SAFE MOTHERHOOD'S TROUBLED HISTORY IN GUATEMALA

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Introduction

In the wake of a safe motherhood initiative launched at a 1987 international conference in Nairobi, Kenya, a substantial body of scholarship has emerged surrounding what countries should do to lower maternal mortality. Each year an estimated 500,000 to 600,000 women die due to complications resulting from childbirth, making this a leading cause of death for adult females in their reproductive years, and a critical humanitarian concern.

The interventions promoted to address maternal mortality have changed substantially over the 15 year history of the initiative. Following the 1987 conference advocates promoted risk assessment during antenatal care to distinguish between women at high and low risk of suffering obstetric complications at delivery, and the training of traditional birth attendants for low risk women. At a follow-up conference in 1997 in Colombo, Sri Lanka, they called for ensuring medically skilled attendants at birth for all pregnant women. Recently, scholars have analyzed the degree to which the presence of skilled attendants can make a difference at a population level (Graham *et al.* 2001; Ronsmans *et al.* 2001; Ross *et al.* 2001; Shiffman 2000) and the importance of basic and emergency obstetric care in the event of complications at childbirth (Koblinsky *et al.* 1999; Maine *et al.* 1996; Ronsmans *et al.* 1997). One of the more contentious debates has been whether scarce resources should be concentrated on ensuring the presence of skilled attendants at all births or on making available emergency obstetric care for women who experience complications at delivery (Maine 1993; Maine & Rosenfield 1999; Tinker & Koblinsky 1993; Weil & Fernandez 1999).

If scholars analyzing safe motherhood policy have differed on remedies, they have been unified in a common concern: discerning which medical interventions are effective in lowering maternal death rates. While this research has been critical to

maternal mortality reduction efforts, it has also been circumscribed in scope. With only a handful of exceptions (Bulatao and Ross 2003, Koblinsky 2003, Van Lerberghe and De Brouwere 2001) studies of safe motherhood in developing countries have ignored deeper structural elements that shape the possibility that these interventions will even be considered or prioritized in the first place. As a result, accounts surrounding the emergence of safe motherhood attention and concerning safe motherhood outcomes have been incomplete.

In this paper we draw on ideas from the population and family planning field, which has a long tradition of structural analysis, to examine structural influences on the emergence of safe motherhood priority in Guatemala, a country that has faced a turbulent political history.

Background

The population field long ago recognized the need to examine social structure. Freedman (1975) modeled fertility using the metaphor of a funnel. At the narrow end of the funnel fertility is most immediately influenced by a set of immediate variables (drawn from Davis and Blake, 1956), including age of entry into sexual unions, a factor that directly shapes exposure to intercourse. These are in turn shaped by factors further removed from fertility, such as norms about ideal family size. Even more distant in the funnel are social, economic and demographic phenomena, such as religious traditions, infant mortality and organized family planning programs. Freedman encouraged scholars to work, "backward from the narrow neck of the funnel to the broadening opening, where we are likely to find that we cannot deal simultaneously with all the important variables in the foreseeable future. But, an inventory of the number and complexity of the variables puts our work in perspective and helps to explain why current studies account for only a small part of the total variance in fertility" (p. 19).

Freedman's work inspired the rise of an institutionalist tradition in fertility and family planning analysis by scholars including McNicoll (1980), Warwick (1982), Ness and Ando (1984), Simmons, Ness and Simmons (1983), Mauldin and Ross (1991), and Greenhalgh (1995). These scholars examined the influence on fertility of social structural factors such as kinship patterns, community organization, economic development levels, state structure, political stability and cultural patterns. Collectively they injected into the field a consideration for context, and sensitivity to how political, economic and social institutions shape fertility, programmatic outcomes and the emergence of programs themselves. Simmons, Ness and Simmons in particular expanded on Freedman's model, arguing that family planning programs and their determinants deserved to be considered as institutions in their own right, requiring particular attention in the funnel of causality. Recently, Santiso and Bertrand (2000) have applied these structural concepts to analysis of Guatemala itself, arguing that the country's contraceptive prevalence rate of 38 percent, the second lowest in the Americas, has been shaped by three difficult structural influences: the ethnic composition of the population; a legacy of political turmoil; and the pervasive conservative influence of the Catholic Church. Their convergence in a single country, they argue, affected the level of political priority for family planning, supply of family planning services, and the demand for children, presenting an obstacle to family planning acceptance in the country.

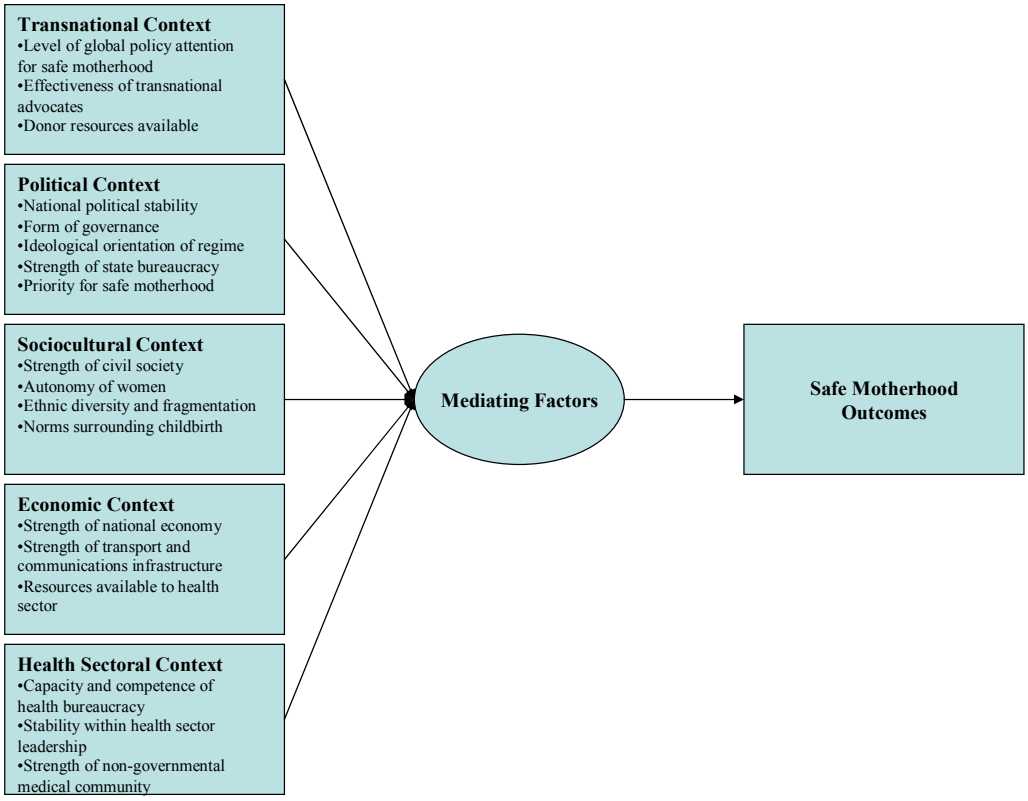
Drawing on these models as well as frameworks from infant and child mortality, safe motherhood scholars have also developed schemata that include social structure. McCarthy and Maine (1992) developed a three-tiered framework that considered immediate outcomes – pregnancy, complications at birth and death or disability in childbirth; intermediate determinants of these outcomes, such as the health status of the mother; and distant determinants of these intermediate factors, including socioeconomic and cultural forces. They emphasized that all factors that may influence maternal mortality must operate through the immediate outcomes of pregnancy and pregnancy-

related complications. Tinker and Koblinsky (1993) adapted the model to create a modified framework.

The difficulty in the safe motherhood field is not the absence of models, but rather the fact that with only a few exceptions scholars have left factors at the more diffuse end of the schemata unexamined. They have focused almost exclusively on the more proximate determinants of maternal mortality: its biomedical causes, such as hemorrhaging and eclampsia, and the medical and technical interventions that might address these causes, such as the provision of emergency obstetric care, safe abortion services and skilled attendants at birth.

In figure 1 we diagram factors at the more diffuse end of the funnel that may shape safe motherhood programs and outcomes.

Figure 1: Structural factors that may shape safe motherhood



The model indicates five sources of structural influence. In our examination of Guatemala in this paper, our focus is on the first two categories – the transnational and the political - although there are strong reasons to believe that the other three categories – sociocultural, economic and health sectoral - are also at work.

Theory from a sub-field of political science – international relations - offers two ideas of value to understanding how transnational forces may shape safe motherhood policy priority and outcomes within nation-states. The second idea is more widely appreciated in the international health field than the first:

(1) Nation-states are socialized into particular policy preferences through their membership in international society

(2) Donor agencies shape national policy priorities through their control over financial and technical resources

The concept behind the first idea is that nation-states, like individuals, are not isolated entities. They exist within societies of other nation-states, and are socialized into commonly shared norms by their encounters with international actors, including officials from other countries and international organizations, and transnational networks of advocates who mobilize for particular causes.

Mainstream international relations scholars traditionally have downplayed such transnational influence. They have sought to understand the behavior of nation-states in the international arena by looking inside states, taking state preferences as given and seeking to demonstrate the utility of their theories by their capacity to predict and explain outcomes in the international system, such as warfare and alliances (Finnemore 1996). The two most well-known paradigms are neo-realist theory, which presumes that states are driven by the pursuit of power and security, and neo-liberal theory, which understands state behavior largely in terms of the pursuit of wealth.

International relations scholars known as constructivists have challenged these mainstream theories, arguing that on any given policy issue, a state may not initially know what it wants but come to hold certain preferences as a result of interactions in international society with other state and non-state actors. For instance, a state originally may not prioritize a health cause such as polio eradication, but come to adopt the cause because domestic health officials learn at international gatherings that other countries are pursuing this goal and they are likely to be left behind. Thus, constructivists argue, state preferences cannot be taken as given (Wendt 1992; Finnemore 1996), but rather should be conceived of as created in the process of transnational interactions.

International organizations play a crucial role in these socialization processes. Agencies such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), the World Trade Organization (WTO) and the United Nations Population Fund (UNFPA) are created by a global community of nation-states with a view to serving their jointly and individually held interests. However, these

organizations may acquire the power to act as independent, autonomous agents, shaping the policy preferences of the nation-states that created them (Abbot and Snidal 1998). For instance, Finnemore (1996) has shown that in a concentrated period of time dozens of nation-states adopted the same bureaucratic innovation: science ministries devoted to the promotion of research and technology. Her explanation is that acting autonomously in the 1970s the United Nations Economic and Social Commission (UNESCO) successfully convinced member states of the value of these bureaucracies, and this belief became a commonly shared norm across the international system.

The second idea concerning international influence is more widely recognized in scholarship on international health. Donors wield considerable power over the health priorities of developing countries by virtue of their control over resources. For instance, over the past decade the World Bank has advocated the reform of developing world health sectors to bring about greater efficiency and effectiveness. In some cases the World Bank has threatened to forego future lending for health in order to pressure states to comply with the agenda (Buse and Gwin 1997). Development agencies of advanced industrial states such as the United States Agency for International Development (USAID) and the United Kingdom's Department for International Development (DfID) have employed similar tactics on other health issues. The point is that international agencies and the governments of advanced industrial states shape developing world health priorities by enticing and threatening states through control over resources.

A second set of structural forces in the model are domestic political influences. Political scientists note that states vary in their dominant ideologies, forms of governance, stability and degrees of social penetration (Huntington 1968; Migdal, Kohli and Shue 1994; Zartman 1995). Some states pursue equitable social development, promote democratic participation, enjoy popular legitimacy and oversee country-wide governing institutions. Other states perpetuate inequality, exclude popular participation, are fragile

and barely govern at the local level. A structural perspective on safe motherhood directs us to inquire about the following national political influences:

- The degree to which national politics are fragmented, contentious and unstable, making it difficult to sustain health priorities over time.
- Whether social actors have the political space to mobilize to pressure the state to make safe motherhood a policy priority.
- The degree to which a state embraces social equity-oriented ideologies that may be conducive to safe motherhood promotion.
- The extent to which the state actually governs and is capable of implementing policy at the local level.

Prior case studies of Indonesia and Honduras have shown how these transnational and national factors interacted positively to generate political priority for safe motherhood and, possibly, reductions in maternal mortality levels (Shiffman 2003; Shiffman, Stanton and Salazar 2003). Guatemala is a more complex case, as some forces appear to have served to raise political priority, while others seem to have obstructed it. In the case study that follows we examine these transnational and national forces, with particular attention to the influence of international organizations and the impact of an unstable political environment.

Methods

We used four types of sources to develop the case study: interviews with officials involved in Guatemalan safe motherhood policy; government reports and documents; donor agency reports; and published research on Guatemalan safe motherhood. We conducted in-depth unstructured interviews with individuals involved in Guatemalan safe motherhood, all in-country, most lasting between one and two hours. We interviewed senior parliamentarians involved in reproductive health; individuals involved in maternal health in the Ministry of Health; a former Minister and Vice-Minister of Health; NGO and private sector consultants; and members of the donor community including the Pan

American Health Organization (PAHO – the Americas branch of the WHO), the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA) and MINUGUA – the United Nations agency responsible for monitoring the peace accords. The government reports we consulted included national health plans, national health surveys and official documents on safe motherhood norms. Of particular importance were 1989 and 2000 reproductive age (RAMOS) mortality surveys (Medina 1989; Ministerio de Salud Pública y Asistencia Social 2003a).

We used a process-tracing methodology in constructing the case history, seeking to employ multiple sources of information in order to minimize bias and establish common patterns of causality. In the language of case study methodology our inquiry was *holistic* in nature and selected based on its *revelatory* and *unique* characteristics (Yin 1994). That is to say, we analyzed the nation-state of Guatemala holistically as a unit rather than any of its sub-regions; we sought to make use of our access to policy-makers to reveal insights that may not have been available otherwise; and we justified selection of Guatemala for analysis because its unique political history gave the case potential to reveal the influence of structure on safe motherhood programs and outcomes. We chose a case study design because of the need to reconstruct holistically the history of the safe motherhood initiative in the country in order to examine the processes at work. The case study approach is better suited than other research methodologies, such as structured surveys and statistical analyses of health service utilization, to achieve this objective (Yin 1994). This is true because the defining feature of the case study is that it considers a phenomenon in its real-life context and is therefore a research strategy well-suited to revealing underlying processes.

The Case

The origins of attention to safe motherhood in Guatemala: 1987-1991

Prior to 1987 there was little programmatic activity in Guatemala aimed at reducing maternal mortality levels. In 1987, however, the situation began to change. In that year an international safe motherhood conference was held in Nairobi, Kenya, launching a global initiative to reduce maternal mortality levels by half by the year 2000. The Guatemalan government sent a senior health official to the conference and signed its concluding declaration, the first indication of national attention to the issue.

PAHO followed up on the Nairobi conference by launching a regional initiative in the Americas. By 1990, member states had approved a strategy to reduce maternal mortality levels by fifty percent by 2000 (PAHO 2002). This objective was to be met through: (1) increasing capacity and quality of institutional delivery care; (2) providing birthing centers for low risk deliveries; (3) increasing social participation and mobilizing communities to identify pregnant women; (4) establishing epidemiological surveillance of pregnant women; and (5) increasing capacity for countries to design programs and improve home delivery care through continuing education of traditional birth attendants and other personnel involved in home delivery (PAHO 2002). PAHO health officials believed Guatemala had high maternal mortality levels and placed the country in a priority group for attention (PAHO 2002). Multiple donors pledged resources for the regional initiative, including PAHO, USAID, UNFPA, UNICEF and the United Nations Development Program (UNDP) (PAHO 2002). USAID offered $50 million for a global project entitled Mothercare, and promised Guatemala a share of funding (MotherCare 1999).

A mid-level official in the Ministry of Health attended a PAHO safe motherhood organizational meeting for Central America in 1989 and responded to the regional call for action by pushing for a study in Guatemala to produce accurate data on maternal mortality levels. He was concerned that ministry statistics, which indicated a maternal mortality ratio of between 90 and 100, significantly under-estimated the extent of the problem. Lobbying international donors, he secured funding for a national study that

aimed to document every maternal death in the country over the course of the year. Completed in 1991, the study confirmed his suspicions, finding a maternal mortality ratio of 248 (Medina 1989).

Subsequently the official organized workshops at departmental levels, giving local health authorities data on the scope of the problem in their areas of responsibility. At these workshops, local authorities produced maternal mortality prevention plans. He also organized a public presentation for the Minister of Health, donor agencies and non-governmental organizations. Responding to the high ratio revealed in the study, the Minister declared maternal mortality reduction a priority issue (Medina 1989). In addition, the Ministry produced a national maternal mortality reduction plan for the years 1992 to 1996.

The dissipation of attention: 1991–1995

In the wake of the study, the minister's expression of commitment, the creation of a national plan and the prioritization of the issue by international donors, hopes were high within the Guatemalan health community that a coordinated national program would be launched. This enthusiasm quickly dissipated as no organization took the lead. Donor agencies, pursuing multiple health programs, diverted their attention from safe motherhood. The ministry, dependent on donor support and lacking capacity to lead national initiatives, re-directed its attention to issues such as infant mortality and to pressing crises, including a measles epidemic that caused five thousand deaths. The national maternal mortality reduction plan was set aside.

A few safe motherhood activities did take place in the early 1990s. However these were not integrated and sporadic: The ministry trained traditional birth attendants, while Mothercare began operations in the country, also training attendants, developing

protocols for the management of complications of pregnancy, and conducting research (MotherCare 1999).

Ties between the state and conservative elements of the Catholic Church also posed barriers to safe motherhood prioritization during this time period. The Guatemalan Nairobi conference attendee, by the early 1990s Vice Minister of Health, helped develop a draft population law favorable to reproductive health and safe motherhood, a bill Congress approved. However, under pressure from the Catholic Church, President Serrano, favorably inclined toward family planning, never published it (Santiso and Bertrand 2000). Also, in 1993 the Guatemalan government was set to support to the pro-reproductive health platform of the forthcoming International Conference on Population and Development in Cairo. However, Serrano was forced from office that year and the next president, Ramiro de León Carpio, unsympathetic to family planning, attacked the Cairo preparation work (Santiso and Bertrand 2000). He nominated his own team to represent Guatemala at the conference, whose members were all strong adherents of the views of the Vatican. The president instructed the Guatemalan delegation to oppose all mention of reproductive rights, including safe motherhood. At the conference Guatemala was one of only a handful of nations that sided with the Vatican and refused to endorse the Cairo Plan of Action (Santiso and Bertrand 2000).

This political environment also influenced the capacity of safe motherhood proponents to acquire accurate data. Through a sample of 75,000 women, health officials planned to determine maternal mortality levels using the sisterhood method in a donor-supported 1995 national infant and maternal health survey. However, an alliance of Catholic Church and government officials objected to the maternal mortality and the HIV components of the survey. In consequence, the government reduced funds for the maternal mortality investigation, allowing only for a sample of 11,000 women, producing highly uncertain results. The survey indicated a maternal mortality ratio of 195, but with a very large confidence interval.

Attention re-appears: 1996-1999

In 1996 the government and leftist guerrillas negotiated peace accords to end a three decade civil war. The agreements committed the government to a number of social development goals, including the reduction of maternal mortality by fifty percent by the year 2000. A United Nations commission, known by its acronym MINUGUA, was put in place to monitor compliance with the accords. For the maternal mortality reduction goal, the 1995 ratio of 190 was used as the baseline, so the target was to be 95 for the end of the decade. Little attention was paid to the fact that the ratio of 190 was a highly suspect figure.

MINUGUA had considerable power to pressure the government to comply with the maternal mortality agreement. It held authority as the monitoring eye for the international community, so any negative pronouncements it made would reflect badly on the Guatemalan government's international standing. However, the domestic political environment remained unfavorable for reproductive health, and the government acted slowly. In 1996 the conservative PAN party, closely tied with the Catholic Church, had gained the presidency. Competing camps on reproductive health emerged underneath new President Arzu (Santiso and Bertrand 2000). One faction opposed government involvement in any reproductive health issue. Its power came in part from its ties with the president's sister, a member of the arch-conservative *Opus Dei* movement in the Catholic Church. It effectively blocked passage of a population law during the PAN era (Santiso and Bertrand 2000).

Another faction led by the Vice President, however, created some space within the administration for cautious movement on reproductive health issues (Santiso and Bertrand 2000). With the consent of a vice minister of health, the head of the maternal and infant health program pushed for a maternal mortality reduction plan. He could

secure only limited government funds in such a political environment, so he cultivated external support from the donor agencies.

The donors were open to these initiatives, as they also were beginning to come together in support of the prioritization of maternal health. In the late 1990s a maternal health monitoring group formed, composed of donor and local officials. Also PAHO, USAID, UNFPA and UNICEF heads met regularly with the Minister of Health and raised the issue of maternal mortality reduction. In addition, USAID's Mothercare expanded its reach in the country and the European Community replicated Mothercare initiatives (MotherCare 1999). Meanwhile, USAID indicated it would seek to generate stronger Guatemalan government commitment to women's health by supporting local advocacy groups (USAID 1997).

In the late 1990s MINUGUA officials became concerned that the government had done little on maternal mortality since the Peace Accords. It joined with other donors and sympathetic Ministry of Health officials, who also desired a maternal mortality baseline, to push for a new national study to get data that could be used to assess government compliance with peace accord commitments. At the same time MINUGUA officials agreed to a new timeline, giving the government until 2004 to achieve a fifty percent reduction (Ministerio de Salud Pública y Asistencia Social 2003a). In 2001, with funding from multiple donors, the Ministry carried out the study, revealing a maternal mortality ratio of 153 (Ministerio de Salud Pública y Asistencia Social 2003a). In follow-up the government issued a document entitled, 'Strategic Guidelines for the Reduction of Maternal Mortality,' that reflected the newest donor ideas on safe motherhood - proposing the strengthening of emergency obstetric care, birth attendance by competent personnel and access to quality maternal and neonatal care (Ministerio de Salud Pública y Asistencia Social 2003b).

A political opening: 2000-2003

The election of a new government created a political opening for reproductive health advocates. In 2000 PAN's rival, the Guatemalan Republican Front (FRG) took power as PAN was voted out of office. The FRG, a party more rooted in Christian evangelical movements and less beholden to the influence of conservative elements of the Catholic Church, was more liberal on reproductive issues. Alfonso Portillo was elected to the presidency, and former president and general Efrain Rios Montt became head of the legislature. Rios Montt's daughter, Zury Rios, also was elected to the legislature and selected as one of the body's leaders. She had a long-standing commitment to reproductive health, stemming in part from her association with APROFAM, the Guatemalan Planned Parenthood Federation.

In 2001, Zury Rios introduced into Congress a bill with a major reproductive health agenda that included explicit mention of safe motherhood (Congreso de la República de Guatemala 2001). Promoting it under the title 'Social Development Law,' a name that would attract little notice among conservative critics, she lobbied and secured signatures of support from most of the female members of Congress. She also employed the power of her father to pressure fellow FRG congressmen to support the bill. In addition, anticipating social opposition once the bill attracted public attention, she allied herself with the UNFPA, another long-standing supporter of reproductive health and safe motherhood. UNFPA officials engaged in a careful lobbying effort of multiple groups in civil society, including journalists and academics. Most notably, while bypassing representatives of the conservative *Opus Dei*, UNFPA did approach the leading Catholic bishops, positioning the bill as an effort to lower infant and maternal mortality, rather than as an initiative to promote reproductive health. Using these tactics, UNFPA secured the support of the bishops who could hardly object to these goals. Shortly thereafter, Rios' and UNFPA's lobbying efforts paid off. When news of the bill reached the media and the conservative archbishop articulated his opposition to it, the bishops distanced themselves from their leader, saying that he did not represent their views, and publicly

expressed their approval of the initiative. In October of 2001, Congress passed the bill, putting into law a set of principles that reproductive health and safe motherhood advocates had been pushing to get on to the national agenda for more than a decade.

Most recently, a new political development has again caused concern for reproductive health and safe motherhood advocates. In two rounds of elections in November and December of 2003 Oscar Berger won the presidency, squarely defeating Efrain Rios Montt and other challengers, and casting the FRG from political power in both the executive and legislative branches of government. Berger's party was a splinter group from the PAN, and he himself is closely allied with the Catholic Church. It remains to be seen whether the passage of the social development law will be sufficient to sustain policy priority for safe motherhood and reproductive health, or whether Berger's victory will again mark a policy reversal.

Conclusion

Structural forces shaped the emergence of priority for safe motherhood in Guatemala and the possibilities for maternal mortality reduction. A conventional analysis that focused only on medical interventions – factors at the narrow end of Freedman's funnel model – would at best offer an incomplete account of the country's safe motherhood situation.

Transnational structural forces were influential, both in terms of the shaping of norms and the provision of resources. International organizations, particularly PAHO, were key in introducing a safe motherhood norm and sparking attention to the issue in the country. USAID and other donors provided resources that sustained limited attention through the 1990s. Another transnational influence – the Peace Accords backed by United Nations authority that included a maternal mortality reduction goal – placed pressure on the Guatemalan state to reduce maternal mortality levels. Also, in 2001 a

transnational-national alliance linking UNFPA and the FRG party helped place reproductive health on the national agenda.

Domestic political and social factors also shaped safe motherhood outcomes. The country's fragmented political situation – in particular the enmity between competing political parties – made it difficult to sustain policy continuity for safe motherhood across elections. Also, the influence on the state of conservative elements of the Catholic Church made it problematic for safe motherhood advocates to institutionalize priority for the cause.

The safe motherhood account we offer is a piece of the story, not a complete analysis. The impact on safe motherhood outcomes and maternal mortality levels of other elements of the structural context, including the country's poverty and inequality, the Ladino-dominated Guatemalan state's marginalization of the Mayan people and the weak health infrastructure that is a legacy of decades of civil war, require considerably more analysis. Also, we have not focused on intermediate and proximate determinants of maternal mortality that lie at the narrower ends of the funnel, factors that are also critical to explaining safe motherhood outcomes. The point we emphasize is that a complete account of safe motherhood outcomes requires an analysis of the entire funnel, not just its narrow end that connects medical interventions to maternal mortality levels, the conventional focus of safe motherhood scholarship. In the 1970s population scholars began to take social structure seriously, enabling them to offer more robust accounts of fertility. We suggest safe motherhood scholars might profitably do the same for maternal mortality.

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