The emergence of political priority for safe motherhood in Honduras

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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. In 1987 a global initiative was launched to address the problem, but few developing countries since then have experienced a documented significant decline in maternal mortality levels.

Honduras represents an exception. Between 1990 and 1997 the country’s maternal mortality ratio – the number of deaths due to complications during pregnancy, childbirth and the postpartum period per 100,000 live births – declined 40% from 182 to 108, one of the largest reductions ever documented in such a short time span in the developing world.

This paper draws on three political science literatures – constructivist international relations theory, policy transfer and agenda-setting – to explain how political priority for safe motherhood emerged in Honduras, a factor that underpinned the decline. Central to the explanation is the unusually cooperative relationship that developed between international donors and national health officials, resulting in effective transfer of policy and institutionalization of the cause within the domestic political system. The paper draws out implications of the case for understanding the political dynamics of health priority generation in developing countries.

Key words: policy transfer, agenda setting, constructivism, safe motherhood, maternal mortality, Honduras

Introduction

Each year developing world health ministries accept financial and technical assistance from dozens of international health policy networks promoting causes such as AIDS prevention, polio eradication, reproductive health, safe motherhood and health sector reform. Despite the resources they offer, these networks must compete for the attention of ministries, since limited health systems capacities prevent governments from giving implementation priority to more than a handful of causes.

Scholars of developing world health policy have analyzed the emergence and forms of these networks (Reich 2000; Walt 2003; Ogden et al. 2003; Widdus 2003), and the structure and effectiveness of health ministries (Berman 1995; Bossert et al. 1998; Olsen 1998). With only a few exceptions (Okuonzi and Macrae 1995; Buse and Gwin 1998; Walt et al. 1999; Walt et al. 2004), they have given little systematic attention to the interactions between the two. Understanding the nature and quality of these interactions is crucial since these have bearing on why developing world governments may prioritize some health causes and neglect others.

This paper investigates network–ministry interactions and their impact on health priority setting through a study of safe motherhood in Honduras in the 1990s. The case is revealing because international officials concerned with safe motherhood interacted repeatedly with Honduran health bureaucrats throughout the decade, and because these interactions resulted in successful policy transfer, implementation and impact. In the 1990s the Honduran state made safe motherhood among its foremost priorities, and the country experienced one of the most dramatic declines in maternal mortality ever documented in such a short time span in the developing world. Between 1990 and 1997 the Honduran maternal mortality ratio declined from 182 to 108 maternal deaths per 100,000 live births (Castellanos et al. 1990; Meléndez et al. 1999). Both the 1990 and 1997 figures are highly reliable, as they are based on Reproductive Age Mortality Surveys (RAMOS), the gold standard in maternal mortality investigations that examine every maternal death in a country over the course of a year and generate statistics for the entire population, rather than sample-based estimates with wide confidence intervals. There have been other cases of documented decline in such a short period of time, but they are few and far between.

Danel (1998) has analyzed the medical and technical interventions associated with the Honduran maternal mortality decline. In this paper, we investigate how political priority emerged for the cause. We employ concepts from three political science literatures – constructivist international relations theory, policy transfer and agenda setting – to examine why successful policy transfer and implementation occurred and to highlight the case’s significance for understanding network–ministry interactions and health priority formation in developing countries.
Background

International policy networks

Over the past decade scholars have given increasing attention to the role of policy networks as actors in the international system. These vary both in form and level of institutionalization. Two of the more widely researched forms are epistemic communities and transnational advocacy networks. Haas (1992b) and colleagues coined the term epistemic communities to refer to groups of professionals who, by virtue of their knowledge-based authority and shared beliefs about causal processes, are able to influence national policies. Among other issues, such groups have been able to influence global trade agreements (Drake and Nicolaidis 1992), nuclear arms control agreements (Adler 1992), commercial whaling practices (Peterson 1992) and ozone protection policy (Haas 1992a). Keck and Sikkink (1998) have examined transnational advocacy networks. These differ from epistemic communities in that their members consist of multiple organizational types, from labour unions to churches, and are linked not by expertise but by shared commitment to particular causes. In the 1990s they have promoted environmental preservation, human rights and many other causes, and have had significant influence at global United Nations conferences (Chen 1996). Scholars have noted the involvement of these networks in international health promotion as well. Ogden, Walt and Lush have analyzed networks involved in shaping policy for sexually transmitted infections (Lush et al. 2003) and tuberculosis (Ogden et al. 2003). Reich, Widdus and Buse and Walt have investigated transnational advocacy networks. These differ from epistemic communities in that their members consist of multiple organizational types, from labour unions to churches, and are linked not by expertise but by shared commitment to particular causes. In the 1990s they have promoted environmental preservation, human rights and many other causes, and have had significant influence at global United Nations conferences (Chen 1996).

Policy transfer and constructivist theory

While attention has been paid to the emergence and forms of these health networks, there has been less research on the means by which they influence national priorities. One concept of value on this subject is that of ‘policy transfer’ which concerns the use of knowledge about policies or administrative arrangements in one time or place to develop such arrangements in another time or place (Dolowitz and March 1996). Stone (1999) notes that scholars employ multiple terms to speak of the concept, including ‘lesson-drawing’, ‘emulation’, ‘external inducement’, ‘convergence’ and ‘diffusion’. She identifies three modes of transfer. Policy may be transferred voluntarily if elites in one country value ideas from elsewhere and import these of their own accord. Policies may be transferred with compulsion if powerful organizations such as the World Bank threaten to withhold lending to countries that do not embrace particular practices. Policies may be transferred via structural forces when policymaking elites play no active role, and ideas enter national systems through processes scholars often refer to as ‘convergence’.

Constructivist theory from the political science sub-field of international relations offers a useful framework for thinking about how policy transfer may occur in certain instances. Constructivism works from the premise 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 such as the policy networks just discussed (Wendt 1992; Finnemore 1996). Mainstream international relations scholars traditionally have downplayed this form of transnational influence, as they have sought to understand the behaviour of nation-states in the international arena by looking inside states, taking state preferences as given (Finnemore 1996). Neo-realism seeks to explain outcomes in the international system, such as alliances and warfare, in terms of the pursuit by states of power and security. Neoliberalism is another version that understands state behaviour largely in terms of the pursuit of wealth. Both assume the nature of state preferences and seek to demonstrate their utility by their capacity to predict and explain outcomes in the international system (Finnemore 1996). In these frameworks international policy networks are viewed as epiphenomenal, unable to alter existing state preferences or serving only to promote the interests that powerful states would pursue anyway.

Constructivist international relations theory challenges mainstream conceptions by raising the issue of how states come to know what they want in the first place. Proponents do not necessarily reject neo-realist or neo-liberal ideas. However, they argue that the pursuit of power, security and wealth cannot explain many critical international outcomes. Constructivist theorists argue 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 are critical global actors in frameworks influenced by constructivism. Organizations such as the World Health Organization (WHO), UNICEF, the World Bank 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 (Abbott and Snidal 1998). International health policy networks, which link these actors with other kinds of organizations, may play similar roles in shaping national policy preferences.

Risse-Kappen (1995) argues that the capacity of international networks to influence national priorities depends on the international and domestic political structures through which these actors must work. He contends, for instance, that, other things being equal, transnational actors will find states with centralized structures harder to penetrate than those with fragmented structures; however, once they penetrate these systems they are more likely to have policy impact. The reason is that unlike democratic, federalist political systems (India, Brazil), power in authoritarian, unitary systems (China, Vietnam) is concentrated in the hands of a few elites. External networks have fewer points of access, but if they are able to gain access and convince state leaders of the legitimacy of their agenda, these leaders are able to mobilize much of the political system in service of the cause.

Ogden et al. (2003) point to another factor that may shape the level of network influence. Analyzing the case of global tuberculosis policy, they show that international health advocates were able to convince many developing world governments to accept a particular treatment regimen. However, the consequence of promoting a uniform solution was its insufficient tailoring to local context and a lack of ownership by domestic health officials. Policy transfer occurred, they argue, but the policy was not always implemented effectively. Their study suggests that international health networks that hand over a measure of control of resources and decisions to domestic officials, and allow for adaptation of policy solutions to local context, may be more effective in institutionalizing national priority for their causes than networks that are inflexible in these respects.

**Agenda setting theory**

Scholars concerned with policy transfer have focused primarily, if not exclusively, on the movement of policies across national borders. Scholars concerned with agenda setting have considered these processes predominantly inside domestic political systems. A previous study employed agenda setting concepts to explain the emergence of political priority for safe motherhood in Indonesia (Shiffman 2003). The following discussion draws from that paper.

Agenda setting is that stage in the public policy process during which certain issues rise to prominence and others are neglected. It is the first stage in the process and precedes three others: policy formulation; the enactment of authoritative decisions; and policy implementation. The most influential theory of agenda setting is Kingdon’s streams model (1984). He argues that agenda setting has a random character and is best described as resembling a garbage can in which problems, policies and politics develop and flow along in independent streams, meeting at random junctures in history and creating windows of opportunity during which particular issues rise to the fore. The problems stream refers to the flow of broad issues facing societies. It is from this stream of issues that agendas are shaped. The policy stream refers to the set of alternatives that scholars, politicians, bureaucrats and other prominent figures propose to address national problems. This stream contains proposals concerning how problems may be solved. Finally, there is a politics stream. National mood, changes in political structure, social uprisings, elections and global political events are among the constituent elements of the politics stream.

Kingdon and others have argued that there are systematic elements in agenda setting which shape the likelihood that an issue will receive national attention. In one of the earliest works on agenda setting, Jack Walker (1974), analyzing traffic safety policy in the United States, argued that among the factors that shape whether an issue rises to the attention of policy-makers is the presence of a clear, measurable indicator to mark that issue. Kingdon confirmed Walker’s insight in his study of health and transportation policy-making in the United States, from which he developed his streams model. Agenda setting scholars argue that indicators make a difference because they have a uniquely powerful effect of giving visibility to that which has remained hidden, serving not just monitoring purposes, the way they are traditionally understood, but also as catalysts for action.

A second factor that researchers have identified is political entrepreneurship (Walker 1974; Kingdon 1984; Doig and Hargrove 1987; Waddock and Post 1991; Schneider and Teske 1992). Whether an issue rises to the attention of policy-makers is not simply a matter of the flow of broad structural forces that stand beyond the reach of human hands. Much depends on the presence of individuals and organizations committed to the cause. As John Kingdon (1984, pp. 190–1) puts it, ‘Entrepreneurs do more than push, push, and push for their proposals or for their conception of problems. They also lie in wait – for a window to open. In the process of leaping at their opportunity, they play a central role in coupling the streams at the window.’

A third factor is the occurrence of focusing events (Kingdon 1984; Birkland 1997). These are large-scale happenings such as crises, conferences, accidents, disasters and discoveries that attract notice from wide audiences. They function much like indicators, bringing visibility to hidden issues. Birkland has demonstrated that disasters, including hurricanes, earthquakes, oil spills and nuclear power plant accidents, lead to heavy media coverage, interest group mobilization, policy community interest and policy-maker attention, causing shifts in national issue agendas.

**Political science theory and the formation of developing world health priorities**

These political science literatures offer concepts useful for understanding network-ministry interactions and their influence on health priority formation in developing countries. Constructivist international relations theory offers a way of understanding how developing world health bureaucracies may come to embrace particular health causes: they may be
We relied on four types of sources to develop the case study:

Methods

We used a process-tracing methodology in constructing the case history, seeking to employ multiple sources of information in order to minimize bias and establish common patterns of causality. Our aim was to investigate how safe motherhood appeared on the Honduran health agenda, the degree to which the cause had been institutionalized in the country, and the factors behind the prioritization of the issue. In the language of case study methodology our inquiry was holistic in nature and selected based on its revelatory and unique characteristics (Yin 1994). That is to say, we analyzed the nation-state of Honduras holistically as a unit rather than any of its sub-regions; we sought to make use of our access to policy-makers to reveal insights that may not have been available otherwise; and we justified selection of Honduras for analysis because of its uniqueness in being one of the few developing countries to have experienced a documented significant decline in maternal mortality in a short time span.

We chose a case study design because of the need to reconstruct holistically the history of the safe motherhood initiative in the country in order to examine the processes at work. The case study approach is better suited than other research methodologies, such as a structured survey and statistical analysis of health service utilization, to achieve this objective (Yin 1994). This is true because the defining feature of the case study is that it considers a phenomenon in its real-life context and is therefore a research strategy well-suited to revealing underlying processes.

The 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 and network–ministry interactions. On the other hand, 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

The development of a national health infrastructure

While Honduras' neighbours – Guatemala, Nicaragua and El Salvador – were engulfed in civil war through much of the 1980s, Honduras faced no domestic insurrection and enjoyed United States support as a Cold War ally and bulwark of anticommunist resistance in the region. These favourable domestic and geo-political circumstances in part explained a heavy USAID presence in the country, and the capacity of the Honduran state to devote a significant portion of its national budget to health infrastructure development.

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...
US$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 US$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, targeting the rural poor (USAID 1988). Between 1978 and 1987 the number of health centres staffed by auxiliary nurses increased from 379 to 533; the number of health centres with doctors from 76 to 116; and the number of hospitals from 16 to 21 (USAID 1988).

Through the 1970s and 1980s, with donor assistance, the government also 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 programme, the first stated objective of which was to decrease maternal mortality (HMHP et al. 1986, 1989). In the 1970s the Ministry of Health initiated a training programme for the approximately 10 000 traditional birth attendants across the country (Martínez 1994; HMHP 1998). UNFPA also supported maternal and child health, financing programmes from 1978 through 1991, with technical support from PAHO, that had explicit goals of reducing maternal mortality (Almanza-Peek 1998a). These legacies facilitated the emergence of political priority and gave health leaders the institutional capacity to address safe motherhood in the 1990s.

Safe motherhood emerges as a national priority

The emergence of safe motherhood as a global priority in the late 1980s raised political attention to maternal mortality reduction in Honduras to a new level. The watershed event was an international conference on safe motherhood in Nairobi, Kenya in 1987, sponsored by the World Bank, WHO, UNFPA and the United Nations Development Program (UNDP). At that time the global dimensions of the crisis – nearly 600 000 maternal deaths per year – were widely publicized, and delegates called for a global reduction of 50% by the year 2000. The conference officially launched a global safe motherhood movement, and solidified an international safe motherhood network that linked these organizations with government bodies, NGOs and safe motherhood advocates across the globe.

At the 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. Responding to this launch, PAHO prioritized the cause, in 1990 producing a plan for the reduction of maternal mortality in the Americas and securing its approval from its member states (PAHO 2002a).

The government of Honduras participated extensively in these global priority-setting initiatives. 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 for maternal mortality reduction, 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).

A 1990 maternal mortality study shocks the political system

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).

An official from the Honduran office of PAHO, who was formerly with the Ministry of Public Health, played a key role in organizing the study. He 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 programme, but only if it had credible data to prove a problem existed. He lobbied and successfully generated financial support for the study from several organizations, including PAHO and UNFPA.

The 1990 RAMOS study 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).2 Furthermore, credible data showing haemorrhage as the leading cause of maternal death, and twice as many maternal deaths occurring at home as opposed to in hospital, suggested not only a problem of a much different scale than anticipated, but also a problem of a different nature. Honduran women were not reaching public or private obstetric services. In some regions, between 80 and 90% of deaths occurred at home. Even in the metropolitan area of Tegucigalpa, nearly one in four maternal deaths occurred at home. Armed with this information and committed to making maternal mortality reduction a political priority, the official 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 and lobbied health officials in the capital and regions of the country. 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 programme (La Tribuna 1991a,b).

Domestic health officials mobilize the political system for safe motherhood

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 longstanding ties with the head of one of Honduras’ seven health regions. The minister was assembling a new team in the capital and asked the regional head to serve as director of the maternal and child division. The official 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, the official 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. He formed a working group that devised national strategies, engaged regional health bureaucracies and organized donor resources and expertise.

This working group became the unofficial centre for national safe motherhood efforts. Meeting regularly over several years and at certain points 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. The group produced a national plan of action for maternal mortality reduction for the period 1991 to 1995, adopting many ideas from PAHO’s 1990 regional plan, while tailoring them to fit local circumstances (AHPF and HMPH 1991).

The group also embarked on an effort to mobilize regional health bureaucracies in service of safe motherhood. As a former regional health leader, the official 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 travelled 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. The official and colleagues also organized annual, national safe motherhood evaluation meetings, bringing together officials from throughout the country to review progress and develop future plans. When some regional heads were still reluctant to make safe motherhood a priority, the official informed their superior, the minister, who spoke to them directly.

Donors provide resources 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 financing 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 a further US$57.3 million to the health sector between 1988 and 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 sub-programme on reproductive health and the health of mothers (Almanza-Peek 1998a,b), providing nearly half a million dollars for reproductive health 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.

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 programmes. 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). Representatives of the Honduran government 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 2002a). Honduras was one of three priority countries (PAHO 2002b) and received additional funding for this purpose.
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 centres, 36 medical health centres and 266 rural health centres (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 (AHPF and HMPH 1991) and health workers lists of pregnant women (Danel 1998, p. 11). Health centres organized community groups to support educational programmes 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 over this period. Antenatal care increased and became increasingly professionalized with smaller proportions of women relying only on traditional birth attendants for care during pregnancy. Use of antenatal care with a medically trained professional increased from 72% around 1990 (AHPF and HMPH 1991) to 85% in the late 1990s (HMPH et al. 2001). Institutional delivery rose from 45 to 61% over this same time period (HMPH et al. 2001), with increases particularly evident in rural areas (HMPH et al. 1989, 1996, as reported in Danel 1998). Likewise, caesarean sections, the most common life-saving procedure among emergency obstetric care practices, increased to 8%, with rural rates reaching nearly 5% in 1998 (Figure 1).

In 1997, a second national RAMOS study was conducted on the country’s maternal mortality levels (Meléndez et al. 1999). The same official who organized the first study again secured donor funding for the second, and once more the results drew the attention of health officials. The investigation revealed a maternal mortality ratio of 108, indicating a significant decline from the 1997 ratio of 182. The report provided strong evidence that increased access to maternal health care played a role in this decline (Danel 1998). For example, whereas a third of maternal deaths occurred in hospitals in 1990, more than half occurred in hospitals in 1997. Dystocia, or prolonged labour, for which effective care can often be provided within 24 hours or more, basically disappeared as a cause of maternal death (decreasing from 4% in 1990 to less than 1% of maternal deaths in 1997). In contrast, haemorrhage, which requires immediate medical attention, remained the leading cause of maternal death in 1997, but was substantially reduced in numbers and a higher percentage of these deaths occurred in hospital. Finally, the reductions in maternal mortality and the percentages of maternal deaths shifting from home to the hospital are apparent in the

**Figure 1.** Honduran safe motherhood process indicators: percentage of births in last 5 years to women 15–44 years with at least one antenatal care visit with medically trained personnel, percentage with an institutional delivery and caesarean section rate

*Sources:* AHPF and HMPH (1991), HMPH et al. (1996), HMPH et al. (2001).
metropolitan area of Tegucigalpa, as well as in the most disadvantaged regions of the country (Meléndez et al. 1999). Although disparities in maternal mortality and access to care remained in 1997, these results suggest that Honduras made important strides in making effective maternal health care available to a broad section of the population.

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. Also, there are no reliable data prior to 1990 on the country’s maternal mortality levels, so we cannot discern trends in periods prior to that year. This being said a change from 182 to 108 represents a decline of 40% in just seven years, a difference rarely seen in the developing world over such a short time span, strongly suggesting the impact of activities undertaken between these years.

Discussion

Political science theory and the case of safe motherhood in Honduras

Between 1990 and 1997 domestic health officials and international donors cooperated to institutionalize safe motherhood as a policy priority in Honduras, resulting in successful policy transfer, implementation and impact on maternal mortality levels. The political science literatures reviewed above – constructivism, policy transfer and agenda setting – help to identify the factors behind these successful outcomes.

Constructivist theory suggests that states may be socialized into particular policy preferences by virtue of their participation in international society. The Honduran state was socialized in this way. Beginning in the late 1980s and continuing through the 1990s international organizations prioritized maternal mortality reduction, facilitating 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 influenced 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. Secondly, these same organizations had local representatives, and representatives of international and donor organizations in a cooperative relationship emerged as the unofficial centre of national safe motherhood efforts. The group included representatives from the Ministry of Health, bilateral donors and United Nations organizations. It shared resources, coordinated strategy, worked collectively to promote priority for the cause across the country, and facilitated adaptation of global safe motherhood policies by encouraging local governments to develop contextually-relevant implementation strategies.

Three factors identified in agenda setting scholarship also were influential. International focusing events, particularly the Nairobi conference, placed safe motherhood on the global health agenda. Regional focusing events, including a safe motherhood conference in Guatemala, raised the issue onto the Central American agenda. Domestic focusing events, including media conferences publicizing results of the 1990 Honduran maternal mortality study, facilitated the rise of the issue onto the national agenda. Also, this study produced a credible indicator – a high maternal mortality ratio – which revealed levels of maternal death far higher than expected, sparking alarm in the political system. In the absence of such evidence, advocates would have had difficulty promoting the cause. Finally, the Honduras PAHO representative and his colleagues acted as political entrepreneurs, organizing the 1990 RAMOS study, deliberately publicizing the results to convince key health officials that the country faced a serious problem, and allying themselves with donor officials to mobilize the health system in service of the safe motherhood cause. They worked as forces behind the scenes pushing to ensure priority was institutionalized in the political system.

In sum, constructivist, policy transfer and agenda setting constructs help us identify the factors that underpinned successful policy transfer and implementation:

1. the effective socialization of the Honduran state into global safe motherhood norms;
2. favourable international and domestic mediating structures, particularly a strong international safe motherhood policy network and domestic political stability, that facilitated policy transfer;
(3) shared power by domestic and international officials that facilitated local embrace of the cause and contextually relevant policy adaptation;
(4) the organization of attention-generating focusing events that gave visibility to the cause internationally and domestically;
(5) the existence of a credible indicator to mark the severity of the problem; and
(6) political entrepreneurship by national health officials to institutionalize domestic priority for the cause.

Study limitations, further research and implications for public health strategy

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 maternal death 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 transnational–national linkages and domestic political factors. In the absence of comparative inquiry we cannot be certain that the factors we point to were the primary causal forces.3 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. 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 domestic political entrepreneurs make a difference? What is it they do that makes a difference?
(4) What features of international health policy networks give them the capacity to influence domestic health priorities? In particular, what is the relationship between network structure and the power to influence?
(5) As donor–government relations in health are so frequently contentious, under what circumstances is productive cooperation likely to emerge?

The latter question is particularly important and little investigated. The authority of the Honduran working 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 members acted collectively to address the country’s safe motherhood problems. Moreover, in some instances the boundaries between the international and national were indistinct. How should we characterize the official who organized the first maternal mortality study? Was he a representative of the international organization, PAHO, who employed his organizationally derived authority to shape the behaviour 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 of which he was a part? 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.

The nature and authority of these locally situated nodes of linkage between international and national forces remain largely unexplored. These deserve considerably more attention for at least three reasons. First, they may be more common than imagined and hold considerable influence over national health priorities in many developing countries. Secondly, their very existence presents a challenge to a basic presumption in constructivist, policy transfer and agenda setting theory that there exists a neat demarcation between the ‘international’ and the ‘national’. In these working groups these two categories may be fused, and in some instances meaningless. Thirdly, their emergence may help explain why policy transfer and implementation proceed effectively.

This latter point may be the most significant lesson that emerges from the Honduran case for health agenda setting in developing countries. Many relationships between international health policy networks and developing world health bureaucracies are fraught with tension. Often donors, wielding control over resources, have sought to impose their priorities upon bureaucracies without considering local interests, the capabilities of domestic bureaucracies, the need for policy adaptation, and the considerable national political manoeuvring that must take place in order to institutionalize a health cause as a domestic priority. It is rare that overseas donor or health network officials have the legitimacy or expertise to pursue such political manoeuvring successfully; that capability, if it exists, almost always resides in the hands of domestic bureaucracies and political officials. While many factors shape the agenda-setting process, as dozens of international health policy networks compete for attention, it may be those that are willing to hand over a measure of control and forge alliances with domestic bureaucracies that stand the best chance of having their causes institutionalized.

Endnotes

1 Since a 1987 global safe motherhood initiative was launched, the only other case of a documented major decline in a poor country confirmed by two Reproductive Age Mortality Studies (RAMOS) is Egypt, which had a maternal mortality ratio of 174 in 1992 and 84 in 2000 (Ministry of Health and Population, Egypt 2001). Historically, there are a handful of developing countries that have experienced documented declines, including Sri Lanka and Malaysia (Pathmanathan et al. 2003), and China (Koblinsky 2003). More recently, a number of countries with moderate levels of maternal mortality around 1990 have documented further declines over the following decade, including Uzbekistan, Azerbaijan, Argentina, Cuba, Costa Rica and Chile (WHO et al. 2001). 2 Other publications have 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 occurring to women during pregnancy, childbirth or the postpartum period, but not necessarily causally related to the pregnant state. The maternal mortality ratio based on the definition of maternal death in the International Classification of Diseases (Revision 10), also reported in the study, is 182.

It should be noted that a number of the factors identified here were also influential in Indonesia (Shiffman 2003), providing additional evidence for their causal power. These include the availability of a credible indicator showing that a problem existed, effective political entrepreneurship and the organization of attention-generating focusing events. Also, there as in Honduras, a relatively stable political system and the development of a national health infrastructure made it possible for international and domestic safe motherhood advocates to promote the cause.

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