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CHAPTER 5

To Not Die in Childbirth: Maternal Health and State Policy, 1930–1980

María Soledad Zárate

Introduction

Health policies that sought to protect maternal and infant health were among the most extensive of their kind during the twentieth century in Chile. In conjunction with labor policies, these characterized, consolidated, and granted prestige to motherhood as one of the prime relationships formed between the state and its female population. It has been posited that these policies favored the protection and benefits of children over those of mothers (Casas 2004; Pieper Mooney 2009). While it is true that these laws were not designed with the explicit purpose of increasing women's autonomy, we would be wise not to discount the gains that they represented for women's health and the autonomy that resulted from greater protection of these women's children. This chapter will cover important actions and goals of maternal-infant health policies in Chile between 1920 and 1980. These policies called attention to and protected, in a very particular manner, women's bodies and combated maternal

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mortality by expanding access to hospitalized births, prenatal check-ups, and food subsidies for pregnant women and new mothers. At the same time, we will also explore some aspects of family planning policies that were proposed to reduce abortion and birth rates. Taken as a whole, these policies worked to contribute to a gradual birth rate reduction while also progressively decreasing female mortality associated with pregnancy, childbirth, and abortion. These policies have also helped to make more visible the difficulties involved in balancing work and motherhood for poor Chilean women in a society that has, historically, not favored the simultaneity of both options.

This chapter revises policies associated with three historic moments. First, we will study those implemented by the Obligatory Insurance Fund (*Caja del Seguro Obligatorio*, CSO), a state-run entity founded in the 1920s that designed its welfare model specifically for blue-collar working mothers. Second, we will analyze the policies of the National Health Service (*Servicio Nacional de Salud*, SNS), founded in 1952, whose mandate was based on offering universal coverage and which significantly broadened benefits for working mothers, homemakers, and the very poor. Finally, we will look at the SNS during the 1970s, after the 1973 coup d'état. During this period, although the SNS conserved some of its existing pillars of maternal protection, it also gradually diminished its radius of coverage and the amount of its subsidies. The principal sources used in this chapter come from a wide range of official documents produced by the aforementioned institutions and the healthcare community, as well as from interviews done with a group of physicians, midwives, and mothers who participated in these programs.[1]

We are interested in understanding different aspects of the relationship that a growing number of women established with state-run healthcare, the limits of this relationship, and the "virtuous" cycle between this relationship and the political maternalism that emerged in Chile during the twentieth century. The influence of political maternalism—understood as the rhetoric and practices that extend the values of care and morality, culturally attributed to motherhood, to political activity—has been particularly important when seeking to comprehend twentieth-century state policies (Koven and Michel 1990). Since 1990, the study of those policies that were specifically directed toward the female population and based on maternalism has grown exponentially. Women's roles as citizens and beneficiaries of the European Welfare State generated debates that questioned the passive role of the female population and offered new analyses of the

powerful relationship between the history of social policies and gender. Many of these new insights have come from evaluating the effects of healthcare policies and the construction of socialized motherhood (Bock and Thane 1996).

In Latin America, many studies highlight the use of motherhood as a moral quality that purifies public action, a historical phenomenon that has permeated feminist struggles and political debates, in general, within this region's history (Chaney 1983; Rosemblatt 1995; Franceschet et al. 2016). The study of political maternalism has also provided a fertile terrain for understanding the limits of the construction of citizenship, traditionally understood as a masculine attribute (Molyneux 2003). Many studies in Chile evaluate the importance of the maternal role as a disciplining agent in Chilean politics—for example, mothers as being principally responsible for the reproduction of new citizens (Valdés et al. 1989; Rosemblatt 1995; Tinsman 2009)—as well as how motherhood has legitimized women's participation in politics (Kirkwood 1986; Power 2009).

Within a framework that consolidated motherhood as a central feminine political function, the health of mothers and children became an urgent issue during the first years of the twentieth century, primarily due to the threat of high mortality that affected both of these groups. The survival of mothers and children, up until at least the 1960s, was a crucial goal for the establishment of an industrial society, the development of the nation-state, economic development, and population growth—topics which have been extensively covered by the History of Women and Public Health in Latin America (Pribble 2011; Biernat and Ramacciotti 2013; Idiart 2013). Asunción Lavrin's work (2005) is especially relevant to the objectives of this chapter due to the foundational nature of the questions that she poses. Her investigation shows how motherhood influenced social and feminist reforms in state formation and modernization in Argentina, Chile, and Uruguay, from the end of the nineteenth century to 1940. Both social and feminist reformers promoted motherhood as a social function—distinguished as the feminine contribution *par excellence* to citizenship in those countries—and bolstered the visibility of the social pairing of mother and child. This pairing was a central component of social legislation and state welfare programs and decisively influenced our comprehension of the relationship between the female population and the Latin American State.

Taken as a whole, the studies that we have referenced here reiterate the thesis that healthcare policies were primarily based on interests concerning

the child, which we find to be undeniable. However, when focusing on health policies specifically directed toward pregnant women and mothers, although in practice these policies implied constraints to the registration of a female citizenship beyond the maternal condition, at least during the first half of the twentieth century, they also benefited mothers as individuals. These policies lowered the risk of dying during pregnancy or in childbirth, and improved health indicators linked to both physiological experiences.

Giving Birth: Between the Factory and the Tenement House

Since the late nineteenth century, the protection of maternal-infant health was a priority for charities and the first mutual-aid societies. Industrialization and rural-urban migration brought with them growing urban poverty accompanied by the many everyday socioeconomic hardships faced by women and children. For this reason, at the beginning of the twentieth century, Chilean politicians were increasingly worried by the high rates of malnutrition and infectious diseases faced by infants and children, the risks associated with pregnancy and childbirth, and the dilemmas posed by women's paid work (Lavrin 2005; Hutchison 2006; Zárate 2007a).

The medical community vigorously promoted maternal-infant health protection, as is evident in professional meetings such as the First Congress on the Protection of Infancy (1912), the First Congress on Public Charity (1917), and the First National Congress on the *Gota de Leche* (Chilean public milk program 1919). High rates of infant mortality due to respiratory and intestinal diseases and high rates of maternal mortality from hemorrhaging, postpartum infections, and accidents during birth were all discussed, as these statistics constituted a serious threat to demographic growth and, for the same reason, became the prime targets of future state health initiatives (Zárate 2007b).

In a context of political-institutional reform, the state began to be committed to social welfare programs during Carlos Ibáñez del Campo's dictatorship (1927–1931). It was at this moment that two key infant-maternal health protections were codified and put into practice: the 1924 Obligatory Insurance Fund Law (Law 4054, *Caja del Seguro Obligatorio*, CSO), which implemented specific benefits for the blue-collar working mother, and reforms to the 1931 Labor Code, which also benefitted these women. Female manual labor, understood as a threat to the health of mothers and

children, inspired the creation of both legal instruments, resulting from legislative agreements between liberal and conservative groups. From the beginning of the twentieth century, this political consensus had been born out of debates on regulations regarding female labor and maternal health protection, which tried to rein in the terrible consequences that industrial capitalism produced in proletarian families, especially with regard to the mother-child relationship (Hutchison 2006).[2]

While ultimately, the inspiration for maternal protection was based on the protection of infancy, a moral consensus was established that trumped any misgivings about intervening in labor relationships, key in the industrial development model. This, necessarily, brought working women to the fore of the public sphere. Hutchison and Lavrin maintain that protecting working women was a more powerful tendency than simply expelling them from the labor market, claiming that this was inspired by French legislation and social Catholicism, a combination found not only in Chile, but also in Argentina and Uruguay.

Although social reformers and leaders from labor organizations highlighted the moral and physical vulnerability in which women workers lived, parliamentary proposals concentrated on maternal protection and creating better working conditions for mothers, which would, in turn, improve the care of their children (Hutchison 2006). The starting point for this crusade was the protection of pregnancy, accomplished through the implementation of maternity leave and prenatal check-ups.

While the healthcare protocols of the CSO were only directed at blue-collar workers, they provided the foundation for future discussions of universal health policies. Through its Medical Department, the CSO lead the way in the founding of public health clinics and emergency rooms as well as urban and rural medical posts that functioned for the next 25 years (Biondi et al. 1944: 2–10).

The CSO implemented a series of measures—the starting point for state support of motherhood and early infancy—which benefitted blue-collar working women during pregnancy, childbirth, and the early months of motherhood. Mothers had access to exams, medical assistance, medicines, and subsidies, like the maternity subsidy, which corresponded to 50 percent of the working woman's salary over four weeks. Additionally, there was a breastfeeding supplement of 10 percent, on the condition that the mother breastfed her child, for at least the first year. Due to the extensive hours and physical labor required in factories, blue-collar working mothers were the first group of women to have prenatal maternity leave, which was

the first step toward the protection of the pregnant body. However, this was a small group of women compared to the universe of Chilean mothers at the time, as it only covered women who were contracted to perform paid work in the manufacturing sector. Domestic servants, for example, an area of significant female participation, were not included.

CSO benefits were for insured female workers, who could be single women and their children. In 1937, benefits were extended to the wives of male workers, which significantly increased the amplitude of coverage, although these women did not have the right to financial coverage of hospitalized childbirth.

In 1936, a high infant mortality rate (from here forward, IMR), stimulated the creation of the Mother and Child Section of the Medical Services Directive. From 1938 on, when the Mother and Child Law was passed (Law 6236), funds were made available for providing coverage to children up until 2 years of age (Zárate 2007b, 2012). Thanks to the Mother and Child Law, there was a significant increase in medical attention for infants. If in 1935 8898 children were seen in the CSO's public health clinics, seven years later that number reached 68,727 (Ortega et al. 1944: 3). Although it is not usually acknowledged, part of this success was due to the collaboration of mothers, as they were the ones who brought their children to the public health clinics, a conclusion that was backed up by the midwives and beneficiaries we interviewed. When examining public health policy, and maternalist policy in general, this is a scarcely explored dimension, particularly due to the lack of sources. However, without women's commitment and interest in following instructions, these results would hardly have been achievable.

Without ignoring the importance of the battle against IMR, the CSO also carried out important studies, principally through surveys, on the social impact of motherhood and paid work. They implemented programs to protect women's health, headed up by female physicians, such as Victoria García Carpanetti, Luisa Pfau, and María Figueroa Ponce. Their principal findings were that pregnant women were not having regular check-ups, and that they did not make effective use of prenatal leave because they were afraid of losing their jobs. Additionally, access to daycare for their children was usually lacking, which also affected their return to work. Night shifts were a common scenario and difficult to eradicate. Among the specific actions they proposed were: campaigns for prevention and assistance with sexually transmitted diseases, educational campaigns related to proper nutrition for pregnant women and wet nurses, giving out

subsidies, and dental health services for pregnant women, promoted by prenatal care. At the same time, postnatal care concentrated on protecting the bodily health of the mother, as well as encouraging breastfeeding and facilitating the distribution of fresh or canned milk (Zárate 2012).

A key policy for making medical assistance a habitual practice for women was convincing pregnant women to visit the CSO's maternal health offices to receive a clinical exam from the fifth month of pregnancy on. This prenatal check-up included dental care as well as thoracic exams and urine tests to detect tuberculosis and sexually transmitted diseases. The increase in pregnancy-related doctor visits reveals a practice that gradually became systematic: if, in 1939, a total of 149,776 pregnant women had doctor visits, in 1941 this number reached 221,500. Well-timed visits, the objective of many medical advertising campaigns directed at women, combated the "ignorance of future mothers about their rights and negligence concerning prenatal check-ups" (Ortega et al. 1944: 8).

In conjunction with prenatal check-ups, the most consistent and central policy of the CSO, directed at mothers and with a strong symbolic component, was professional assistance during childbirth at home and in the hospital. Its importance was strategic for the survival of mothers and children and legitimated medical intervention in an activity where midwives had traditionally dominated. Up until the 1930s, the Maternity House, located in San Borja Hospital in Santiago and financed by public charity, was practically the only institution that assisted in childbirth. Clinical reports showed that post-birth septicemia and hemorrhaging were the principal causes of death during childbirth for very poor women there (Zárate 2007a).

Combating maternal death during childbirth was a task that the CSO took on in a twofold manner: offering to deliver midwifery services at home and, alternately, hospitalization for labor and delivery for those women who were insured and the wives of the insured. Both polices were responsible for substantially better conditions when the poorest Chilean women gave birth.

Encouraging home births, if the physical conditions and medical prognosis so allowed, had important allies, primarily due to the fact that post-birth infections were more frequent in birthing centers than in the home of the mothers giving birth, which is quite surprising, actually, if we take into account the poor hygienic conditions of that time. Home births were also a good solution for the constant lack of beds in the maternity wing of the Charity Hospital. The CSO gave each home-visit midwife a briefcase,

which not only contained obstetric instruments to carry out their activities, but also other necessary materials that Raúl Ortega, chief physician of the Mother and Child section, detailed in 1940: “sheets, irrigator, rubber sheet, nail brush, lavatory, water pitcher, indispensable medicines; in short, everything necessary for installing a birthing room in a modest house” (Ortega 1940: 537).

Coverage of hospital births was a foundational policy that grew discretely between 1930 and 1940. Of the 25,000 births attended by the CSO in 1939, only 8000 were assisted in birthing centers (Ortega 1940: 538). The reasons for opting for a hospital birth were basically due to the possibility of controlling for clinically risky circumstances for the mother and child, as well as it being a valuable resource for the CSO when confronting the social aspects of women’s health. Single pregnant women, domestic servants, women who had to cover large distances on foot in the countryside and the city’s shantytowns were all part of the population that would “inevitably” need this service. A few days’ hospital stay could be key to recuperation, although it was also frequently problematic for women who did not have family networks that could help, in their absence, with the domestic chores and the family care work for which they were responsible.

Professional assistance during birth was one of the most strategic instruments used to combat maternal mortality and encourage the improvement of women’s health. For this reason, it was a shared aspiration with women’s organizations from the 1930s onward, such as the Movement for Chilean Women’s Emancipation (*Movimiento de Emancipación de Mujeres de Chile*, MEMCH) (Antezana-Pernet 1997). However, resistance among the population, particularly the peasant population, was an obstacle that the CSO knew only too well. According to several studies, families preferred the “ignorant midwife” not so much due to being low cost or free of charge, but rather because they trusted her historically. It was within this framework that the obstetric assistance offered by the charity houses and rural assistance posts began to take off in the 1940s (Ortega 1940).

The protection that the CSO provided to pregnant women, women in labor, and new mothers constituted a policy that promoted access to subsidies and care that up until that point was totally unknown and which directly impacted on bodily health. The foodstuffs they received during pregnancy and breastfeeding contributed to bodily recuperation in circumstances rife with poverty and malnutrition.

The commitment of the medical and social work community to the CSO Mother-Child Department's orientations, and the gradual construction of a solid healthcare system—represented by other state institutions, such as the General Charity Directorate and the General Directorate of Infant and Adolescent Protection (*Dirección General de Protección a la Infancia y Adolescencia*, PROTINFA)—meant that maternal-infant health became an important goal that was made visible on a social and urban level. The protection of blue-collar motherhood was also encouraged by feminist and women's organizations that debated and pressured for the broadening of political and civil rights for women, wherein a central role was given to the protection of working women and their children. The figure of the blue-collar working mother as capitalist victim, and as constituting the main beneficiary of health policies during the 1930s and 1940s, was one of the primary articulating pillars of Chilean feminism, and was especially promoted by the MEMCH, which identified this group as one of the most vulnerable (Lavrin 2005; Antezana-Pernet 1997; Gaviola et al. 1986).

Maternal Health: An Indicator of Social and Economic Development

From the end of the 1940s on, the CSO was criticized, both internally and externally, due to a number of factors: function redundancy and the need for widening the coverage of care and improving the quality of the services provided. These criticisms strengthened a substantial reform that gave birth to the SNS that combined existing healthcare services, among them, the CSO. As the SNS was fundamentally inspired by the principles of social medicine, it provided universal coverage. The main objectives of its technical and administrative departments were health protection, health promotion, and reparation through healthcare (Valenzuela et al. 1956). The SNS's mandate was to provide complete medical attention at no cost for workers who contributed to the Social Security Service (*Servicio del Seguro Social*), their wives and children (up until 15 years of age), in conjunction with those on disability and old-age pensions. Additionally, there was also the "passive" population benefitted by this mandate, such as homemakers, students, and the indigent, beneficiaries who represented approximately 70 percent of the total population of the country (Rodríguez 1976).

The Department of Maternal-Infant Care and Promotion of Health implemented five areas of action: professional care during childbirth;

increasing prenatal check-ups; the implementation of complementary food programs directed at mothers, wet-nurses, and babies; medical assistance for babies, toddlers, and children, and from the 1960s on, the implementation of the first family planning program (from here on, FPP). In line with international debates, principally those encouraged by the World Health Organization, the SNS promoted the improvement of obstetric and pediatric care, as they were understood as indicators of socioeconomic development (Zárate and Godoy 2011). Under this premise, the timely care of mothers and their children not only strengthened the demographic growth of the country, but was also a tool that contributed to the development and the broadening of rights to quality healthcare.

During the CSO's time, campaigns focused on childcare outreach (so-called *puericultura* in Spanish), fulfilled the role of educating women on rules of hygiene, as well as warning of the dangers of the lack of maternal responsibility. From the 1950s onward, the SNS's health guides and reports—particularly in the context of more community participation and health education during the 1960s—show us that there was a more comprehensive and "empathetic" relationship with female beneficiaries (Servicio Nacional de Salud 1961), which we also observed in the testimonies of our interview subjects. While mothers continued to be seen as those principally responsible for infant healthcare, reflections gradually emerged which also identified poverty as an important obstacle that affected maternal commitment. Interviewees indicated that they valued the support that they could receive in infant care tasks. Good results for healthcare policies depended on mothers' understanding and their becoming convinced of these benefits.

Among the SNS's policies, three lines of action made up the focus regarding the specific care of mother's bodies: professional assistance during childbirth, an increase in prenatal check-ups, and FPP. Hospital assistance during childbirth increased significantly: in 1960, 57 percent of all live births on a national level were attended in SNS hospitals ("El fomento de la salud" 1964). The greater number of women who had access to this assistance was the expression of a silent but robust transformation: the privatization and medicalization of a physiological experience that generated new relationships between healthcare professionals and women in labor. The increased demand for beds in birthing centers was also explained by the increase in women who presented signs of abortion at the end of the 1950s. While this transition took place predominantly during the 1950s and 1960s, the SNS continued to support home births in the hands of qualified midwives, understood as an emergency assistance that primarily

occurred in rural areas, a social work aspect that was widely recognized by the midwives interviewed.

Prenatal check-ups, encouraged early on by the CSO, expanded significantly thanks to the commitment of a wide medical community: nurses, midwives, and social workers visited public health clinics and homes, attracting pregnant women and convincing them of the sanitary, educational, and social advantages that clinical revision of their pregnancies would bring them. As a consequence of the passing of the 1957 Prenatal Family Allowance Law, the number of prenatal check-ups increased. This law called for distributing milk and cash subsidies from the sixth month of pregnancy on to insured pregnant women and to the wives of the insured in all insurance funds. The number of pregnant women who had access to prenatal check-ups doubled: from 459,270 women in 1958 to 920,721 in 1962 (Zárate and Godoy 2011: 146).

Since the 1930s, maternal death was a key issue for the CSO, SNS, and women's organizations. The possibility of dying during childbirth was related to accidents and hemorrhaging, to dangerous operations, and to the appearance of post-birth septicemia. The measures implemented by both services began to see results in the 1950s, according to one study that estimated that the maternal mortality rate in three birthing centers in Santiago had gone down from an average of 22 to 1.1 deaths per 1000 live births between 1932 and 1955 (Avendaño et al. 1956).

Regardless of these positive indicators, lowering the mortality rate for women and children was still the principal objective of maternal-infant policy in the 1960s. This was also due to an increasingly central phenomenon that specifically affected the physical health of mothers: the alarming increase in abortion rates. According to Onofre Avendaño, one of the main researchers on women's health and family planning between 1960s and 1970s, in 1965 there was one abortion for every two live births, suggesting that there were, annually, "140,000 abortions or miscarriages, of which at least 96,000 are abortions and a crime. Of every three abortions or miscarriages, one results in complications and requires hospitalization and medical treatment" (Boletín APROFA 1965: 1). The high rates of abortion transformed this practice into a serious public health problem. Its influence on maternal mortality indicators, as well as the care it demanded of hospitals, was significant (Pieper Mooney 2009; Rojas 2009). It is also important to point out that the CSO did not develop a policy for dealing with abortions, and so, in the 1960s the medical and political community could not fall back on previous healthcare experiences (Del Campo 2008).

One pioneering study from this period argued that abortion was responsible for two-fifths of all maternal deaths in Chile. In 1963, 312 women died due to this cause, and those were only the women who made it to a hospital (Armijo and Monreal 1966: 39). The maternal death rate reached 27.9 deaths per 10,000 live births in 1965, due to the practice of clandestine abortions (Rosselot and Mardones-Restat 1990). In Santiago, between 1958 and 1960, hospital attention accounted for 24 percent of all resources allotted to obstetric care, and in the area of emergency services, 42 percent of all admittances were due to abortion and miscarriage. Studies that reconstructed the attitudes and justifications for the decision to have an abortion found that this was understood as a means of contraception by young married women. The debate on abortion during the 1960s gradually became inclined toward an increased understanding of the cultural and socioeconomic reasons for having an abortion and less on the criminalization, which had been the habitual response to this practice (Zárate and González 2015).

The growth of medical publications on the abortion "epidemic" alerted the medical and political community about this grave public health problem. They also decisively promoted the first Birth Control Regulation Policy (BCRP), passed in 1965 and put into practice during the Christian Democratic government of Eduardo Frei Montalva (Avendaño 1975). This resulted in the execution of the first family planning program, which had among its principal objectives to achieve a decrease in abortion and maternal mortality and the promotion of responsible paternity, through the distribution of contraceptive methods and pregnancy prevention education.

Thanks to the support of private international agencies such as the Rockefeller Foundation, the Population Council, and the Ford Foundation, among others, and the UN, through Latin American and Caribbean Demographic Centre (CELADE) from the 1950s on, and the Association for the Protection of the Family (APROFA), this program was implemented in the SNS's public health clinics and hospitals. This program was strongly supported by doctors and midwives that prescribed contraceptive methods and the influence of this policy had immediate effects on the capital's hospitals (Viel 1967). As is evident from the reports sent by Chilean doctors to the Rockefeller Foundation, the work of this medical team was also to guard against women's unrestricted access to these methods while promoting educational assistance and greater understanding of the sociocultural conditions of the population served. The medical commentary on the distribution of contraceptives showed that this policy was primarily directed toward married couples. However, the midwives we interviewed,

as well as the testimonies collected by Tinsman (2009) on the 1960s and Raczynski and Serrano (1985) on the 1970s and 1980s, maintain that this program was usually only attended by women and that, in fact, many of these beneficiaries were not married.

FPP not only lowered the number of children for poor families, combating poverty and underdevelopment, but also increased the medical services and assistance that mothers received from the Chilean State. However, FPP was not oriented toward the totality of the female population of that period, but, rather, to 100 percent of women who received hospital care due to abortion or miscarriage and to 40 percent of women assisted in childbirth in those same hospitals, primarily those who already had several children, in addition to those who were suffering from grave chronic illnesses (Zárate and González 2015: 217).

In the mid-1960s, maternal and infant health indicators were still a concern. Infant mortality reached 120 children per thousand live births and malnutrition affected 60 percent of the children under 6 years, despite the significant efforts that had been made since the foundation of the CSO. The maternal mortality rate was of 27.9 per 10,000 live births and more than a third were the consequence of abortions. Professional assistance in childbirth reached 52 percent on average, but in rural areas, it had not exceeded 40 percent (Szot 2002: 130).[3]

During the three years of the Popular Unity government, maternal and infant mortality rates continued to decrease and there were also advances that had a specific impact on women's health. The protection of mothers was strengthened by three measures: first, by extending the postnatal leave to 18 weeks for all female workers, regardless of children's health condition, establishing it as a universal right. The second measure consisted of securing daily distribution of half liter of milk, not only for breastfeeding babies but also for the pregnant women. And third, they offered professional assistance in childbirth, gynecological care—especially in the early detection of uterine cervical cancer—and the services of family planning. These became concerns that had a particular development in some care settings (Faúndez 1996; Zárate and González 2015).

Targeted Maternal-Infant Policies: Poor Women during the Military Dictatorship

In a strictly statistical sense, the dictatorship did not have a negative impact on the meta-statistics that had driven the principal maternal-infant policies since 1920. However, after the coup d'état, the state apparatus was

gradually reduced and there were changes in the justification, objectives, and beneficiaries of these social policies. The new goal of these social policies was to offer assistance only to those who were absolutely incapable of providing for themselves. Social demands were progressively shunted into the private sector, disarticulating the previous actions of labor unions and professional associations (Vergara 1990).

In order to combat poverty, the social policies implemented by the Military Regime favored targeting those populations who lived in extreme poverty. For example, there were subsidies and direct transfers like the 1981 Unique Family Subsidy (SUF), directed at the country's poorest households. Access to benefits, and their scope was a direct consequence of the points that every family could obtain on community surveys, which identified the poorest members of the population (Raczynski 1995).

In the area of Healthcare, the Military Regime reorganized the old SNS and converted it into the National System of Health Services (*Sistema Nacional de Servicios de Salud*, SNSS), which included 27 regional services. In order to finance these services, a system of vouchers was implemented and the administration of health posts and public health clinics in the poorer, peripheral areas of cities was given over to the municipalities. With the 1981 reform, the growth of private healthcare was promoted and the system of private health insurance in Chile, the *Instituciones de Salud Previsional* (ISAPRES), was created. In 1986 the New Healthcare Law was put into place which, "extended the commercialization of medical care previously provided by the public health system, establishing a close relationship between the economic inputs of the beneficiary to the system and the compensation that this beneficiary would receive, in terms of the quantity and the quality of the services to which he/she has access" (Vergara 1990: 45–46). With this measure, the new law essentially eliminated the old "distinction between white and blue-collar workers". Access to healthcare would now depend on a system of "free choice", wherein beneficiaries could "choose" to be attended in state or private establishments, duly registered in the National Health Fund (Fondo Nacional de Salud, FONASA) (Vergara 1990).

What was at stake was reducing the costs of public health for the state, which was achieved, in part, through the suppression of the free healthcare services by the old SNS. Reduced fiscal support and the ISAPRES reform also reduced the number of patients and health professionals.[4] However, without a doubt, the most serious consequences of the Military Regime's transformations were the questioning of socialized medicine itself, the

disarticulation of territory-based healthcare organization, and the devaluation of community-based healthcare. Documents and oral histories show that these processes represented a radical disjuncture between the population and the new state founded by the military regime. For example, the decrease in numbers of healthcare professionals is identified by many of our interviewees as a particularly important loss for maternal-infant health, as this meant a significant reduction in healthcare and educational interactions between mothers and professionals.

In spite of these transformations, some priority areas of free care for the indigent and the poor remained: vaccine programs; health education; detection of clinical diseases; primary care for pregnant women, new mothers, and children; and doctor visits for healthy children up to six years of age. Additionally, there were nutritional interventions related to the National Program for Complementary Nutrition (PNAC), which had a relatively low cost but an important impact on indicators such as infant mortality and malnutrition[5] (Vergara 1990).

The Military Regime contributed to improving maternal-infant healthcare and nutrition programs in four ways: by linking healthcare and nutrition programs, by incorporating medicinal components into previously existing preventative programs, by bolstering the caloric content and variety of foodstuffs distributed by the state, and by concentrating its efforts on pregnant women and children under 6 years of age who were classified as being at "biomedical risk", which was done through perfecting the exchange of information within the system so as to make it more efficient. These improvements were related to the prenatal check-ups program, the healthy child program, and the PNAC, and clearly fit in with policies of prevention and social investment that favored the poorest 60 percent of the population (Raczynski 1995: 229).

By focusing their healthcare policies on the poorest mothers, the Military Regime gave priority to women who had historically not previously accessed state benefits. Although the SNS was a universal coverage policy, a significant percentage of the population, especially those classified as indigent, was never adequately covered in the earlier period. Targeting this population increased the technical level and the administration of these social programs. At the same time, its effects marginalized groups that had previously had access to social services. In the area of maternal-infant health, there were some negative effects. For example, by limiting coverage of PNAC to only malnourished mothers and children, the program lost its preventative, universal coverage nature (Vergara 1990). This change also

reduced the interest of mothers in taking their children to the program, since the costs of accessing it were understood as being greater than the perceived benefits. On the other hand, mothers who wanted to work and did not have malnourished children faced many difficulties when seeking to access daycare or other types of childcare. This was a disincentive for female entry into the labor force precisely in a period when combating women's poverty was becoming salient on an international level (Raczynski 1995).

The Military Regime's Mothers: Between Pro-natalism and Family Planning

Different investigations have documented the emergence of pro-natalist discourse in the Military Regime. If, from the 1960s on, demographic debates referred to the dangers of overpopulation and the possible local effects this tendency would have on Chile (Romero 1969), in the 1970s this discussion took an opposite turn. In tandem with other nationalist regimes, the Military Junta transmitted early in their administration a policy of promoting demographic growth (Ministerio de Salud 1974), in which motherhood was valued as an essential resource for national reconstruction and the protection of the family (Pinochet 1974). These ideas were spread through organizations such as the Women's Secretariat and also through the intervention of territory-based organizations, for example, the mothers' centers (Valdés et al. 1989; Valdivia 2010).

Inspired by the principles of the National Security Doctrine, the Military Regime transmitted a new population policy in 1979, which supported its pro-natalist stance. In this, the state promoted human development through maximizing life expectancy at birth and the integral development of the individual and the family; commitment to an increase in population; the inalienable right to life; an indirect reference to abortion; and that the state should protect the prohibition of sterilization as a contraceptive method (ODEPLAN 1979), a procedure that, according to other sources, was carried out in the 1970s and 1980s (Raczynski and Serrano 1985). Motherhood as an exclusive and inherent function of women was held aloft in the scheme of national re-foundation proposed by the Regime, wherein a woman's greatest contribution to the state would be through being a "patriotic mother" (Pieper Mooney 2009).

In spite of the Regime's undeniably pro-natalist and maternalist discourse in the 1970s, the family planning program continued with its principal functions and tasks that it had done before the coup. This was

accomplished through the Extension of Maternal-Infant Health and Family Welfare Program (PESMIB), financed through international organizations and administered since 1972 by the state. This program privileged attention for the maternal-infant population through 25 locations in vulnerable areas, and added a new task: the diagnosis and treatment of cervical and uterine cancer which, up until that time, was a clinical issue with little state coverage (Zárate and González 2015). This program required a greater number of midwives, nurses, and nurse's aides. Greater training and staffing needs to address the demand for the family planning program meant that nurse's aides were assigned greater responsibilities when attending to women and that midwives had the possibility of prescribing medication and inserting intrauterine devices (IUDs) in 1974 (Avendaño 1975).

We have evidence that some physicians acted against the family planning policy during the 1970s, taking out IUDs, speaking out against contraceptive use, or even spreading misinformation about contraception among the female population, for example, in relation to its necessity and relevance (Pieper Mooney 2009; Casas 2004; Jiles 1992). It is highly likely that this was the case. Contraceptives were part of an ideological battleground in post-coup Chilean society, one that could easily tip into political persecution. In spite of this, new studies and the revision of primary sources, like PESMIB and APROFA records, tell us that the Military Regime wanted to be present in conferences and debates on family planning, that it maintained policy related to the distribution of contraceptives through PESMIB, promoted relations and agreements with APROFA that promoted health personnel training, women's health campaigns, and transmitted information on contraceptives through the country's public health clinics (Cartilla APROFA 1979; APROFA 1979; Azócar 2012; Goldflam 2016; Ministerio de Salud 1976). Without a doubt, the clearest evidence that FPP continued operating was the growth in the volume of beneficiaries, in spite of the political climate: if in 1965, when the program was founded, the percentage of beneficiaries was 2.5 percent; in 1985, this number reached 22.7 percent (Viel 1989).

The promotion of responsible parenthood was a commitment that the Chilean government made with international organizations, such as the WHO in the 1960s and it was also maintained during the Military Regime. The World Population Conferences in Tehran (1968) and Bucharest (1974) reinforced the consideration of family planning as a basic and indispensable right for human dignity, and this had a great effect in Latin America (Felitti 2012). Both international meetings merited sending

delegations of Chilean physicians, both during the Christian Democratic government and the Military Regime (Avendaño 1975).

If we follow the statements and actions of family planning leaders during the Military Dictatorship, we can see how it was difficult to fully reverse what was already a world-wide trend: the fact that the promotion of birth control was a health policy that contributed to the reduction of poverty. By the mid-1970s, family planning policies had consolidated, thanks to medical-institutional ties, and to networks and international organizations that existed since the 1960s. Instead of an instrument of "feminine liberation", these policies were understood to be an anti-poverty and development resource, and, perhaps even more importantly, they had the support of women. The relationship that the Military Regime maintained with APROFA, a private organization that was an important resource in the passing of the Family Planning Bill in Chile offers clear evidence of this trend (Goldflam 2016).

While the primarily welfare orientation of the Military Regime did not eliminate the rights-based nature that healthcare had acquired in relation to maternal-infant protection, it undoubtedly had a regressive effect that we have not been able to document here (Vergara 1990; Casas and Valenzuela 2012). However, a preliminary analysis of interviews done with women who received services in the 1970s has shown a welfare climate that shifted between rights and compassion.

Two years after the coup d'état, in 1975, the infant mortality rate was 55.4 per thousand live births. This was an important decrease in comparison with the start of the twentieth century. Along with a reduction in infant mortality, a reduction in the rates of maternal mortality and abortions also continued to be key objectives of maternal-infant protection policies, policies that no longer provoked a negative public reaction. In the mid-1970s, with maternal-infant mortality and abortion rates considerably lower, a hospital birth rate of close to 90 percent, and a sustained increase in the use of contraceptive methods, the job of the Military Regime was basically to capitalize on the results of policies that had already been in place for 30 years. These policies already had the support of a wide state and professional infrastructure and a system of networks, in both rural and urban settings, which had been put in place by the SNS up until 1973. One of the processes most promoted by the SNS, professional attention during childbirth—almost always in hospital settings—was consolidated during the 1970s and by 1975 had already reached 88 percent of all births (Szot 2002: 132).

Conclusions

By the 1970s significant progress had been made in the field of maternal-infant policies since they were first implemented in the 1920s. Hospitalized assistance during childbirth, which reached 50 percent of the urban population by the 1940s, covered 87 percent of women by the mid-1970s. In 1950 prenatal check-ups for women were at about 40 percent, but by 1980 that figure reached 90 percent. If in 1960 the infant mortality rate was 120 per 1000 live births, by 1980 this rate had been reduced to only 31 per 1000 live births. The important changes brought about by FPP included: the reduction in fertility rates from 5 children per woman in 1950 to only 2 children per woman in 1987. The decrease in birth rates was similar: in 1965 it was 139 live births per 1000 women, while in 1985 it was only 77 (Larrañaga 2006: 139). Maternal mortality due to abortion and miscarriage also fell from 11 per 10,000 live births in 1960 to 1.7 in 1990 (Szot 2002: 133).

It would be correct to assert that concern for the infant population was the principal reason for maternal-infant health policies. However, this conclusion underestimates the relevant historical aspects of these policies and does not account for what these policies achieved for poor and working-class women since 1920: offering them a viable healthcare alternative to mainly private and Catholic-run philanthropic services. Along with increasing the volume of women assisted, the healthcare of mothers and children was gradually dissociated from an act of charity, and it was associated instead with a state responsibility. The first policies directed toward the maternal health of blue-collar working mothers were not just the point of entry of these women to the welfare system, but also their point of entry to the state itself. The protection of pregnancy, the conditions during childbirth, maternal mortality, abortion, and access to family planning were all given a public and political dimension which strengthened the discussion of the protection of blue-collar motherhood and the gradual healthcare rights that this condition progressively acquired.

The CSO's policies offered healthcare benefits to women in their role as mothers, and not as women per se, preferentially favoring those who were active in the blue-collar, working-class economy. However, it is also true that blue-collar workers' wives were also included in new policies when the CSO modified its criteria for benefits. Maternity leave established the protection of mothers, but also for mothers as workers: there was considerable discussion about what was the best time for returning to

work after the birth of a child—a measure that was completely in line with international debates on women workers' rights at the time.

The maternal health benefits offered by the SNS meant that there was an extension of these rights to other women in the population, particularly those who were part of the "passive" population, which signified an important increase in welfare coverage. Maternal state welfare measures were extended to the poor shantytowns and rural areas of the country, promoting sanitary controls during pregnancy and childbirth, as revealed in statistical increases of these controls. This process was extended up until the profound transformations imposed by the Military Dictatorship in the 1970s, when healthcare services were privatized and consolidated, as part of the new practice of "targeting", a new welfare model wherein the state's responsibility in healthcare was concentrated on those who were living in extreme poverty.

If we consider that healthcare benefits have always been marked by Chile's development models and by the fluctuating participation of women in the labor market, we see that the policies considered here reveal an important amount of state responsibility—accompanied by some women's organizations like the MEMCH—in making visible, treating, and accompanying the principal clinical and social needs of women, who were already, or would be mothers. The policies achieved changes, first by benefiting blue-collar working mothers and, from 1952 on, by extending these benefits to a wide swath of women that included working women, homemakers, and those women classified as "indigent", excepting those women who already had access to healthcare through private insurance funds.

The increase in the provision of healthcare for pregnant women and new mothers, from the hospitalization of childbirth to the gradual decrease in maternal-infant mortality rates, is a testament to substantial transformations in healthcare that are not only a reflection of medical and institutional efforts, but also of the gradual and strategic commitment of women themselves. Questions related to the reception of these policies are, without a doubt, very difficult to solve, due to the lack of primary sources, most notably women's opinions. However, one way of enriching this information on the relationship between mothers and the Chilean State is through the use of interviews with SNS-assisted beneficiaries from the late 1950s onward.

Within the framework of political maternalism, maternal-infant policies were an instrument that definitely conditioned female citizenship, with all the limits that are implied when restricting said citizenship to motherhood.

However, this finding cannot obscure a central point: those maternal-infant policies contributed significantly to reducing maternal death rates and making women the central beneficiaries of state-provided healthcare up until the 1970s.

Notes

1. This chapter is the result of two research projects. The first, developed in the FONDECYT Project Regular N° 1100977, 2010–2012: "Salud, Mujeres y Estado: Transición y modernización de las políticas sanitarias de protección materno-infantil. Chile 1952–1973", in which the researcher Lorena Godoy participated. And the second, FONDECYT Project Regular N° 1161204, 2016–2019: "Profesiones sanitarias femeninas en Chile 1950–1980. Prácticas, relaciones de género e identidades laborales", in which the researcher Maricela González participated. We did 15 interviews with physicians, 15 with nurses, and 15 with midwives who worked in the SNS during the 1960s and 1970s and with 15 beneficiary mothers who accessed services during this same period. The interviews were semi-structured and their audio was recorded and transcribed in its entirety.

   These were done in Santiago between the end of 2010 and 2017. All participants signed an informed consent form, approved by the Ethics Committee of the Universidad Alberto Hurtado.
2. See also Catalina de la Cruz, this volume.
3. Professional assistance in childbirth did not necessarily imply hospital attention, but considered the participation of a physician and/or a midwife.
4. The ISAPRES (Instituciones de Salud Previsional), founded in 1981, are private entities that operate on the basis of an insurance plan, which are entitled to receive and administer the mandatory health contribution (7% of their taxable remuneration) of the workers and people, who freely and individually opted for these benefits instead of the state health system (FONASA). With these contributions, the ISAPRES finance health benefits and the payment of medical licenses.
5. See Goldsmith Weil, this volume.

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