the need to articulate efforts with the 'agent of ancestral medicine' to the care during pregnancy, birth and postnatal (ibid). However, while it is recognised that there is a need to have a joint position, it is evident that the ancestral health practitioners are not valued as such. In fact, all the interviewees that worked in the MSP highlight that the midwives are allowed to enter the health centre, and that they do so as family members. This implies that they are not practitioners and that they are not able to follow their ancestral practices[31]. This was confirmed by two indigenous women interviewed that stated that their midwives were only 'looking' at what the doctor did during the delivery. Also, the doulas[32] are banished in the public system in the urban area of Quito even though the health personnel are fully, as stated by a member of the *Red Mundial de Doulas* working in Pichincha, interviewed. Consequently, they used to enter health centres and hospitals in secretly depending on the doctors opinion and with no recognition for their work (not even payment) until February 2019, when the further formalisation and bureaucracy of the system completely restricted their access (ibid).

Not only is bureaucracy stated as a problem by the doulas, but also by other health practitioners of the MSP and the indigenous women interviewed for this research. Firstly, two general doctors and the nutritionist mention they have only 20 minutes to attend to the patient where they have to fill in personal data (sex, age, ethnicity, etcetera) in the online and the physical system, take anthropometric measurements, check the patient, give instructions and write prescriptions, which compromises the quality of the service delivered. This is even more challenging when the patient's maternal tongue is not Spanish as was the tongue of the health personnel interviewed (ibid). Nevertheless, according to them the language issue has

[31] There is plenty of research about the importance of the midwife at the moment of delivery, particularly in indigenous communities located in the Andean region.

[32] Different from midwives, their work is only in supporting the pregnant woman emotionally with no direct intervention in the birth, according to this interview.

been stronger in the urban area with the increase of the Haitian migration, because most of the indigenous also speak Spanish at least as a second language. Secondly, the indigenous women interviewed stated that currently they prefer to receive attention in private health units in the nearest city because they receive immediate attention. On the contrary, in the public health centre they first need to ask for an appointment and later they will receive attention. It was not clear how long they had to wait, but the appointment was not on the same day they asked for it. This implies that they needed to spend double the time as well as the money in transportation for an appointment.

The birth and postnatal component mention the following steps (table 2.4) showing a clear intent to have a more comprehensive maternal healthcare, but in practice there are some issues particularly related with steps a, b, and e-.

Table 3.1

Steps during birth and postnatal periods

a.	Allow the accompaniment of a person chosen by the mother during all the process,
b.	Guarantee a warm environment respecting the intercultural practices,
c.	Assist the mother in their movement and their taken of a free position,
d.	Provide relief medicine,
e.	Avoid invasive and unnecessary procedures and cesarean sections,
f.	Guarantee integral practices including immediate attachment and breast feeding in the first hour,
g.	Perform the need proceedings to the newborn in front of the mother,
h.	Identify risks of complications in the mother and the new born,
i.	Allow contact with newborn requiring hospitalisation and inform about the situation,
j.	When the mother and the baby are discharged, provide information about family planning, alarm signs and book an appointment for the first check-up.

My elaboration based on MSP [2016]

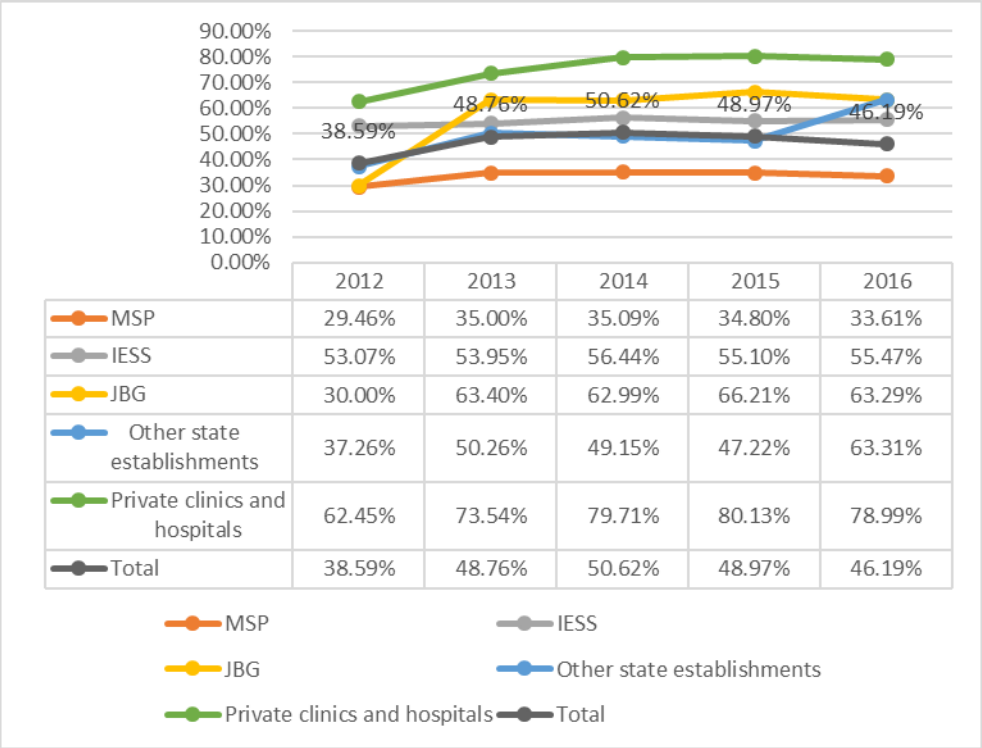
While midwives are 'allowed' to assist in the process, they are not part of the public sector, implying that, if a woman requires them, she needs to pay for their work with her own means. However, considering the relationship between the mother and the midwife is not necessarily market driven, such service is not necessarily commodified but neither totally accessible. Also, there are efforts to try to guarantee intercultural practices, but there is a misleading idea that it is only related to vertical birth. Finally, in 2015 around 46% of all the registered births in Ecuador were cesarean sections (INEC in Carvajal 2016: 113). This is an anomaly, considering this is a higher percentage than can be expected on the basis of 'natural' processes of giving birth[33] and the indigenous women are the only ones with a prudent percentage. Thus, this could imply a re-commodification of birth that put pregnant women through another kind of risk. This is a shift from the risk run by the birthing mother to the technical convenience and income generation for medical doctors/gynaecologists. Therefore, it could be said that going to the health centre will actually imply a 50% probability of having a c-section for the woman, which offers a 3.5% higher risk of death and 5 times more

[33] According to the WHO (Carvajal 2016: 70), a prudent percentage is between 5 and 15%.

probability of infection (PNUD 2014 in Carvajal 2016: 87). As a result, not going to the centre is not an irrational choice after all *cetreris paribus*.

There is an increase in caesarean births but important differences exist when classified by the providers (figure 3.1). In the private sector, around 80% of births were c-sections in 2016, and in the public sector, the JBG is the organisation with the highest increase (100%) between 2012 and 2016, despite the reduction of births attended. In other words, the JBG only increased the caesareans during such a period with the highest increase between 2012 and 2013 (appendix 6) which matches the allocation of $4.8 million from the MSP to the JBG for service provision (MSP 2012: 3).

Figure 3.1
Caesareans 2012-2016 (percentage of births)



	2012	2013	2014	2015	2016
MSP	29.46%	35.00%	35.09%	34.80%	33.61%
IESS	53.07%	53.95%	56.44%	55.10%	55.47%
JBG	30.00%	63.40%	62.99%	66.21%	63.29%
Other state establishments	37.26%	50.26%	49.15%	47.22%	63.31%
Private clinics and hospitals	62.45%	73.54%	79.71%	80.13%	78.99%
Total	38.59%	48.76%	50.62%	48.97%	46.19%

My elaboration based on MSP [2017]

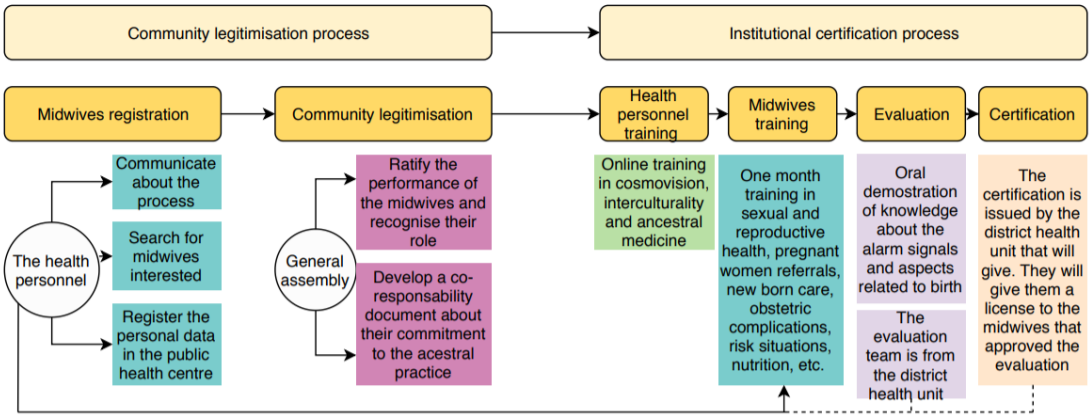
In the second case, the document for the articulation of midwives ancestral knowledge into the national system of health mentions the midwives as central to the community and proposes to recognise them as allies to reduce maternal mortality (MSP 2016a). As a result, its aim is to establish articulation mechanisms (figure 3.2) by:

> Organising and executing the process of community legitimisation and accreditation of the midwives, strengthening (their) knowledge through maternal health and neonatal training by the health team, (and) define monitoring and evaluation mechanisms (MSP 2016a: 12)

While this text mentions the word *strengthening* which implies the midwives already have knowledge about the topic, the word *dialogue* is not included that requires health practitioners of the MSP to also strengthen their knowledge about ancestral practices, which in the end is what 'interculturality' is about. Also, the need is pointed out for an interaction between ancestral and scientific knowledge, but the question is if it is a horizontal interaction what is encouraged which could imply a small scale redefinition of the state or if it is the health

personnel teaching the midwives how to do their job? In addition, during this research, no meetings were found where both practitioners share knowledge[34]. In fact, both trainings for the public health personnel and for the midwives are separate (figure 3.2). Therefore, the process fails to create spaces for dialogue, a key characteristic of the normative conceptualisation of interculturality as a political proposal to transform power relations according to Tubino (2004). Nevertheless, it is innovative because it also counts on the participation of the community, and is different than previous trainings in this regard which is a vital change because it tries to incorporate a participatory approach.

Figure 3.2
Process of community legitimisation and institutional certification of midwives



My elaboration based on MSP (2016a)

Affordability

While the affordability issue was already discussed in the universalism section, there are two further points to be highlighted from these research findings.

Firstly, the fact that midwives are not included in the public provision implies that having access to such services has a degree of commodification. Women need to pay for their service, which is $30 for the delivery[35] according to an interview of a midwife from *Amupakin*- which implies a reduction in their disposable income. A similar situation occurs with doulas; however, despite the fact that they can be very important for women, their practices are relatively new, compared with midwives, and their services usually requested by women in higher income quintiles as mentioned in an interview with a doula. Moreover, the main issue with the payment as well as lack of midwives in the public sector is that they could constrain the access of women to the entire health system (private and public). In this research, there is no clear evidence to support that the exclusion of midwives in the public sector has constrained the access to it[36]. Nevertheless, as argued by a member of *Amupakin:*

[34] Organising knowledge-sharing sessions could be very challenging because of the power dynamics among the participants, but it does not imply that they should be excluded from the process.

[35] This includes the delivery, two nights in the health centre, medicines, and mother and baby care, and this is distributed 50% to the house maintenance and 50% to the midwife, according to a midwife from *Amupakin* interviewed.

[36] The women interviewed did not mention directly that the lack of midwives in public centers was a barrier to assist to this spaces, and there are no numerical data to support this statement.

> When the health system was not free (…) they used to came to the midwives, but since it is free they go to the health centre because here (in *Amupakin*) we charge the $30 (…), but the people of the community don't have such money and now they don't come as frequently as before.

This shows that the no payment in the public sector has removed barriers to its access; however, women are forced to choose between their ancestral traditions and this free of charge service provision, in a State with an 'intercultural' project.

Secondly, the issue of transportation has been mentioned in all the interviews as a paramount barrier to having access to the public health provision. As already argued, it is in many cases not only expensive with prices of $20 per one-way trip in a truck during the day for the indigenous women interviewed (personal experience), but also not available because of the lack of highway, hour of the day, and/or natural conditions (for example, a rising tide). This is paramount because "when the hospital is far away, not only the distance but also the mode of transport becomes an important determinant of how soon medical help will become available" (Sundari 1994: 179). But more transcendent, if there is no means of transportation, or even worse, if the price is unaffordable, this makes whatever is provided actually not available.

Chapter 4 Micro level analysis: what do 'the others' say about the health reforms?

What can be called in economics the supply side, and particularly for this research the State supply side, was already addressed in the last chapters and so far, the 'demand side' is missing. This is explored in this section in an innovative manner by following two perspectives: a) the viewpoints of some indigenous and mestizo mothers about maternity through their own lived experiences, and b) the standpoints of a group of midwives about the relationship between the 'intercultural process and health reform' and maternal health, and the struggles of two women's associations working in maternal health in rural and urban contexts in Ecuador. These are presented as a result of reflection during the research regarding a missing voice in the MDGs' discourse, the initiatives to promote safe motherhood in the supranational arena and the Ecuadorian health reform. This required me to step back and ask the beneficiaries/recipients or participants, as they are called in this research, how they have experienced these reforms, and what can be improved.

3.1 "But if you really want to know what I think..."

This section is organised on the basis of interviews held with three rural indigenous women and two urban mestizo women living in the province of Pichincha. It addresses the position during birth, the place of delivery, and the role of midwives.

"*Compañerita*, that's why I take care of myself (not to have more children). The pain of the delivery is horrible. It makes you feel sorry", one of the indigenous interviewees told me when asked about her births. Despite the normal pain that all women she knew had suffered during it, she remembered that her experience was "worst" because the doctor obligated her to lie down because of her age, she said. She was 32 years old at that time. This woman was also told that this way was the only correct form and she accepted it, but now she told me, that lying down does not make sense for her "because the baby needs to go down". This point of view was also shared by another indigenous mother who mentioned:

> I have given birth lying down in a private (office) because the midwife couldn't do anything, but the second (time I gave birth) was at midnight. I couldn't go out, so I gave birth with my mother by squatting at the edge of my bed. But if you really want to know what I think, it is better to give birth like my mother gave (birth), but the doctors said it's not and to lie down is better.

In this regard, the rural practitioners interviewed in this research agree and highlight that despite such a position it is difficult for them to give support as their patients are in labor less time compared to women in a lying down position. However, they mention that in urban areas, giving birth in different positions to lying down is challenging for the majority of women in the health units and due to the infrastructure already set up. Despite of this, as argued by a member of *El Parto es Nuestro* women with whom she had worked, they are frequently overwhelmed by questions and judgments of the health personnel at the moment of birth, such as "Why do you want to give birth as an indigenous if you are not indigenous"?

Additionally, one of the most stunning findings was when one indigenous woman was asked about why she did not attend the health center, she told me laughing "because I wanted to be *macha*"[37], and she added, "You know indigenous women are strong". Then I

[37] Given the context, the world can be translated as brave and strong.

remembered that in the past, when working with them, they mentioned me that mestizo women had forgotten how to be strong. This was on my mind because they had told me that all men are weak, but not the women; indigenous women are still strong, but the mestizo women had forgotten how to be like this. In this context, it can be said that the construction of women differs between the urban mestizo women and this group of indigenous, and one of its consequences could be associated with not going to the health centre because it is a sign of weakness. As a result, public policies promoting indigenous women to attend the health unit could be problematic because it goes against their view of a strong woman jeopardising their health outcomes. The question here remains if a home delivery system, instead of the current system promoting women to go to the health centre, could actually help to improve the health outcomes in the indigenous population.

It is vital to highlight that the construction of indigenous women does not imply that they do not have support during the pregnancy, birth, and postnatal care. In fact, all the indigenous women interviewed in this research mentioned that they first went to the midwife because she was closer in distance than the health centre or she was part of the community, and only when the midwife could not handle a situation, did they go to the health centre. One of them mentioned that the midwife "accommodates the baby" and on the day of the delivery she was not allowed into the room but "she only saw what the doctor was doing and then remained in the waiting room". In this regard, there are thousands of anthropological studies about the relationship between mother-community-midwife, such as Gonzales and Corral (2010) who mention that in many indigenous communities they are recognised as people of wisdom and are chosen to help in the birth based on a trust relationship. Despite this, there is currently no form of actual inclusion in the public health system.

3.2 "(The MSP) said the midwives here needed to take written exams, but all the *mamitas* are illiterate"

The information here was based on a one-to-one interview with a midwife about her experience and a group interview with midwives working in rural areas. I started by asking if they had heard about the government's intercultural health project and had follow up questions.

The midwife told me she remembered three things: the trainings, the manual (previously discussed), and the experience of working together in their *wasi*[38] and these were later repeated to the group of midwives too. In relation to the first, she pointed out that "they were already organised from the top", but the midwives could in fact negotiate important things. For example, she said that after the training, "they (the MSP) said the midwives here needed to take written exams, but all the *mamitas*[39] are illiterate", so they old them "there is no way the *mamás* will take a written test, but we can take an oral test answering what we know. And all of us passed". She also highlighted that the MSP told them:

> (…) In your house use whatever material you have, but always use gloves. The *mamas* said we do not use gloves, we have our prepared medicine to wash our hands, and sterilise birth material. We don't use gloves and if you want to obligate us to use gloves, it's going to be very difficult and we are not going to be able to. We know there are many diseases and all of this, which is why we have our medicine that we use to take care of ourselves. So, they told us it does not matter, and you cannot work without gloves. But it is agreed that in our house we will not use gloves

[38] Home in Quichua.

[39] This is the diminutive of *mamá* that they use to refer to the midwives.

In the second topic, one of midwives interviewed in the group mention "the manual doesn't work for us" because, according to her, there is no information about anything they do and there is no understanding of the role and the practices of the midwife in maternal health. For example, the importance that "our medicine is fresh, and we take care of it right away from the *chacra*[40] the moment we need it", means they could not go to the health centre with *all* they need, as required by the MSP according to them. Also, the midwife interviewed alone had a similar idea about the manual. However, what I see as more annoying not only for her but also for the group of midwives interviewed is that as one mentioned, "they (the MSP) said that supposedly all midwives sign it (the manual), and that they asked us this in the last 10 years, but we have been working for 30 years and nobody has asked us anything", and therefore they feel this is not their process.

Different form the trainings, the manual is not only seen as not useful, but also as an imposition for all the midwives interviewed in this research. Despite saying that they first accepted the trainings "by not saying no" and that there were complications during them, where "they wanted to tell us how to do everything", in fact, they also felt that they learned some things, like identifying risk signals during pregnancy. Nevertheless, the manual and "what they (the MSP) called cultural adequate birth" do not lead to the midwives' inclusion in the state health system, so this could also be part of why it is seen as not useful.

In relation to the third issue, working together was completely useless for the midwife interviewed alone. She mentioned "they (the MSP) told us that we gave our *wasi* in exchange for working together and the *mamás* will be paid. We gave them but with no signed document. They worked here, and every year told us there is no budget to pay the midwives because they are not professionals and don't have a title", but she mentions "we are not professionals but we have experience". Later, the midwives decided to take the MSP staff out of their *wasi* and continued working for the maternal health in their community with their association, and with no support from the State. This shows the strength of both indigenous women and midwives; however, one of the strongest barriers they now face is the lack of economic resources and means of transportation.

The MSP looked for the midwives support; however, one of them said the only opportunity offered for the *mamás* in the health centre is to work (paid) cleaning, otherwise they are only allowed to enter, as any other relative, and in the best scenario they are treated as auxiliary nurses. In fact, she added:

> the MSP) tells us to go only to help, to support, to collaborate, be volunteers ,(…) but we want to work because we all have families (…) they said they value us so we asked for a wage, but they told us there is no budget.

Nevertheless, the state has hired people from the community who are named TAPS (Technicians in Primary Health Care) and who, according to the doctors interviewed for this research, offer support to geographically localised specific areas in their territory, find people at risk in the community (including pregnant woman), and "convince them to go to the health centre". According to the MSP [2017], their role is the direct involvement with the community encouraging the participation and co-responsibility for health and, in order to do so, they receive training in sexual and reproductive health, focusing on adolescent health, breastfeeding and nutrition. This shows that the training for midwives and for the TAPS had completely different results and that the exclusion of the midwives in the public health system was not related to the lack of resources, because the MSP has in fact hired people from the community, but that the MSP had preferred to train other people, which is not only

[40] Crops in Quichua.

contradictory in an intercultural process, but also inefficient considering there are already available resources.

Conclusions: summary, reflections and follow-up

In this research, I identified and look for explanations for some gaps between the State provisioning and the needs of the female population from various ethnic groups, in relation to maternal healthcare during 2007-2017, which are in the context of a fragmented and limited universal process of healthcare and development of an intercultural project. Taking an innovative approach of mixed methods and using qualitative and quantitative techniques to gather data, I evidenced that these gaps jeopardise the access of some indigenous women to the public system.

Firstly, the universalism process had been shaped with the interaction of economic, cultural, and structural factors implying a gendered meaning of de-commodification and thus constraining the use of public facilities despite their payment since 2008. Hidden costs, including transportation and high opportunity costs as a consequence of social norms, are key constraints that make access difficult. But more transcendent, when there is no means of transportation or even worse, when they are not affordable, 'whatever is provided' becomes actually not available. Hours of attention, the need to personally schedule an appointment for a different day, lack of trusted personnel, and historical discrimination are all barriers to attend the health unit. Furthermore, cultural constructs of maternity operate in the decision making process of attending the health centre, and thus policies that do not consider this may fail. However, betting on a change of habits had been the State's way to address 'the difference' which follows the historical path of civilising and modernising national projects.

Therefore, further research is called for to address to what extent home-birth and the training of midwives to act independently in low risk pregnancies could be a suitable policy choice to deal with demand constraints and reduce maternal mortality in the Ecuadorian context. This not only includes the universal and intercultural projects, but also the lack of transportation means and infrastructure with particular differences with countries with successful results[41]. Nevertheless, it is imperative to take into account that despite the fact that it could contribute to tackling demand constraints, traditional practices are not necessarily the result of preferences, but the only affordable option or way to avoid systematic discrimination. Therefore, it does not mean they have to be preserved, but that those involved can choose; otherwise, problematic practices and conditions could be justified following this path (for example,. gender roles and poverty). Thus, the analysis of culture and tradition cannot be isolated from deprivation and poverty.

Moreover, in this universalism process the role of the private sector had been paramount in increasing the scope of provision, the central aim of the Ecuadorian State. With an enormous increase of public and private partnerships that contributed to the income concentration in the health sector, the scope increase had actually followed an employment based approach. This model is particularly insufficient in economies with a high proportion of workers in the informal sector and a dependence on the State which also hinges on the volatility of oil prices and, in periods of crisis and budget cuts, this could result in systematic failures and a catastrophic loss of wellbeing. Ultimately, considering the anomalies in the private healthcare system, including for profit and nonprofit entities in many cases monetarily sponsored by the State, such as a possible re-commodification of delivery through the amount of caesarean births, future research is called for. The aim is to study what the process of these partnerships was, who the beneficiaries of the economic groups are, and what the

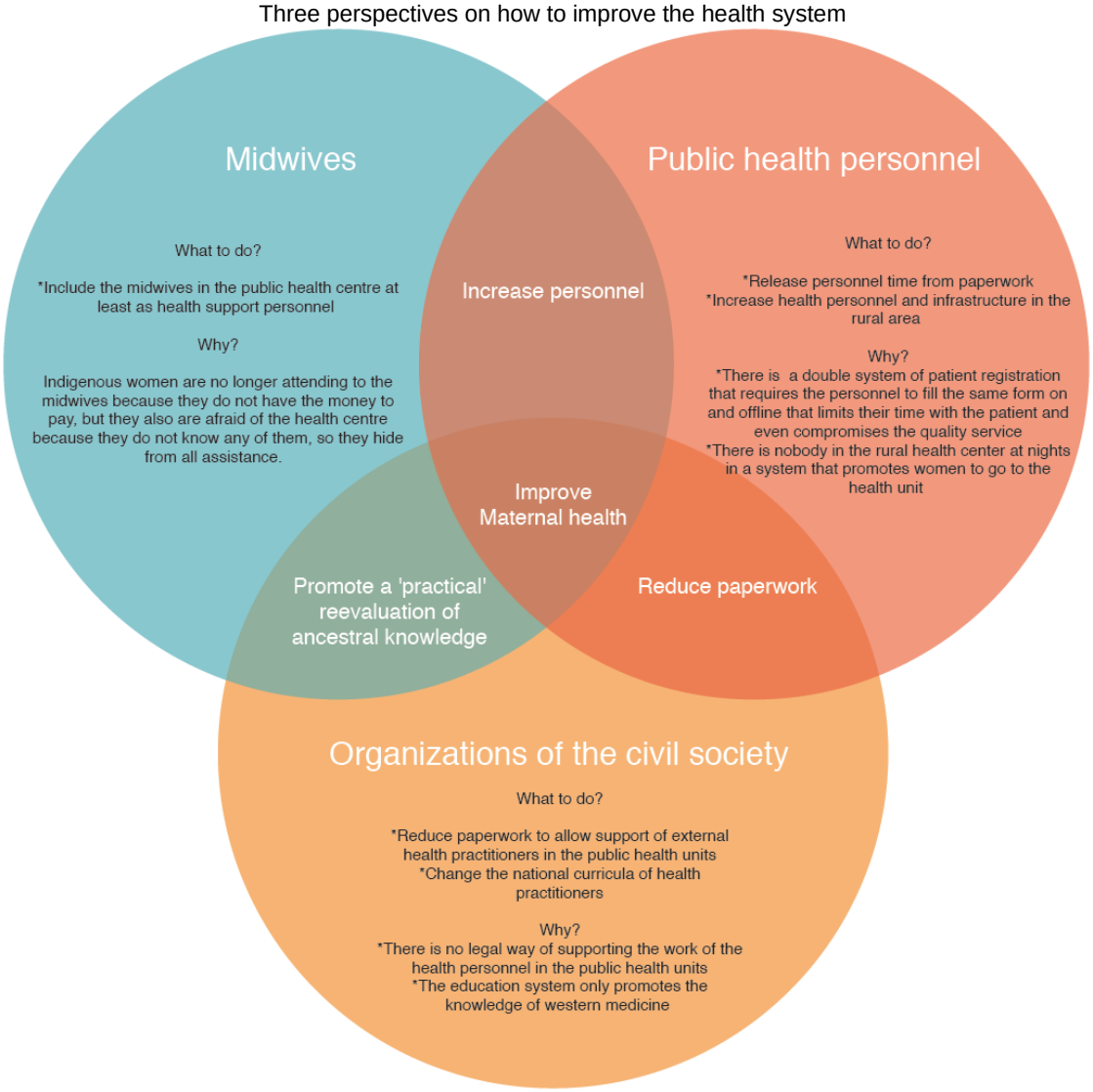
[41] In the Netherlands, for example, the outcome of planned births at home is at least as good as it is in planned hospitals (Wiegers et al. 1996), with no increased risk of death(van der Kooy et al. 2011).

opportunity cost of the allocation of these resources into partnerships is instead of the public sector self-improvement.

Secondly, the intercultural and universal processes lead by the Ecuadorian State had encountered each other, in both policy and practice, particularly in the application of small scale projects where innovative approaches were taken. They include an intent to have a comprehensive package of maternal health and the participation of the community in certain parts of the process, although the perception of the recipients is mixed and remains unanswered if a horizontal dialogue among the participants was actually promoted. An important reminder in this regard is that the 'inclusion' policies usually make the structures of asymmetry, characteristic of colonial societies, invisible.

Additionally, in order to contribute to the decisions and policy making debates about how to improve the system to ensure the right to comprehensive maternal healthcare, which is part of the research objective, I have developed a rudimentary proposal based on the interviews in the context of this research, which emphasises the voice of indigenous women, health practitioners and mothers, a fundamental requirement for a real improvement. The proposal (figure 4.1) addresses three 'meeting points' founded on the interviews: The first two promote a 'practical' reevaluation of ancestral knowledge and increased personnel in the health unit presenting an enormous opportunity to include the midwives in the public system. This offers to contribute to an increase in the relationship of trust between the pregnant women and the public sector, as well as to support the work in the health units. In practical matters, this could be done through the already existing form of TAPS. The last immediate measure is to reduce the paperwork considering that now there is a duplicated system. This is an 'easy' action that could help to increase the capacity of attention. Finally, it is worth saying that this is simplistic and limited to improve the supply side, but it shows where immediate efforts could be used to improve the system for better outcomes and experiences, a fundamental lack in the literature reviewed in this research, and therefore I believe it contributes to such debates.

Figure 4.1
Three perspectives on how to improve the health system



My elaboration based on the interviews

Appendices

Appendix 1
List of participants interviewed for this research (June-October 2019)

No.	Relevant characteristic for the research	Interview's main topic	Area of work
1	Indigenous woman	Personal experiences of maternity (women that gave birth in the last 5 years)	Agriculture and domestic work
2	Indigenous woman		
3	Indigenous woman		
4	Indigenous woman		
5	Midwife	Personal experiences in working with the MSP and with indigenous population	Amupakin: association of indigenous midwives working mainly with rural women
6	Midwife		
7	Midwife		
8	Midwife		
9	Midwife		
10	Activist	Personal experience in activism, the policy making of reforms on maternal health issues	El Parto es Nuestro: local group working on policy advocacy, women empowerment, and support to pregnant, birth and postnatal women on the basis of solidarity.
11	Activist		
12	Mestizo woman activist	Personal experience in activism, working in MSP health centres, and own maternity	Red Mundial de Doulas: organisation working on capacity building of women accompanying and supporting other women during their pregnancy, birth and postnatal
13	Public health practitioner	Experiences in working in rural settings and with indigenous populations	MSP
14	Public health practitioner		
15	Public health practitioner	Experiences in working in urban settings and with minorities	
16	Public health practitioner		

My elaboration

Appendix 2
Welfare regimes and its' outcomes

Liberal	Corporatist	Social democratic
It is characterized by modest universal transfers with restricted access to social provision and stigma, which implies a minimal decommodification effect.	The provision aim to preserve traditional family patterns and encouraging motherhood.	It pursues welfare promoting equity where the right to work is equally important as the right to income protection and it is not centred in minimal needs views.
As a result, it has a dual and stratified system of social provisioning where the state uses a narrow targeted and residual approach	Therefore, the State intervention only occurs when the family collapses.	Consequently, it follows a universal view where all are entitled to public provisioning

My elaboration

Appendix 3
Professional assistance during the delivery, classified by regions and income quintiles 1995-2014 (percentage of the women who had a delivery in the last 5 years)

	1995	1998	1999	2006	2014	Percentage change 2006 and 2014
National	76.53	79.10	77.20	85.57	93.67	9.47
Coast	81.78	86.30	83.62	91.25	97.79	7.17
Andes	72.05	70.35	70.27	81.92	91.38	11.55
Amazon	52.88	63.33	*	61.74	76.08	23.24
Q1	45.2	51.3	49.1	68.6	82.1	19.77
Q2	74.0	73.1	71.2	87.7	94.7	8.01
Q3	81.7	84.7	86.9	93.8	97.9	4.42
Q4	91.3	94.9	92.7	97.4	98.7	1.28
Q5	95.3	98.3	98.8	99.6	99.9	0.31

My elaboration based on INEC (2014)

Appendix 4
Health personnel comparison 2003 and 2012

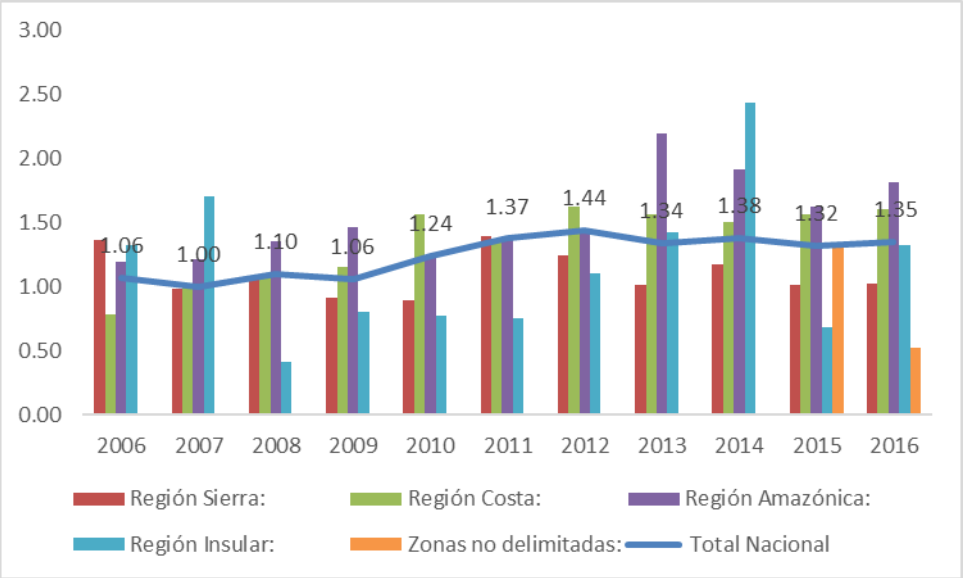
Specialities	2003	2012	Diff.
Total	16,667	26,539	9,872
General practitioners	4,471	6,968	2,497
Anaesthesiologists	1,255	2,016	761
Paediatricians	1,406	1,982	576
Gynaecologists and obstetricians	1,519	1996	477
General Surgeon	1,514	1978	464
Traumatologists	820	1277	457
Ophthalmologists and Otolaryngologists	631	960	329
Radiologists	294	568	274
Laboratory	216	449	233
Plastic surgeons	320	543	223
Cardiologists	603	824	221
Neonatologists	275	436	161
Neurologists	364	514	150
Gastroenterologists	403	547	144
Urologists	471	613	142
Intensivists	325	464	139
Pulmonologists	194	259	65
Nephrologists	168	228	60
Oncologists	177	234	57
Other	774	826	52
Geriatrists	43	84	41
Haematologists	124	162	38
Psychiatrists	300	305	5
Dermatologists	-	402	402

Fetologists	-	75	75
Endocrinologists	-	193	193
Allergists	-	74	74
Diabetologists	-	131	131
Internal Medicine (Internist)	-	1,081	1,081
Public health practitioners	-	63	63
Epidemiologists	-	73	73
Family and community health practitioners	-	214	214

My elaboration based on INEC [2015a]

Appendix 5

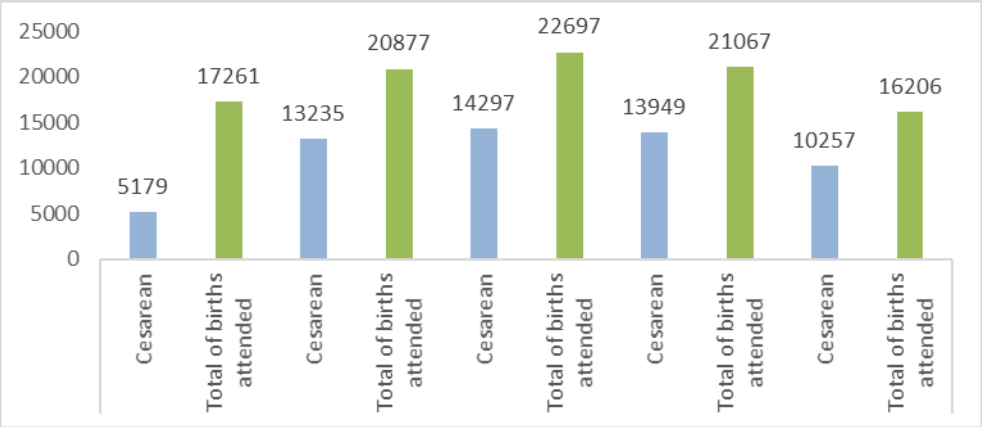
Rate of obstetricians working in health establishments 2006-2016



My elaboration based on INEC (2016a)

Appendix 6

Percentage of caesarean sections in the JBG in the period 2012-2016



My elaboration based on MSP [2017]

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