GENERATING POLITICAL WILL FOR SAFE MOTHERHOOD IN HONDURAS

Jeremy Shiffman, Ph.D.*
Assistant Professor of Public Administration
The Maxwell School of Syracuse University
Syracuse, New York 13244-1090 USA
Telephone: (315) 443-4928; Fax: (315) 443-9734
e-mail: jrshiffm@maxwell.syr.edu

Cynthia Stanton, Ph.D.
Assistant Scientist
The Johns Hopkins Bloomberg School of Public Health
Baltimore, Maryland USA
e-mail: cstanton@jhsph.edu

Ana Patricia Salazar
Independent Consultant
Tegucigalpa, Honduras
e-mail: anapatricia_s@yahoo.com

June 3, 2003

*Corresponding author

Keywords: Safe motherhood; Maternal mortality; Political will; Honduras; Agenda setting; International relations theory
Abstract

Each year an estimated 500,000 to 600,000 women die due to complications from childbirth, making this one of the leading causes of death globally for women in their reproductive years. Few developing countries have experienced a documented significant decline in maternal mortality levels, despite a global initiative to address the problem.

Honduras represents an exception. Between 1990 and 1997 the country’s maternal mortality ratio – the number of deaths due to childbirth per 100,000 live births – declined forty percent from 182 to 108, one of the largest reductions ever documented in such a short time span in the developing world. This paper offers an explanation for the emergence of political priority for safe motherhood in Honduras, a major cause underpinning the decline. We argue that this emergence was connected to five factors: an existing legacy of priority for maternal health in the country; the appearance of safe motherhood on the global health agenda; the alarm generated in the Honduran health system by a 1990 study revealing a significantly higher level of maternal death in childbirth than was thought to exist; the subsequent mobilization of the health bureaucracy by a group of mid-level civil servants; and the collaboration of this group with a network of international donors with offices in Honduras.

More broadly, we argue that safe motherhood scholarship has been unable to produce adequate accounts of maternal mortality change in developing countries because of an excessive focus on analysis of medical and technical interventions to the neglect of political and social processes. We draw on political science scholarship concerning agenda setting and international relations to explain the emergence of political priority for safe motherhood in Honduras, and to demonstrate the need to consider both processes and interventions, not just interventions alone, in order to offer comprehensive accounts of maternal mortality change.
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; Sloan et al. 2001) 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 few exceptions (AbouZahr 2001; Campbell 2001; De Brouwere et al. 1998), scholars have neglected larger issues central to safe motherhood policy development such as how political priority emerges, policy ideas appear and health bureaucracies are mobilized. Above all else, this body of scholarship has paid virtually no attention to the political and social processes that underpin the emergence of priority and intervention choices.

In response, a study concerning Indonesian safe motherhood employed agenda setting theory from political science to examine the issue of the generation of political priority (Shiffman 2003). The study argued that four factors interacted in the 1990s to raise safe motherhood from near obscurity in the country to national-level prominence:

1. the organization of attention-generating focusing events in the form of international and national symposia that brought country-wide attention to safe motherhood

2. the appearance of an indicator, a high maternal mortality ratio from a national survey, that marked the severity of the problem and incited alarm in the political system

3. the political entrepreneurship of mid-level civil servants working behind the scenes to push the cause inside the bureaucracy and political system

4. the availability of a politically-palatable policy alternative, in the form of a program to place midwives in each of Indonesia’s more than 50,000 villages, that convinced senior political leaders that effective action could be taken to address maternal mortality.

The study considered only the case of Indonesia, limiting the generalizability of the conclusions. Another study limitation was its emphasis on domestic rather than international factors. The author suggested that research be conducted on the same issue in other settings to evaluate the generalizability of the conclusions and to investigate the causal power of international factors.

This paper addresses these issues of replication and international influence. We examine the emergence of priority for safe motherhood in one of the developing world’s
few confirmed cases of maternal mortality decline. Between 1990 and 1997 the Honduran maternal mortality ratio declined from 182 to 108 maternal deaths per 100,000 live births, representing one of the largest reductions ever documented in the developing world over such a short time span. We seek to evaluate to what extent, if at all, the four factors identified in the Indonesia study had causal power in raising the issue to national prominence in Honduras, whether other factors were also influential, and what power international forces exerted. We do not seek to offer a comprehensive explanation for the Honduran maternal mortality decline, although we hope this account makes a contribution. Our objectives are to investigate the generation of political priority for safe motherhood in Honduras, and to suggest the value of considering both processes and interventions, not simply interventions alone, when seeking to explain maternal mortality change in developing countries.

In the following section we discuss the theoretical background to our investigation. We then consider the case of safe motherhood in Honduras. In the discussion and conclusion, we draw out elements that explain the emergence of priority for safe motherhood in Honduras and discuss the value of considering process in analysis of public health policy-making in poor countries.

**Background**

Agenda setting is the initial stage in the public policy process during which some issues rise to national prominence while others are neglected or ignored completely. Political scientists concerned with agenda setting have identified systematic features shaping the likelihood that an issue will rise to national attention. These include: the presence of indicators to mark the severity of a problem; the existence of attention-generating focusing events such as national symposia and natural catastrophes; the availability of political entrepreneurs who are willing to champion a cause; and the
creation of sensible policy alternatives by groups of experts concerned with particular issues (Birkland 1997; Kingdon 1984; Walker 1974). The Indonesia study drew on this research to explain the emergence of safe motherhood as a policy priority.

Political scientists concerned with agenda setting have focused almost exclusively on processes inside the nation-states of advanced industrial countries. Such a domestically-oriented, advanced industrial focus ignores crucial dimensions of agenda setting processes in less developed nations, which are more exposed to transnational influence. While not commonly classified as agenda setting scholarship, theory from another sub-field of political science – international relations - offers two ideas of value to agenda setting, the second 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 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 & 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 Bank has threatened to forego future lending for health in order to pressure states to comply with the agenda (Buse & Gwin 1998). 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.

We now turn to the case study to examine the factors that shaped the rise of safe motherhood on to the national agenda in Honduras. We pay particular attention to the four factors identified in the Indonesia study – focusing events, indicators, political entrepreneurship and policy alternatives – and the two international factors just discussed – norm creation in international society and donor power through resource control.

Methodology

We used four types of sources to develop the case study: interviews with officials involved in Honduran safe motherhood policy; government reports and documents; donor agency reports; and published research on Honduran safe motherhood. We conducted in-depth unstructured interviews with 30 individuals involved in Honduran safe motherhood, 25 of which occurred in the country. We interviewed each of the five individuals who led the maternal and child health division of the Ministry of Public Health between the years 1986 and 2002; a number of senior officials in the Ministry; NGO and private sector consultants; and members of the donor community including the Pan American Health Organization (PAHO – the Americas branch of the WHO), USAID, UNFPA, UNICEF and the World Bank. The government reports we consulted included
national health plans, national health surveys, safe motherhood strategy papers and official documents on safe motherhood norms. Of particular importance were the 1990 and 1997 reproductive age (RAMOS) mortality surveys that provided evidence of a maternal mortality decline in the country and information on its possible causes (Castellanos et al. 1990; Melendez et al. 1999). Donor documents included regional and national safe motherhood plans of action from PAHO, USAID-Government of Honduras health agreements and evaluations, and UNFPA project plans and reports for Honduras. Among the published studies on Honduras we consulted, a World Bank report (Danel 1998) was particularly valuable for historical analysis on safe motherhood policy development and for evaluation of interventions. The entire manuscript was reviewed for factual accuracy by several Honduran officials centrally involved in safe motherhood policy in the country.

We began our research with three aims. First, Honduras had acquired a reputation as a safe motherhood success story. We sought to contribute to knowledge on effective safe motherhood strategy by investigating the sources of the country’s maternal mortality decline. Second, we noted a strong focus on medical/technical intervention in safe motherhood scholarship to the neglect of other issues, and wanted to analyze a case of maternal mortality decline from another angle. Third, we wished to follow up on the Indonesia study on the emergence of political priority for safe motherhood. We sought to assess the study’s conclusions critically and to discern whether a similar pattern existed in Honduras, with a view to advancing theory on how and why countries come to prioritize particular public health causes.

We used a process-tracing methodology in constructing the case history, seeking to employ multiple sources of information in order to establish common patterns of causality. In the language of case study methodology our inquiry was *holistic* and *replicative* in nature and selected based on its *revelatory* and *unique* characteristics (Yin 1994). That is to say, we analyzed the nation-state of Honduras holistically as a unit
rather than any of its sub-regions; we intended to evaluate conclusions from a previous case study; 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 Honduras for analysis because of its unique place in the world of safe motherhood programs as one of the few developing countries to have experienced a documented significant decline in maternal mortality.

Our research design imposes limits on internal and external validity. In-depth exploration enables us to develop hypotheses concerning why political priority may have emerged for safe motherhood in Honduras and to suggest general propositions concerning public health agenda setting. On the other hand, as with the Indonesia study, the design creates uncertainty about the conclusions, as they are grounded in consideration of only a single case. Additional comparative research on other countries that controls for alternative explanations will be necessary in order to assess the causal power of the factors we identify. Also, any generalization to other settings must be done with caution given elements of the sociopolitical and health context that are unique to Honduras.

The case: Honduran safe motherhood

Analysis of the history of safe motherhood in Honduras indicates that five factors shaped the emergence of political priority for maternal mortality reduction in the country in the 1990s:

1) a legacy of attention in the 1970s and 1980s to maternal health and health infrastructure development
2) the appearance of safe motherhood on the global health agenda in the late 1980s
3) the 1990 publication of a study in Honduras revealing significantly higher levels of maternal death in childbirth than officials previously believed existed

4) the subsequent mobilization of the health bureaucracy for safe motherhood by a group of mid-level civil servants

5) the collaboration of this group with a network of Honduran-based international donors who already prioritized maternal mortality reduction

A legacy of attention to health

In the 1970s and 1980s, with donor assistance, the government developed the country’s health infrastructure to reach under-served populations. It also prioritized maternal health. These legacies facilitated the emergence of political priority and gave health leaders the institutional capacity to address safe motherhood in the 1990s.

Surrounded by neighboring countries engulfed in civil war, Honduras remained relatively politically stable during the 1980s, securing the favor of U.S. political leaders who saw the country as a bulwark of anti-communist resistance during the Cold War. These political factors in part explained the capacity of the government to devote a significant percentage of its national budget to the health sector, and the extensive USAID presence in the country. In 1987 health comprised 11.7% of the national budget (USAID 1988), considerably higher than the regional average. USAID supplemented this funding with grants of $54 million for health sector development and rural water and sanitation projects between 1981 and 1988 (USAID 1988). The agency cooperated closely with the Inter-American Development Bank (IDB) (USAID, 1988), which in 1987 approved a $27 million loan for the construction and equipping of hospitals across the country (USAID 1988). The Ministry of Health used domestic and donor resources to sustain a policy of extending health services throughout the country (USAID 1988).
Between 1978 and 1987 the number of health centers staffed by auxiliary nurses increased from 379 to 533; the number of health centers with doctors from 76 to 116; and the number of hospitals from 16 to 21 (USAID 1988).

As they expanded this infrastructure, the government and donors prioritized maternal health. In 1968 the Honduran government, supported by USAID, established a project for the health of mothers and infants (Almanza-Peek 1998a) and in 1974 started an official maternal and child health program whose first stated objective was to decrease maternal mortality (HMPH et al. 1986 and 1989). In the 1970s the Ministry of Health initiated a training program for the approximately 10,000 traditional birth attendants across the country (HMPH 1998a; Martinez 1994). UNFPA also supported maternal and child health, financing programs from 1978 through 1991, with technical support from PAHO, that had explicit goals of reducing maternal mortality (Almanza-Peek 1998a).

**The appearance of safe motherhood on the global health agenda**

The emergence of safe motherhood as a global priority in the late 1980s raised policy attention to maternal mortality reduction in Honduras to a new level. In 1985 the World Health Assembly issued its first major proclamation on the subject of maternal mortality. This was followed by a watershed event in international maternal mortality reduction efforts, the 1987 Safe Motherhood Conference in Nairobi, cosponsored by the WHO, the World Bank, the UNFPA and the United Nations Development Program (UNDP). The global proportions of maternal mortality – more than 500,000 deaths a year – were widely publicized during and after this gathering (WHO 1990). The meeting officially launched the international Safe Motherhood Initiative that sought to lower global maternal deaths by at least half by the year 2000.

Responding to the launch of the international initiative, PAHO prioritized the cause of maternal mortality reduction. By 1990 PAHO had produced a plan for the
reduction of maternal mortality in the Americas and secured its approval from its member states. Echoing the global aim, the plan called for reducing maternal mortality in the region by 50% or more by 2000 (PAHO 2002b). The plan urged countries to adopt a reproductive risk approach to maternal mortality reduction, encouraging governments to mobilize communities to identify pregnant women, enhance the capacities of traditional birth attendants, provide birthing centers for women considered to be at low risk for maternal death in childbirth, develop a national network of homes for pregnant women considered to be at high risk for maternal death, and enhance the quality of institutional delivery care at the first referral level (PAHO 1990).

The government of Honduras participated at multiple levels in these global priority-setting initiatives. For instance, it was a member of PAHO and its minister of health participated in safe motherhood policy meetings. Also, Honduras was listed as one of the regional priority countries and the government approved of the PAHO initiative. Throughout the 1990s government delegations participated in global meetings that reaffirmed international goals for maternal mortality reduction, such as the 1994 International Conference on Population and Development in Cairo. Officials also joined in follow-up regional meetings, including an official Central American launch of the global safe motherhood initiative at a conference in Guatemala in 1992 (APROFAM et al. 1992).

**The political shock of the 1990 Honduran maternal mortality study**

The appearance in 1990 of a credible study revealing a high level of maternal mortality in Honduras spurred national health officials to respond to these global and regional calls for action. Prior to the study many health leaders believed Honduras did not have a serious maternal mortality problem, taking for granted a 1983 figure, derived
solely from hospital-based estimates, of 50 maternal deaths per 100,000 live births (Castellanos et al. 1990).

Individuals from three organizations – the Honduran office of PAHO, the National Teaching Hospital of Honduras, and a private consulting organization named Management Sciences for Health that received USAID funding - independently perceived the need for the study and ultimately came together to bring it about. Two doctors played a central role: Jose Cipriano Ochoa who formerly headed the women's health division of the Ministry of Public Health and moved to PAHO in the late 1980s, and Marel Castellanos, a gynecologist in the National Teaching Hospital of Honduras. Castellanos was seeking a thesis topic for his medical students and came up with the idea of a hospital study of maternal mortality. He approached Ochoa, who was also concerned about generating an accurate measure of national maternal mortality. Ochoa suspected the country had a maternal mortality problem, knew from his experience in the Ministry that Honduras had no reliable maternal mortality data, and had internal knowledge from his PAHO position that the organization was about to make safe motherhood a priority and allocate funds for the cause. He believed that Honduras could secure resources for a national program, but only if it had credible data to prove a problem existed. When Castellanos approached Ochoa for assistance on a study, Ochoa responded positively, encouraged him to expand it to include not just hospital but also non-institutional maternal mortality, and promised to help secure funds if Castellanos would participate in the study design.

Ochoa lobbied and successfully generated financial support for the study from PAHO and UNFPA, organizations that for more than a decade had been involved in maternal health in Honduras and that had recently become leaders in the global Safe Motherhood Initiative. Ochoa also secured USAID funding and the involvement of Management Sciences for Health, with the support of their representative Dr. Gustavo Corrales who later played a critical role in safe motherhood policy development. In 1989
and 1990, Ochoa, Castellanos, and Management Sciences for Health doctor Vincent David designed and supervised the implementation of the most comprehensive maternal mortality survey in Honduran history, seeking to document every maternal death that occurred in the country between April 1989 and March 1990.

The results shocked health officials. The research uncovered 381 maternal deaths during the study period, revealing a maternal mortality ratio of 182 maternal deaths per 100,000 live births, nearly four times the previously accepted figure (Castellanos et al. 1990). Moreover, the study showed that most deaths did not occur in hospitals, as was believed, but rather in homes in rural areas. Also, the study indicated that hemorrhage and infection, not eclampsia as was previously thought, were the leading causes of maternal death in childbirth, and that considerable variation existed across regions of the country in levels of maternal death.

Armed with this information and committed to making maternal mortality reduction a political priority, Ochoa and his colleagues actively publicized the study’s results. They produced and distributed over 1000 copies of the report, presented the study to the media, briefed international organizations on the results, lobbied health officials in the capital and regions of the country, and presented the study at a Latin American regional conference on perinatology. By the end of 1990 new health minister Cesar Castellanos (not related to Dr. Marel Castellanos) had commented in the national media on the study, noting that the country had a serious problem with maternal mortality and that the government was in negotiations with UNFPA to generate funds for a national program (La Tribuna 1991a and 1991b).

**Mobilization of the domestic health system by mid-level bureaucrats**
Public efforts by the study’s authors brought national attention to the issue. Entrepreneurship behind the scenes by mid-level health officials made the issue an ongoing priority.

The new health minister had long-standing ties with Dr. Alvaro Gonzales Marmol, head of one of Honduras’ seven health regions. Minister Castellanos was assembling a new team in the capital and asked Gonzales to serve as director of the maternal and child division. Gonzales agreed on the condition that he would have direct access to the minister, even though several levels of bureaucracy stood between the two men. The minister assented to the request.

As he took up his new post in September 1990, Gonzales paid careful attention to the published study, taking advantage of his access to the minister to convey to him the seriousness of the country’s maternal mortality problem and the need to make safe motherhood a policy priority. He then employed his close ties with the minister, other health officials and donors to lead an effort to mobilize the health system in service of the safe motherhood cause, forming a working group that devised national strategies, engaging regional health bureaucracies and organizing donor resources and expertise.

This working group became the unofficial center for national safe motherhood efforts. Meeting regularly over several years and certain points every week, the group included members of the Ministry’s division of maternal and child health, Dr. Ochoa from PAHO, and local representatives of USAID, UNFPA, UNICEF, Management Sciences for Health and other donors and agencies. Gonzales, in consultation with group members, produced a national plan of action for maternal mortality reduction for the period 1991 to 1995. The group adopted and promoted many ideas from PAHO’s 1990 regional plan of action (HMPH 1991). Specifically they called for a reproductive risk approach, and advocated the mobilization of communities to identify pregnant women; the expansion of maternal and child health centers for normal deliveries; the establishment of maternity waiting homes next to hospitals for women at risk of
complications during delivery; the improvement in standards of care in hospitals; the creation of norms for safe delivery; the training of doctors, nurses and traditional birth attendants in these norms; and the referral of women experiencing complications at birth to higher level facilities.

The group also embarked on an effort to mobilize regional health bureaucracies in service of safe motherhood. As a former regional health leader, Gonzales was aware of the many health problems his colleagues had to face with limited resources, and of the challenge he therefore confronted in convincing them to prioritize safe motherhood. For this reason, members of the working group traveled to each of the regions, spending a week or more with leaders, hospital directors and other officials involved in safe motherhood, presenting the results of the study, persuading them of the seriousness of the problem, and facilitating the creation of local action plans. The existence of the 1990 study proved to be a powerful tool in generating regional attention as it provided credible evidence that a problem existed. When some regional heads were still reluctant to make safe motherhood a priority, Gonzales informed their superior, Minister Castellanos, who spoke to them directly.

Gonzales and colleagues also organized annual national safe motherhood evaluation meetings, bringing together officials from throughout the country to review progress and develop future plans. In addition, they mobilized other parts of the central health bureaucracy. Of particular importance, they engaged the Ministry’s division on social mobilization, that assisted with a national campaign to engage communities and local governments in safe motherhood efforts.

The engagement of donors for safe motherhood

These advocacy efforts may have had limited impact had they not been backed by financial and technical resources. In this respect existing donor commitment to safe
motherhood and the participation of their local representatives in the working group proved crucial.

The only major safe motherhood intervention funded primarily from the central government health budget was the training of several thousand traditional birth attendants. Local governments provided some additional resources and donors many more. USAID supported maternal mortality reduction through a renewal of a grant to the country, providing $57.3 million to the health sector between 1988 to 2000 (USAID 1988) and sponsoring a mid-term evaluation of the grant that recommended safe motherhood be the country’s top health priority (Population Technical Assistance Project 1998). UNFPA approved new funding for Honduras for 1991 to 1995, including a subprogram on reproductive risk and the health of mothers (Almanza-Peek 1998a and 1998b), providing nearly half a million dollars for reproductive risk projects in two regions of the country. The Honduran office of PAHO offered technical expertise, receiving financial backing from the Netherlands and other donors (Martinez 1994). The World Bank financed a Honduran Social Investment Fund that provided financing for safe motherhood (Martinez 1994). A Swedish-assisted initiative, termed ‘Project Access,’ carried out health system decentralization in order to increase access to facilities for the poor (Population Technical Assistance Project 1998). Other donors that provided financial or technical assistance for safe motherhood included the Germans, the Canadians, the Spanish, the European Union, UNICEF and the Latin American Center for Perinatology in Uruguay. The Center was instrumental to developing national norms for quality of care in maternal health.

Donor efforts at the regional level in the Americas also helped to sustain political priority and the capacity of the Honduran health system to carry out safe motherhood programs. In 1991 PAHO, UNFPA, UNICEF, USAID and the IDB formed an inter-agency committee to work to institutionalize commitment to safe motherhood and other health initiatives throughout the region (PAHO 1996). As mentioned above, Honduras
government representatives participated in a Central American launch of the global safe motherhood initiative in 1992. Encouraged by PAHO, the spouses of heads of state in the Americas region, including the Honduran first lady, made safe motherhood a central topic of attention at their annual meetings from 1993 on (PAHO 2000). With U.S. first lady Hillary Clinton playing a central role, the spouses backed a USAID and PAHO regional safe motherhood initiative begun in 1995 to upgrade emergency obstetric care facilities in high maternal mortality settings (PAHO 2002b). Honduras was one of three priority countries (PAHO 2002c) and received additional funding for this purpose.

As of 2002, these regional efforts were continuing in Latin America and influencing the Honduran government. Regionally, donors founded an inter-agency task force on maternal mortality in 1999, coordinated by PAHO (PAHO 1996). The task force produced a consensus document on maternal mortality reduction discussed and reviewed by PAHO’s 14 member states, including Honduras (PAHO 2001; PAHO 2002b; PAHO 2002c). In 2002 PAHO was also in the process of preparing a new regional plan for the reduction of maternal mortality in the Americas (PAHO 2002a), a follow-up to the plan approved in 1990. The idea emerged in discussions with 11 ministers of health from the region (PAHO 2002a), including the Honduran minister. Domestically, the Honduran Ministry of Health produced a new maternal mortality reduction plan for the years 1998 to 2001, with an aim of reducing the maternal mortality ratio from 108 to 70 by 2004 (HMPH 1998b). The government’s health plan for the period 2002-2006 prioritized maternal mortality reduction (Secretaria de Estado en el Despacho de Salud 2002). USAID continued its safe motherhood involvement through ongoing health sector assistance, the World Bank via a $27.1 million loan for health systems reform aimed at extending access to the poor (World Bank 2002), and UNFPA through a reproductive health grant for the period 1996-1999 (UNFPA 1997).

Outcomes
These Honduran government and donor efforts resulted in substantial expansion of the country’s health and safe motherhood infrastructure, with resources concentrated in those regions identified by the 1990 report as having the highest levels of maternal mortality. Between 1990 and 1997 seven new area hospitals were opened, 13 birthing centers, 36 medical health centers and 266 rural health centers (Danel 1998, p. 5). The number of doctors rose 19.5%, the number of professional nurses 66.4% and the number of auxiliary nurses 41.9% (from Ministry of Public Health statistics, cited in Danel 1998). In 1993 and 1994 half of the country’s approximately 11,000 traditional birth attendants were trained in the reproductive risk approach (Martinez 1994). Community leaders developed censuses of women of reproductive age (HMPH 1991) and health workers lists of pregnant women (Danel 1998, p. 11). Health centers organized community groups to support educational programs directed at pregnant women (Martinez 1994). The Ministry of Health published the Norms for the Integrated Care of Women employed at health facilities throughout the country (Danel 1998).

Access and utilization by Honduran women of safe motherhood services increased markedly (figure 1), with antenatal care use increasing from 73 to 84 percent between 1989 and 1994. Also skilled attendance at delivery rose during the 1980s and 1990s, particularly in rural areas (1987 and 1996 Epidemiology and Family Health Surveys, as reported in Danel 1998), as did the percentage of women delivering in health institutions and receiving at least three antenatal care visits.

Figure 1: Honduran safe motherhood process indicators

(ABOUT HERE)

In 1997, a second national study was conducted on the country’s maternal mortality levels (Melendez et al. 1999). Ochoa again secured donor funding for a study, and once more the results drew the attention of health officials. The investigation
revealed a maternal mortality ratio of 108, a reduction of 40% from the 1990 figure of 182. As noted above, political and health infrastructural developments were taking place globally and in Honduras well before 1990 so it is unlikely the decline was solely a function of activities taken in the time period between the two studies. This being said, these activities almost certainly had considerable influence, and the decline was one of the largest ever documented in the developing world in such a short time span.

Discussion

Honduras, Indonesia and safe motherhood agenda setting

The agenda setting factors identified in the Indonesia safe motherhood study provide a partial but incomplete explanation for the rise of safe motherhood on to the Honduran national policy agenda. As in Indonesia, the organization of attention-generating focusing events, the existence of an indicator marking the seriousness of the problem, and effective political entrepreneurship shaped political priority for safe motherhood. Unlike Indonesia, the existence of a politically-palatable policy alternative played no major role in Honduras. In addition, the international factors discussed above – the norm-shaping function of international society and the power of donors through control of financial and technical resources – had significant impact in Honduras. These factors may also have had influence in Indonesia; however that study did not highlight their role.

Commonalities and differences across the two cases

Attention-generating focusing events shaped policy priority for safe motherhood in both countries. The international safe motherhood conference in Nairobi in 1987 prompted the organization of a national safe motherhood symposium in Indonesia in 1988, and sparked a flurry of safe motherhood meetings in the country throughout the
1990s. Similarly, the Nairobi conference moved PAHO to take action on safe motherhood throughout the Latin American region, contributing to policy attention in Honduras.

Also, in both countries the appearance of a credible number indicating high levels of maternal death in childbirth contributed to the generation of political priority for safe motherhood. In Indonesia a national demographic and health survey in 1994 revealed a high maternal mortality ratio, reinforcing political commitments already in place. The 1990 RAMOS study had an even stronger effect in Honduras, sparking alarm in the political system and contributing to a new phase in national safe motherhood efforts.

Political entrepreneurship by mid-level officials was also critical to the construction of policy attention in each country. In Indonesia civil servants from several ministries were responsible for drawing the attention of national political officials to the issue of safe motherhood. In Honduras, Dr. Ochoa of PAHO and his colleagues not only helped to organize the 1990 RAMOS study but also deliberately publicized the results to convince key health officials that the country faced a serious maternal mortality problem. Thereafter, mid-level bureaucrats in the Ministry of Health allied themselves with donor officials to mobilize the health system in service of the safe motherhood cause.

One factor that mattered in Indonesia played no major role in Honduras: the availability of a politically-palatable policy alternative. In Indonesia, a proposal to place midwives in each of the country’s more than 50,000 villages captured the attention of senior political officials, who agreed to allocate national funds for such a program. In Honduras multiple interventions were undertaken, but none played an agenda-setting function.

International influences

International factors shaped policy priority in Honduras in three ways (each of which deserves further exploration in the Indonesian case).
First, the Honduran state was socialized into safe motherhood norms by virtue of its position in an international society of nation-states. In the 1970s and 1980s developing world governments, international organizations and bilateral donor agencies drew attention to maternal health issues. Beginning in the late 1980s and continuing through the 1990s they built on this legacy and explicitly prioritized maternal mortality reduction. In doing so they facilitated the creation of a global norm that maternal death in childbirth is unacceptable and that states must act to address the issue. The Honduran government was socialized to embrace the norm through two concurrent processes. First, Honduran officials were members of a number of international organizations that prioritized safe motherhood. In particular the Honduran government actively participated in PAHO, which urged its member states to pay attention to the cause. Through participation in these and other forums, Honduran government officials came to learn of and pay attention to the issue. Second, these same organizations had local presence in the Honduran capital. Their representatives, many of whom were Honduran nationals, interacted with Ministry of Health officials, and a number jumped back and forth between positions with the donor agencies and the Ministry. These individuals served as conduits of priority, linking transnational and national forces.

Second, donors, through control over financial and technical resources, shaped the Honduran government’s behavior. USAID, the IDB, the UNFPA, UNICEF and PAHO are just a few of the bilateral and international agencies that prioritized maternal health and made considerable funds and technical assistance available, attracting the interest of Honduran health officials. Safe motherhood would not have been prioritized to the extent it was in Honduras had these donor resources been unavailable.

Third, a working group composed of donor and government health officials formed in the Honduran capital, emerging as the unofficial center of national safe motherhood efforts. The authority of this group highlights the fact that the forces shaping priority for safe motherhood in Honduras were not unidirectional, flowing from
international to domestic actors alone. Influence moved in both directions, merging as these working group members acted collectively to address the country’s safe motherhood problems. Moreover, in some instances the boundaries between the international and national were indistinct. Who was Dr. Ochoa? Was he a representative of the international organization, PAHO, who employed his organizationally-derived authority to shape the behavior of the Honduran state? Or was he a Honduran citizen who utilized his position in PAHO to generate resources for an existing national policy priority? And what was the status of this working group that included Ochoa? It included Honduran nationals, some of whom were employed by the government and others by international donors, as well as nationals of other countries, all working together for the objective of reducing maternal mortality in the country. As they engaged in this initiative, they formed a collectivity defined not so much by nationality or organizational affiliation but by cause.

This third form of international influence is the one least investigated in international relations, agenda setting, and international health policy theory, and is completely absent in safe motherhood scholarship. While the influence of transnational forces on national health policy-making has generated some research, the nature and authority of these locally-situated nodes of linkage between transnational and national forces remain largely unexplored. The very concepts of ‘transnational’ and ‘national,’ often taken to demarcate clear boundaries and to pertain to specific referents, have a constructed character and are far less straightforward in meaning than appears. Such working groups undoubtedly exist in many developing world capitals and deserve considerably more research attention, both because of their potential influence on health policy-making, and because their existence presents challenges to conceptualizations of agenda setting that seek to present neat demarcations between the ‘transnational’ and the ‘national’.
Further research on public health policy agenda setting

Our case study design involving a single country and health policy issue enables us only to raise questions and suggest answers, not to provide definitive conclusions. The governments of many nation-states were exposed to and participated in the creation of a global norm concerning the unacceptability of mothers dying in childbirth. Only a handful such as Honduras embraced the norm and acted decisively to address the problem. We have explained the divergent reaction by considering a set of domestic social and political factors, and a set of transnational-national linkages. In the absence of comparative inquiry we cannot be certain that the factors we point to were the primary causal forces. There is a need for further research that considers multiple states and health policy issues in order to assess the validity of these causal claims, and to discern systematic features of health agenda-setting processes.

This need for further research is reinforced by the fact that the factors that shaped policy priority for safe motherhood in Honduras and Indonesia overlapped but did not coincide. This result should not be surprising. Agenda setting is a complex process, and the factors that shape the rise of issues on to national agendas almost certainly vary by setting and health policy subject. Additional comparative inquiry will enable scholars to refine theory on developing world public health policy agenda-setting and to address the subject of contextuality. Among the issues that should be investigated are:

(1) What kinds of focusing events shape policy attention for health causes? What are the features of focusing events that give them agenda-setting power?

(2) Under what conditions do indicators have agenda-setting power? Under what conditions do they fail to have impact?

(3) Under what circumstances can/do political entrepreneurs make a difference? What is it they do that makes a difference? What features mark political entrepreneurs? Where do they tend to be located in developing world bureaucracies and societies?
How does the construction of a coherent (even if inaccurate) causal account of a health problem shape its possibility for emerging on a national health agenda?

By what modes do international organizations, bilateral donor agencies and health advocates from advanced industrial countries influence the health priorities of developing countries? Under what circumstances do they fail to have such influence despite their control over resources?

How prevalent in the developing world are effective government-donor working groups for specific health causes, such as the one that emerged in Honduras? What explains their power? As government-donor relations in health are so frequently fraught with tension, what explains the emergence of productive cooperation?

A recently published article has sought to push the safe motherhood field in new directions, expressing disquiet over the state of scholarship (Miller et al. 2003). Raising the question ‘where is the E in MCH?’ the authors argue that much safe motherhood program planning has been based on good ideas rather than demonstrated effectiveness and call for an evidence-based approach to maternal mortality reduction. While this call is sensible, it is also narrowly circumscribed, as the evidence referred to is only for medical and technical interventions. As such, the article largely retraces old paths. A much broader research agenda is necessary, one that continues to seek evidence on medical and technical interventions but moves well beyond this terrain.

Conclusion

Many safe motherhood scholars have concentrated on analysis of health interventions to the neglect of processes, overlooking the ways in which political priority and policy ideas emerge. Their explanations for maternal mortality change in developing countries therefore have been inadequate. The case of Honduran safe motherhood reveals the insufficiency of such an intervention-oriented research agenda. Medical interventions shaped Honduran maternal mortality change, but analysis of these do not
comprise a complete explanation for the decline. Agenda setting and international relations theory highlight factors that were also critical: the attention-generating effects of focusing events; the political shock caused by indicators; the entrepreneurship of mid-level bureaucrats; the norm-shaping power of international organizations; the financial influence of donors; and the collaboration of domestic and donor health officials. Scholars of safe motherhood and developing world health policy would benefit from supplementing their intervention-oriented inquiries with consideration of the social and political processes that give rise to policy priority and ideas. Strictly intervention-oriented research agendas miss many critical questions and can only hope to offer partial accounts of maternal mortality and health transitions in developing countries.
Acknowledgements

Research for this article was made possible through a grant from the Bill and Melinda Gates Institute for Population and Reproductive Health of the Johns Hopkins Bloomberg School of Public Health. Funding from the Institute is gratefully acknowledged. The authors would like to thank Jessica Hughes for her valuable research and translation assistance. The authors would also like to thank the many donor and government officials who were generous with their time and insights, and without whom it would have been impossible to evaluate the Honduran safe motherhood experience.
References


Almanza-Peek L (1998a) *El Fondo de Poblacion de las Naciones Unidas y la evolucion de la salud reproductiva en Honduras*. UNFPA, Tegucigalpa.


PAHO (1990) *Regional plan for the reduction of maternal mortality in the Americas*. PAHO, Washington, DC.


PAHO (2002b) *Regional strategy for maternal mortality and morbidity reduction [Provisional agenda item for 130th session of the executive committee]* PAHO, Washington, DC.


Figure 1: Honduran safe motherhood process indicators
Notes

1 Other publications have erroneously reported a maternal mortality ratio of 220 for 1990. The figure 220 came from the 1990 study, but was the pregnancy-related mortality ratio: the number of deaths per 100,000 live births to pregnant women regardless of cause. Thus, the ratio included deaths that were not related to pregnancy or childbirth. The actual maternal mortality ratio, also reported in the study, is 182. Both the 1990 study and the 1997 study were reproductive age maternal mortality surveys (RAMOS). They employed similar methodologies to investigate every maternal death in the country over the period of a year. Such studies represent the gold standard in maternal mortality investigations as they are comprehensive and in-depth, and cover entire populations, not just population samples.