POLITICAL HISTORY AND SAFE MOTHERHOOD DISPARITIES BETWEEN GUATEMALA AND HONDURAS

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Abstract

Each year more than 500,000 women die due to complications from childbirth, making this a leading cause of death globally for adult women of reproductive age. Nearly all studies that have sought to explain the persistence of high maternal mortality levels have focused on the supply of and demand for particular health services.

We argue that inquiry on health services is useful but insufficient. Historical and social structural factors also shape maternal mortality levels, and the very emergence and effectiveness of safe motherhood programs that seek to make such services available. Robust explanations for safe motherhood outcomes require examination of factors lying deeper in the causal chain.

In this paper we compare the cases of Guatemala and Honduras to examine historical and structural influences on maternal mortality. Despite being a poorer country than Guatemala, Honduras has a superior safe motherhood record. We argue that three historical and structural factors stand behind this difference: Honduras’ relatively stable and Guatemala’s turbulent modern political history; a conservative Catholic Church in Guatemala but not Honduras that has blocked priority for reproductive health; and the presence of a marginalized indigenous population in Guatemala but not in Honduras that the state has had difficulty reaching.
Introduction

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. Maternal mortality reduction is now an international priority, one of a select group of health objectives among the Millennium Development Goals and a focal concern of the World Health Organization’s 2005 World Health Report (World Health Organization 2005). Drawing heavily on quantitative health service and demographic data, a substantial body of scholarship has emerged surrounding the determinants of maternal mortality and what countries should do to lower death levels. 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) 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; Paxton et al. 2005). 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 and Rosenfield 1999; Tinker and Koblinsky 1993; Weil and Fernandez 1999), although more recently there has been recognition of the need for these interventions to work in tandem (Fortney 2005; World Health Organization 2005), and to be integrated into efforts to strengthen health systems as a whole (World Health Organization 2005).

Despite this substantial body of research, much cross-national variance in maternal mortality levels remains unexplained. One reason may be that with only a handful of exceptions (De Brouwere, Tonglet and Van Lerberghe 1998; Bulatao and Ross 1999; Koblinsky 2003; Pathmanathan et al. 2003) studies of safe motherhood in
developing countries have ignored historical and structural elements that may shape maternal mortality levels and the possibility that these interventions will even be prioritized in the first place. The research concentration on health service interventions may be due to a desire to focus on factors more readily manipulated by government and human action. If our goals in maternal mortality research extend beyond intervention to include explanation, however, we must consider factors deeper in the causal chain that are not easily altered by human agency.

In this paper we draw on concepts from a field that has a tradition of attention to social structure and history – fertility and family planning – and apply these to safe motherhood. Specifically, we consider political history and social structure to examine divergent safe motherhood outcomes in Honduras and Guatemala. The neighboring Central American countries make a particularly interesting comparison as they are similar on a number of dimensions. Each nation-state emerged from Spanish colonialism and received independence in 1821. Both have small populations (Honduras has 6.8 million people and Guatemala 14.3 million). Catholicism is the most widespread religion in both. Each has a semi-stable democracy after a long period of authoritarian rule. Inequality is pervasive in both: Honduras and Guatemala have high Gini coefficients - 56.3 and 55.8 respectively (1998 figures from CIA World Factbook 2004). Each country is poor, Guatemala with a gross national income (GNI) per capita of US $1910 and Honduras of $970 (World Bank 2003). Finally, in the late 1980s precisely the same set of international donor organizations pushed the two governments to prioritize safe motherhood, offering them funding and technical assistance to do so (personal interviews with Honduran and Guatemalan government, donor and NGO officials; August 2002 and August 2003).

However, despite these similarities, and the lower GNI per capita and slightly higher income inequality in Honduras than Guatemala, Honduras has a markedly better safe motherhood record. As of the late 1990s, 62 percent of Honduran women gave birth
in health institutions, compared to only 40 percent of Guatemalan women (HMPH et al. 2001; INE et al. 1999). The most recent maternal mortality ratios (MMR) – the number of deaths due to complications from childbirth per 100,000 live births – stood at 108 for Honduras in 1997 and nearly fifty percent higher - 153 - for Guatemala in 2000 (Meléndez, Ochoa and Villanueva 1999; Ministerio de Salud Pública y Asistencia Social 2003). These MMR figures are highly reliable as they are derived from reproductive-aged mortality surveys (RAMOS) – the gold standard in maternal mortality measurement – that investigate entire populations and therefore do not require confidence intervals. Most significantly, between 1990 and 1997 Honduras recorded one of the most dramatic declines in maternal mortality ever documented in such a short time span in the developing world, dropping 41 percent from 182 to 108 (Castellanos, Ochoa and David 1990; Meléndez, Ochoa and Villanueva 1999). While Guatemala may have experienced a decline in the 1990s - a 1989 survey recorded a maternal mortality ratio of 219 (Medina 1989) - there are differences in data quality between this and the 2000 survey that make inferences on change across time highly tenuous.¹

Analysis of the supply of and demand for maternal health services, the dominant mode of inquiry in safe motherhood studies, by itself is insufficient to explain the divergence in safe motherhood outcomes across the two countries. Such a mode of analysis begs the question why supply and demand diverged in the first place. Following work by Santiso-Galvez and Bertrand (2004) on the factors behind low contraceptive use in Guatemala, we suggest that a full account of this divergence must consider three differences in history and social structure operating on supply and demand. Two have predominantly shaped supply: Honduras’ relatively stable and Guatemala’s turbulent modern political history that has facilitated the development of a stronger national health infrastructure in the former than the latter; and a conservative Catholic Church in Guatemala but not Honduras that has allied with the state to block priority for the provision of reproductive health services. A third has operated primarily on demand: the
presence of a large marginalized indigenous population in Guatemala but not in Honduras that the state has had difficulty reaching and that is suspicious of modern medical practices. These factors in turn facilitated Honduran health officials and obstructed their Guatemalan counterparts in making safe motherhood a national health priority in the 1990s.

In this paper we compare the safe motherhood experiences of these two countries as a means of advancing a more general argument: in public health fields such as safe motherhood that do not have such a tradition, scholars can develop more robust explanations for many modern health outcomes by complementing examination of quantitative health service and demographic data with analysis of historical and structural context.

**Background**

Fertility and family planning scholars long ago recognized the need to examine history and social structure. Freedman (1975) modeled fertility using the metaphor of a funnel. At the narrow end of the funnel fertility is influenced by a set of immediate variables (drawn from Davis and Blake, 1956), including contraceptive use and 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. Factors in the funnel shape both fertility control demand - individual level behavior and contraceptive use patterns - and supply - the availability of means for achieving such control (Simmons 1992). 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), Simmons (1992) and Greenhalgh (1995). These scholars examined the influence on fertility of historical and 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 history and political, economic and social institutions shape fertility, programmatic outcomes and the emergence of programs themselves. Recently, Santiso-Galvez and Bertrand (2004) have applied these structural concepts to analysis of Guatemala, arguing that the country’s contraceptive prevalence rate of 38 percent, the second lowest in the Americas, has been shaped by four difficult historical and structural influences: anti-imperialistic leftist movements of the 1960s and 1970s; 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 on paper, but rather the fact that with only a few exceptions scholars have left factors at the more diffuse end of the schemata unexamined. Their research has focused almost exclusively on the more proximate determinants of maternal mortality: its biomedical causes, such as hemorrhaging and eclampsia, and the supply and demand for 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 four sets of factors at the diffuse end of the funnel that may shape maternal mortality levels and the likelihood that safe motherhood programs emerge and are effective in supplying services and meeting demand:

**Figure 1: Structural factors that may shape safe motherhood**

It may be in the transnational arena that countries learn to prioritize safe motherhood in the first place. Nation-states, like individuals, are not isolated entities. They exist within a society of other nation-states, and are influenced by officials from other countries, international organizations and transnational networks of activists (Haas 1992; Finnemore 1996; Keck and Sikkink 1998; Wendt 1992). Examining the role of international organizations, officials from other countries and transnational activists in pushing the safe motherhood cause and providing financial resources is critical.

National political factors also may be influential. 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 control country-wide governing institutions. Other states perpetuate inequality, exclude popular participation, are fragile and barely govern at the local level. Presumably, states in the former category are more likely to prioritize and effectively address maternal mortality than those in the latter: their social equity-oriented ideologies may be conducive to safe motherhood promotion; social actors such as women’s groups will have the political space to mobilize to pressure the state to take action; national political stability will facilitate safe motherhood policy continuity; and once legislation is passed, governing institutions will have the capacity to implement policy at local levels.

With respect to socio-cultural factors, medical anthropologists have discovered considerable differences across ethnic groups in attitudes and norms surrounding birth and medicine that have direct bearing on maternal mortality outcomes (Obermeyer 2000; Hay 2000). They have demonstrated that birth and decisions to seek medical care cannot be viewed in purely bio-medical terms but must be understood as phenomena with cultural and social significance. Population scholars have explored extensively the relationship between religion and reproductive health outcomes (Dharmalingam and Morgan 2004; McQuillan 2004). Other studies have investigated the association between maternal mortality and the position of women in society (Glei and Goldman 2000; Shiffman 2000).

Finally, economic development levels may influence government capacity to improve population health (Pritchett and Summers 1996) and establish effective safe motherhood programs (Bulatao and Ross 1999). Governments of poor countries may not be able to afford transportation infrastructures that enable women in remote areas to reach health facilities in the event of complications in childbirth. Governments may also lack the resources to build health centers and obstetric facilities that can save mothers
lives. Furthermore, impoverished families may be unable to afford such healthcare even if it is available and accessible.

These are only a few of the possible connections that may exist between structural factors and safe motherhood outcomes. These potential relationships point to the need for scholars to consider history and social structure in their explanations concerning maternal mortality.

**Methods**

We used four types of sources to develop national case studies of Guatemala and Honduras: interviews with officials involved in safe motherhood policy; government reports and documents; donor agency reports; and published research on Guatemalan and Honduran safe motherhood. We conducted in-depth semi-structured interviews with 49 individuals involved in Guatemalan and Honduran safe motherhood, 44 of which occurred in these two countries. Most lasted between one and two hours. We interviewed senior parliamentarians involved in reproductive health; individuals involved in maternal health in the respective Ministries of Health; former Ministers and Vice-Ministers 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), UNICEF, the World Bank and MINUGUA – the United Nations agency responsible for monitoring the peace accords in Guatemala. The government reports we consulted included national health plans, national health surveys and official documents on safe motherhood norms. In particular, we examined 1990 and 1997 reproductive age (RAMOS) mortality surveys from Honduras (Castellanos et al. 1990; Meléndez et al. 1999) and 1989 and 2000 RAMOS surveys from Guatemala (Medina 1989; Ministerio de Salud Pública y Asistencia Social.
We used a process-tracing methodology in constructing each case, seeking to employ multiple sources of information in order to minimize bias and establish common patterns of causality (Yin 1994). After gathering information, we reconstructed the history of the safe motherhood initiative in each country. An analysis of the Honduran case was published in 2004 (Shiffman, Stanton and Salazar 2004). We then analyzed the cases comparatively to identify historical and structural factors that may explain variance in outcomes across the two countries.

Factors Affecting Safe Motherhood in Guatemala and Honduras

International prioritization of safe motherhood

The Guatemalan and Honduran states came to pay attention to safe motherhood in the late 1980s and early 1990s through nearly identical sequences of events: international donor encouragement, followed by national studies revealing high levels of maternal death in childbirth, leading to initial mobilization of national political systems.

In 1987 donors organized an international safe motherhood conference in Nairobi, Kenya, launching a global initiative to reduce maternal mortality levels by half by the year 2000. A representative from the Guatemalan government attended (former official in Guatemalan Ministry of Health, personal interview, August 18, 2003). 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). Guatemala and Honduras were placed in a priority group of high maternal mortality countries (PAHO 2002). Officials from both governments participated in the Central American launch of the global safe motherhood initiative at a conference in Guatemala in 1992 (APROFAM et al. 1992). Multiple donors pledged resources, including PAHO, USAID, UNFPA, UNICEF and the United Nations Development Program (UNDP) (PAHO 2002). USAID offered $50 million for a global project entitled Mothercare that was implemented in both Guatemala and Honduras (MotherCare 1999).

In Guatemala, a mid-level official in the Ministry of Health responded to the regional call for action by pushing for a study to produce accurate data on maternal mortality levels (former official in Guatemalan Ministry of Health, personal interview, August 19, 2003). He was concerned that ministry statistics, which indicated a maternal mortality ratio of between 90 and 100, significantly underestimated 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 (former official in Guatemalan Ministry of Health, personal interview, August 19, 2003). 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.
A former Honduran Ministry of Health official working for PAHO led the organization of his country’s first RAMOS study in 1990 (donor, Honduran Ministry of Health and hospital officials, personal interviews, July 30, August 12 and August 21, 2002). He knew of PAHO’s interest in maternal mortality reduction, and believed that Honduras could secure resources for a national safe motherhood program only if it had credible data to prove a problem existed. He lobbied and successfully generated financial support for a study from PAHO and UNFPA, among others (Shiffman, Stanton and Salazar 2004).

As in Guatemala, the results shocked health officials. The research revealed a maternal mortality ratio of 182 maternal deaths per 100,000 live births, nearly four times the previously accepted figure (Castellanos et al. 1990). The official and his colleagues actively publicized the study’s results (donor and Honduran Ministry of Health officials, personal interviews, July 30 and August 12, 2002). By the end of 1990 a new health minister 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).

**The legacy of civil strife**

While both states mobilized to address safe motherhood in the early 1990s, Honduras was in a much better position to make use of newly available donor resources since, in contrast to Guatemala, it already had in place a solid health infrastructure to serve the poor. This difference, in turn, was influenced by the countries’ divergent political histories over the prior three decades.

Honduras has been among the more politically stable Central American states due to a stabilizing (although repressive) military presence in politics, the absence of a major insurgency, and since the 1980s an increasingly consolidated democratic system. The
growth in power of the military was a function of the extensive U.S. support to Honduras as a Cold War ally and bulwark of anti-communist resistance in the region. In 1986 alone the Reagan administration provided $81.1 million in military aid to the country in exchange for Honduran cooperation in the contra war in Nicaragua and counter-insurgency efforts in El Salvador (Ruhl 1996). With the conclusion of the Cold War and the end of these insurgencies in neighboring countries the U.S. government lost interest in supporting the Honduran military. The consequent decline in power of the armed forces created space for democratic politics (Ruhl 1996). Since 1982, when a new constitution was promulgated, Honduras has developed an increasingly stable democratic system. Six elections have been held since that year for the presidency and Congress, all largely free and transparent (Taylor-Robinson 2003). Two parties with similar ideological orientations - the Liberal (PLH) and National (PNH) parties - have traded power, carrying out three peaceful handovers of government (Taylor-Robinson 2003), and maintaining continuity in national social and health policies.

These stable geo-political and domestic circumstances in part explain a heavy USAID presence in the country from the 1970s on, and the capacity of the Honduran state to devote a significant portion of its national budget to health infrastructure development (Shiffman, Stanton and Salazar 2004). 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 Ministry of Health used domestic and donor resources to sustain a policy of extending health services throughout the country, targeting the rural poor (USAID 1988). Through the 1970s and 1980s, with donor assistance, the government also prioritized maternal health. Among the earliest initiatives was a USAID-supported project begun in 1968 by the Honduran government for the health of mothers and infants (Almanza-Peek 1998a).
Between 1978 and 1987 the number of health centers staffed by auxiliary nurses increased by 37% from 379 to 533; the number of health centers with doctors by 52% from 76 to 116; and the number of hospitals by 31% from 16 to 21 (USAID 1988). In the following decade 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). Between the 1987 and 2001 National Epidemiology and Family Health Surveys, the percentage of women delivering in institutional settings rose from 40.5% to 61.7%, and the percentage receiving prenatal care in these settings rose from 64.8% to 82.6% (HMPH et al. 1989; HMPH et al. 2001).

In contrast to Honduras, Guatemala’s modern political history has been among the most turbulent in Latin America (Jonas 2000; Chase-Dunn, Jonas and Amaro 2001). In 1954 the CIA backed a coup that overthrew a democratically-elected government committed to social reform. A succession of right-wing military-dominated authoritarian governments followed, with a brief civilian interlude from 1966 to 1970. Responding to Guatemala’s numerous social ills, in 1960 a guerrilla insurgency arose, launching a civil war that lasted until 1996. Initially the fighting was concentrated in the eastern region of the country but in the 1970s it spread to the western highlands where much of the indigenous Mayan population lived (Jonas 2000). A semi-democratic political system was restored in 1986; however, elections were less than transparent and civilian governments, dominated by land-holding and business elites, continued to rely heavily on army backing in order to sustain power. To date no civilian government has won re-election, and each new ruling party, deviating ideologically from its predecessor, largely has abandoned existing social and health policies.

Under such conditions of right-wing military rule, political instability and insurgency there was little possibility that health could become a priority sector or that an
An effective health system could develop in areas of the country where the civil war was concentrated. During the war the construction of new health units in these areas ceased, and few health workers were willing to locate to the areas of conflict, exacerbating existing shortages of medical personnel (Santiso-Galvez and Bertrand 2004). In 1990 government health expenditure amounted to only 2.1 percent of GNP (World Bank, as reported in Bitrán, Ubilia and Prieto 1998), and the country had only 17 doctors per 100,000 people, most of whom lived in urban areas (Hurtado and Saenz de Tejada 2001, as reported in Goldman and Glei 2003). As of the early 1990s the country had the institutional capacity to provide birthing care to only one-fifth of Guatemalan women (Schieber and Delgado 1993 as reported in Goldman et al. 2001). A 1995 survey of 60 communities located in four departments revealed that only 42 percent had a health center or post within the community, and only 28 percent a nurse or doctor able to serve pregnant women (Encuesta Guatemalteca de Salud Familiar 1995, as reported in Goldman et al. 2001).

**Political position of the Catholic Church**

The political position of the Catholic Church is another difference between the two countries that has influenced safe motherhood prioritization and the supply of services. While many Guatemalan priests and bishops have championed the causes of the poor, the conservative senior leaders of the country’s Catholic Church have used strong ties with the state to block reproductive health promotion (Santiso-Galvez and Bertrand 2004; present and former Ministry of Health, donor and NGO officials, personal interviews, August 14, 18 and 19, 2003). By contrast, Honduran church leaders have been reformers, promoting social change and posing few barriers to reproductive health policy.
Conservative Guatemalan church influence on politics began early in the modern era. Archbishop Mariano Rossell was hostile to the social reform-oriented, democratic governments of Juan José Arévalo and Jacobo Arbenz that led the country from 1944 to 1954, issuing pastoral letters warning the faithful of the growing influence of communism in the country (Cardenal 1990b; Brett 2002). He welcomed the restoration of military rule in 1954 by Castillo Armas, and offered strong support for succeeding military administrations. Subsequent archbishops were also staunch defenders of the military regimes (Cardenal 1990b). These governments reciprocated by amending the constitution to bring back Church privileges such as tax exemption and a declaration that the teaching of religion in schools was of national interest (Cardenal 1990b). In 1953 archbishop Rossell opened the door to even greater church influence on politics by inviting Opus Dei, an arch-conservative branch of the Catholic Church, to establish a presence in Guatemala (Cardenal 1990b).

These political leanings and state ties formed the backdrop for ongoing intervention by the Church leadership to block reproductive health initiatives. One continuous conduit of this influence on reproductive health has been the United States-based Mercedes Wilson, a member of Opus Dei and the sister of Alvaro Arzú, president of the country from 1996 to 1999 (present and former Ministry of Health, donor and NGO officials, personal interviews, August 14, 18 and 19, 2003).

In the late 1980s during the Cerezo administration the archbishop sent a letter to President Reagan accusing the private Guatemalan family planning association of promoting massive sterilization among the indigenous population, leading to a threat by the Ministry of Health to shut down the association. The accusations later proved to be false (Santiso-Galvez and Bertrand 2004). In 1993 the Guatemalan government was set to support the pro-reproductive health platform of the forthcoming International Conference on Population and Development in Cairo. However, President Serrano, sympathetic to family planning, was forced from office that year. The next president,
Ramiro de León Carpio, a devout Catholic and unsympathetic to family planning, attacked the Cairo preparation work (Santiso-Galvez and Bertrand 2004). 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 (Santiso-Galvez and Bertrand 2004). In 1996 the conservative PAN party, closely tied with the Catholic Church, gained the presidency. Competing camps on reproductive health emerged underneath new President Alvaro Arzú (former Ministry of Health officials, personal interviews, August 14 and 18, 2003). One faction opposed government involvement in any reproductive health issue and effectively blocked passage of a population law during the PAN era (Santiso-Galvez and Bertrand 2004; former Ministry of Health officials, personal interviews, August 14 and 18, 2003).

The Church also influenced the capacity of safe motherhood proponents to acquire accurate data (NGO official, personal interview, August 13, 2003). 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 figures.

Leaders of the Honduran Catholic Church, by contrast, have served as strong advocates for the rural poor, pushing for social reform, land redistribution and economic justice (Shepherd 1993; Cardenal 1990a). The Church organized several institutions in the 1960s to serve these causes. These included rural ‘Radio Schools,’ originally set up for education but evolving into agents of radical reform, and the Christian Social Movement (CSM), an umbrella grouping of student, religious and other organizations pushing for change in the countryside that eventually involved nearly one quarter of the
population (Shepherd, 1993). In the face of state pressure in the 1970s top leaders of the Church hierarchy backed down from this radicalism (Cardenal 1990a); however they continued to act as monitors and critics of the state (Melendez 1992). When the state has promoted pro-poor social policies, such as the development of maternal health services in the 1970s and 1980s and support for safe motherhood in the 1990s, Honduran church leaders, unlike their Guatemalan counterparts, have either supported these initiatives or refrained from interfering.

**Ethnicity**

The presence of a large indigenous population in Guatemala but not Honduras represents another source of divergence in safe motherhood outcomes across the two countries, particularly with respect to the demand for services. Approximately 40 percent of Guatemalans are *ladinos*, mestizos of Spanish-indigenous ancestry, and approximately 60 percent are members of 21 cultural-linguistic groups of pure indigenous ancestry that are descendants of the original Mayans (Richards and Richards 2001). In Honduras 90 percent of the population is of mixed Spanish-indigenous origins and only 7 percent of pure indigenous ancestry (CIA World Factbook 2004). The large Mayan population in Guatemala shapes safe motherhood outcomes in two ways. First, targeted by the army during the country’s civil war, many Mayans view the state with suspicion and are reluctant to approach any of its institutions, including its healthcare facilities. Second, many hold distinct beliefs surrounding childbirth that make them wary of western biomedical practices (Santiso-Galvez and Bertrand 2004; Metz 2001). Honduras by contrast has no sizeable segment of the population that is inherently mistrustful of government healthcare facilities or western biomedicine.

In the 1970s up to 500,000 Mayans joined leftist guerrillas in opposing government forces (Jonas 2000). The Guatemalan army responded with ferocity,
attempting to destroy Mayan culture and identity. Between 1981 and 1983 440 villages
were wiped out, nearly 150,000 civilians killed and over one million individuals
displaced, much of this occurring during the brutal regime of General Efraín Ríos Montt
(Jonas 2000). A later report revealed that Mayans comprised 83 percent of the war’s
casualties (CEH 1999 as reported in Warren 2001). While a peace accord was signed in
1996 that included a separate agreement on the identity and rights of indigenous peoples
(Warren 2001), Mayan peoples continue to be far more impoverished than *ladinos* and
ongoing targets of racism. Such maltreatment has made Mayans suspicious of
institutions associated with the state, including its medical facilities, where they are
frequently subject to rude treatment and where few medical personnel speak indigenous
languages.

Cultural beliefs surrounding childbirth also have presented a barrier to Mayan use
of modern maternal health services. Many Mayan people accord cosmic significance to
birth (Santiso-Galvez and Bertrand 2004), believe fertility to be predetermined (Metz
2001) and consider family planning commensurate with ‘killing children’ (Ward,
Bertrand and Puac 1992). These cultural considerations underpin the decisions of many
Mayan women to deliver at home with traditional birth attendants rather than in medical
institutions with skilled providers (Glei and Goldman 2000). In Honduras, there is
variance in the population in the use of skilled attendants at birth and institutional
facilities for delivery; however these differences are associated predominantly with
socioeconomic variables - education and urbanization - rather than ethnic or cultural
factors (HMPH *et al.* 2001; Danel 1998).

The influence of culture on safe motherhood becomes clear when we disaggregate
outcomes by ethnicity (table 1). Guatemala’s high maternal mortality ratio of 153 masks
a striking difference between *ladinas* and Mayans. The 2000 Guatemalan RAMOS study
(Ministerio de Salud Publica 2003) revealed that 156 *ladina* women died in 223,243 live
births in the year covered by the survey, a maternal mortality ratio of 70, lower even than
the Honduran national figure of 108. By contrast, 426 Mayan women died in 202,167 live births, a maternal mortality ratio of 211, more than three times higher than that for ladinas. Beyond this, only 16 percent of Mayan women deliver in health facilities, compared to 55 percent of ladinas (INE et al. 1999). Several studies have shown that the differences between ladina and Mayan women in use of pregnancy-related care are not associated with differential access to services, which are comparable for poor members of both groups, but rather with socio-cultural variance connected to ethnicity (Glei and Goldman 2000; Glei, Goldman and Rodríguez 2003).

Table 1: Safe motherhood indicators by ethnicity

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<thead>
<tr>
<th>Indicator</th>
<th>Ladinas</th>
<th>Mayan Women</th>
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<tbody>
<tr>
<td>Live Births</td>
<td>202,167</td>
<td>211</td>
</tr>
<tr>
<td>Maternal Mortality Ratio</td>
<td>108</td>
<td>211</td>
</tr>
</tbody>
</table>

Political mobilization by public servants

As noted above, in the late 1980s, responding to global prioritization of the issue, civil servants in Honduras and Guatemala promoted the cause of safe motherhood. Honduran advocates managed to institutionalize maternal mortality reduction as a priority in the political system in the subsequent decade (Shiffman, Stanton and Salazar 2004). Hampered by a difficult political environment, Guatemalan promoters until recently were unable to make progress in this regard (present and former Ministry of Health, donor and NGO officials and parliamentarians, personal interviews, August 11, 12, 13, 14, 18, 19, 20, 2003).

After the appearance of a study in 1990 revealing a high maternal mortality ratio, a working group in the Honduran Ministry of Health formed to coordinate national maternal mortality reduction efforts (former Ministry of Health and donor officials, personal interviews, August 12, 16, 20, 21, 23, 2002). This group became the unofficial center for national safe motherhood efforts (Shiffman, Stanton and Salazar 2004). Meeting regularly over several years, at times on a weekly basis, the group included
members of the Ministry’s division of maternal and child health, the initiator of the maternal mortality study from PAHO, and local representatives of USAID, UNFPA, UNICEF and other donors and agencies (former Ministry of Health and donor officials, personal interviews, August 12, 16, 20, 21, 23, 2002). The group produced a national plan of action for maternal mortality reduction for the period 1991 to 1995 (AHPF and HMPH 1991). The group also embarked on an effort to mobilize regional health bureaucracies in service of safe motherhood (former Ministry of Health officials, personal interviews, August 18 and 20, 2002). Members 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. They also organized annual national safe motherhood evaluation meetings, bringing together officials from throughout the country to review progress and develop future plans. Donors supported these initiatives with financing. USAID provided $57.3 million to the health sector between 1988 and 2000 (USAID 1988) and recommended that 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 health and the health of mothers (Almanza-Peek 1998a and 1998b). 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). By the end of the decade safe motherhood was one of the country’s top health priorities, and the efficacy of these efforts were confirmed in a second RAMOS study in 1997 that revealed a decline of 41 percent in the country’s maternal mortality ratio in just seven years.

In the wake of a national maternal mortality study of 1989 in Guatemala and the minister of health’s expression of commitment, safe motherhood proponents held high
hopes that a coordinated national program would be launched. This enthusiasm quickly dissipated as no organization took the lead (former Ministry of Health and donor officials, personal interviews, August 19 and 20, 2003). 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 other health issues. While a few safe motherhood activities took place in the early 1990s, these were not integrated and sporadic.

In 1996 the government and leftist guerrillas negotiated peace accords to end the 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 (present and former UN Guatemala officials, personal interviews, August 11 and 14, 2003). A United Nations commission, known by its acronym MINUGUA, was put in place to monitor compliance with the accords. However, the domestic political environment remained unfavorable for reproductive health, and the government took little action on its maternal mortality commitment. Concerned about this government inertia, in the late 1990s MINUGUA officials joined with other donors and sympathetic Ministry of Health officials to push for a new national maternal mortality study to get data that could be used to assess government compliance with peace accord commitments (present and former UN Guatemala officials, personal interviews, August 11 and 14, 2003). In 2001, with funding from multiple donors, the Ministry carried out the study, which revealed a high maternal mortality ratio of 153 (Ministerio de Salud Pública y Asistencia Social 2003a).

The study results and the election of a new government created a political opening for safe motherhood and reproductive health advocates. In 2000 the Guatemalan Republican Front (FRG) took power, a party rooted in Christian evangelical movements and less beholden to the influence of conservative elements of the Catholic Church than its predecessor. Former president and general Efrain Rios Montt became head of the
legislature and his daughter Zury Ríos one of the legislature’s vice-presidents. She had a long-standing commitment to reproductive health, stemming in part from her association with the Guatemalan Planned Parenthood Federation (former Ministry of Health official and present parliamentarian, personal interviews, August 18, 19 and 20, 2003). Allying with the Guatemalan UNFPA office, she managed to gain passage of a reproductive health law that mentions safe motherhood explicitly (Congreso de la República de Guatemala 2001; parliamentarian and UN officials, personal interviews, August 19 and 20, 2003). Amidst ongoing political instability, it remains to be seen whether passage of this bill will be sufficient to spark meaningful political priority for maternal mortality reduction.

**Conclusion**

Despite being a more impoverished country, Honduras has a safe motherhood record that is superior to Guatemala’s. Honduras has a low maternal mortality ratio by Central American standards, it has experienced a documented significant decline in maternal death levels, and its health officials have institutionalized priority for safe motherhood within the political system, creating the possibility for further reduction. By contrast, Guatemala’s maternal mortality ratio remains among the highest in Central America, evidence for a decline since the advent of the global safe motherhood movement is uncertain, and reproductive health advocates still struggle to get the government to pay attention to the problem.

Analysis of health service availability and utilization, the dominant mode of inquiry in safe motherhood studies, can offer only a partial explanation for the divergent safe motherhood outcomes between the two countries. The differences are rooted in deeper social and political forces: contrasting experiences with civil turmoil; disparate political orientations of Catholic Church leaders; and divergent ethnic compositions.
These forces in turn have hampered Guatemalan safe motherhood advocacy, while presenting only minimal obstacles to Honduran promoters.

The development of robust explanations for national maternal mortality transitions and cross-national variance in maternal mortality levels will require considerably more scholarly attention to history and social structure. We suggest a number of factors that deserve particular consideration:

- **Social norms surrounding female autonomy**
  Drawing on the experiences of Sri Lanka, Costa Rica and Kerala, Caldwell (1986) has argued that societies that value female autonomy and empower women have significantly higher life expectancies and lower infant mortality levels than those that do not. Does such a relationship hold also for maternal mortality, and if so, why?

- **Religious and cultural values**
  Hay (2000) and others have emphasized the role that cultural norms surrounding fate play in shaping decisions to seek pregnancy care. In what ways may cultural change that induce transformations from fatalistic worldviews to ones that emphasize human agency lead to increased use of safe motherhood services and lower maternal mortality levels?

- **Structural transformations in society and the economy**
  A number of explanations for fertility decline have drawn on concepts from modernization theory to argue that as societies move from rural, agricultural to urban, manufacturing bases, norms surrounding ideal family size and use of contraception shift (Notestein 1976; Freedman and Freedman 1992; Greenhalgh 1995). Do such transformations in social and economic structure also promise to induce changes in ideas surrounding the use of modern pregnancy care and in the availability of these services, even in the absence of deliberate government action to promote such maternal health-related shifts?
• The vibrancy of civil society

Caldwell (1986) argues that many countries that have experienced major mortality transitions have had vibrant, open, populist civil societies that have exerted pressure on the state to prioritize social welfare concerns such as education and health. Is a dynamic, open civil society also associated with national maternal mortality transition?

• The historical conditions that shape the mobilization of national public health communities

De Brouwere, Tonglet and Van Lerberghe (1998) have demonstrated that the mobilization of public health communities was critical to the reduction of maternal mortality in developed countries a century ago. What social and political conditions make such mobilization more probable in developing countries at present?

• A nation-state’s position in international society

Nation-states differ in their degree of integration into international society and their susceptibility to influence from ideas that emerge from outside their borders (Risse-Kappen 1995). Will governments embedded in dense networks of donor relationships, such as Honduras and Bangladesh, be more likely to prioritize safe motherhood than ones that are relatively isolated?

These are issues that sit at the diffuse rather than the narrow end of the funnel of maternal mortality causality. A number of public health fields routinely consider such factors in explanations for health outcomes, including fertility (Freedman 1975, Greenhalgh 1995, McNicoll 1980), child mortality (Mosley and Chen 1984) and increasingly HIV/AIDS (Trechler 1999). Safe motherhood is among the public health fields that have yet to develop such a tradition. The dearth of these kinds of inquiries may be one reason that cross-national differences in maternal mortality levels remain largely unexplained. Consensus may be developing concerning which health services are
most critical for maternal mortality reduction (Fortney 2005; World Health Organization
2005). However, these are determinants only at the funnel’s narrow end. Considerably
more structural and historical inquiry will be necessary to understand what factors induce
maternal mortality transitions, and why societies prioritize maternal health services in the
first place.
References


MotherCare. 1999. “Scaling up MotherCare,” *MotherCare Matters* (8)2.


Figure 1: Structural factors that may shape safe motherhood

**Transnational Context**
- Prioritization by international organizations
- Diffusion of ideas across borders
- Effectiveness of transnational advocates
- Donor resources available

**Political Context**
- National political stability
- Form of governance
- Strength of civil society
- Ideological orientation of regime
- State penetration of society

**Socio-cultural Context**
- Ethnic diversity and fragmentation
- Norms surrounding childbirth
- Autonomy of women
- Religious traditions

**Economic Context**
- Strength of national economy
- Strength of transport and communications infrastructure
- Resources available to health sector

**Mediating Factors**

**Safe Motherhood Outcomes**
Table 1: Safe motherhood indicators by ethnicity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Honduras - Total</th>
<th>Guatemala – Total</th>
<th>Guatemala – ladina women</th>
<th>Guatemala – Mayan women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (number of maternal deaths per 100,000 live births)</td>
<td>108</td>
<td>153</td>
<td>70</td>
<td>211</td>
</tr>
<tr>
<td>Percentage of women delivering within health institutions</td>
<td>61.7</td>
<td>40.4</td>
<td>55.0</td>
<td>16.1</td>
</tr>
</tbody>
</table>

Notes

1 Medina originally found a maternal mortality ratio of 248. GSD and Measure/Evaluation (2000) revised the figure downward to 219, correcting for an excess of 18 deaths in the numerator and the use in the denominator of live birth figures from the National Institute of Statistics (Ministerio de Salud Pública y Asistencia Social 2003). Even then, there remain uncertainties surrounding the 1989 figure because guerrillas destroyed the health records of dozens of municipalities in the civil war (NGO official, personal interview, August 13, 2003), so the national live birth figure used to calculate the 1989 maternal mortality ratio was highly imprecise.

2 Using data from a Guatemalan Survey of Family Health that investigated rural women concerning pregnancy care and delivery, Glei and Goldman (2000) found that contrary to their expectations access did not vary across ethnic groups. For instance, 41.5 percent of indigenous women who could not speak Spanish had a health center in their communities. The percentage for ladina women was 34.9 percent.