THE STATE OF POLITICAL PRIORITY FOR MATERNAL MORTALITY REDUCTION IN NIGERIA AND INDIA

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Abstract

Background Achieving the ambitious maternal mortality reduction aims of the Millennium Development Goals will require more than generating sufficient donor support and carrying out appropriate medical interventions. It also will necessitate convincing governments in developing countries to give the cause political priority. The generation of political priority, however, is a subject that has received minimal research attention.

Objective To assess the state of political priority for maternal mortality reduction in India and Nigeria, which rank number one and two respectively among all countries in number of maternal deaths in childbirth, and together contribute nearly one-third of the global total.

Methods Qualitative in-depth interview study, using a case study process-tracing methodology. Interviews with 28 Nigerian and 27 Indian leaders, as well as analysis of documents and demographic surveys from each country

Results After decades of neglect, policy windows have opened in these two countries, giving hope for future maternal mortality reduction. However priority in each country is only emerging. In Nigeria, advocates have yet to coalesce into a potent political force pushing the government to action. In India, national figures have given maternal mortality political prominence, but priority within most states is weak, and implementation barriers numerous.

Conclusion To achieve the MDG maternal mortality reduction aims, maternal mortality reduction advocates in India and Nigeria must not only develop effective technical strategies to deliver obstetric care but also careful political strategies to institutionalize priority within political systems at both national and sub-national levels.

INTRODUCTION

The Millennium Development Goals (MDGs), poverty alleviation objectives agreed to by United Nations member states, establish an ambitious target for the reduction of maternal mortality. They call for a decrease in the world's maternal mortality ratio by seventy-five percent from 1990 levels by the year 2015. With an estimated 585,000 maternal deaths in childbirth in the year 1990,[1] and no evidence of significant progress since then, the achievement of this objective remains a daunting task.

Achieving the MDG maternal mortality goal will involve more than securing international donor resources and developing effective technical and medical interventions to ensure that pregnancies are wanted and safe. It also will be contingent upon generating the commitment of political and social leaders within developing countries to back the cause of safe motherhood with sustained advocacy, financing and technical resources. Generating such commitment is a major challenge, since few governments in the developing world have prioritized this issue.

Despite the importance of national priority, there is only a handful of published research[2,3,4] on these political dimensions of the issue. Almost all research concerns one or more of four *technical* questions:

- How high is maternal mortality and how can it be measured?
- What are its biomedical causes?
- Which healthcare services are needed to address it, and what problems exist with these services?
- How can we surmount social and cultural obstacles that prevent women from accessing these services?

Even if we can ascertain that maternal mortality is high, determine its biomedical causes, identify effective medical interventions, and transcend social obstacles, there is no guarantee that political leaders will prioritize the issue or take action. Policy-makers

in developing countries are burdened with thousands of issues to sort through each year, and limited resources to deal with these problems. A question that emerges is how to ensure that political and social leaders pay attention and devote resources to *this* particular issue, given its severity and the competing pressures on their time and resources.

This study considers the political rather than the technical or medical dimensions of the issue. It is concerned with the subject of political priority: the degree to which political and social leaders at national and sub-national levels identify a cause as a concern, and back up that concern with the provision of financial, technical and human resources commensurate with the severity of the problem. We analyze this subject in two countries that may have the most serious maternal mortality crises in the world: Nigeria and India. With only two percent of the world's population, Nigeria contributes ten percent of the world's maternal deaths.[5] Each year as many as 60,000 Nigerian women die due to pregnancy-related complications,[6] a problem particularly severe in the country's northern states.[7] Globally only India has a larger number of maternal deaths from pregnancy-related complications, as many as 136,000 annually.[8]

This paper combines information from two separate reports on India[9] and Nigeria.[10] It considers three questions: (1) What is the state of political priority for maternal mortality reduction in Nigeria and India? (2) What challenges do Nigerian and Indian safe motherhood advocates face in promoting the cause? (3) What do these cases suggest about strategies for generating political commitment for safe motherhood in other countries with high maternal mortality?

METHODS

We used a process-tracing approach to conduct this research, a qualitative case study methodology commonly employed in political science inquiry. Process-tracing

involves employing multiple sources of information, including in-depth exploratory interviews, in order to reveal social and political processes, establish common patterns of causality and minimize bias.[11] It is a research strategy particularly well-suited to uncovering underlying political processes and dynamics, the major objective of this study.

We conducted semi-structured interviews with 28 individuals in Nigeria and 27 individuals in India centrally involved with safe motherhood at both the policy formulation and implementation levels. We conducted these interviews in November 2004, July 2005 and September 2005. Most lasted between one and two hours. Using a snowball sampling technique, we identified the key members of the safe motherhood policy communities in each country. We interviewed past and present senior officials in the national ministries of health; national legislators; national planning commission members; state health officials; representatives of civil society organizations and non-governmental organizations; officials from donor organizations most directly involved in safe motherhood including the World Bank, the British Department for International Development (DFID) and the United States Agency for International Development (USAID); representatives from their domestic implementing agencies; UN health officials from UNICEF, the United Nations Population Fund (UNFPA) and the World Health Organization; representatives of international foundations working on safe motherhood; and members of the media with a focus on health. While there were some common questions asked of each interviewee, including his or her assessment of the state of political priority for the cause, we did not employ a uniform survey instrument since each interviewee had unique knowledge about safe motherhood. Instead, we asked open-ended questions in an exploratory way to elicit that unique knowledge.

In addition to the interviews, we reviewed multiple documents, including demographic and health and other surveys; government policy documents, health reports

and safe motherhood guidelines; documents from bilateral and multilateral donors; national government development plans; reports from non-governmental organizations and foundations; and published research on Indian and Nigerian safe motherhood and maternal mortality.

NIGERIA

Maternal mortality and health service conditions

Nigerian safe motherhood advocates confront adverse social, cultural, health sectoral, economic and political conditions that create high maternal mortality levels, and that make their work particularly challenging.

The several dozen studies that have attempted to determine maternal death rates in Nigeria uniformly show high national levels, large urban-rural disparities and wide variation across geographic regions, with maternal mortality particularly severe in the country's predominantly Islamic northern states. One of the more reliable studies, a 1999 Multi Indicator Cluster Survey, estimated a maternal mortality ratio (MMR) of 704 deaths per 100,000 live births for a period of six to twelve years preceding the survey.[12] It found a significantly higher rural than urban MMR (828 versus 531), and considerable variance across regions, ranging from 165 in the Southwest to 1549 in the Northeast. The leading biomedical causes of maternal mortality are the same as those found in many developing countries: hemorrhaging, sepsis, unsafe abortion, anemia, malaria, toxemia and cephalo-pelvic disproportion.[13]

The quality of maternal healthcare facilities in Nigeria is poor. A 2003 study of 12 randomly-selected states revealed that only 18.5% of facilities overall and only 4.2% of public facilities met internationally accepted standards for essential obstetric care.[14] Approximately two-thirds of all Nigerian women and three-quarters of rural Nigerian

women deliver outside of health facilities and without medically-skilled attendants present.[15,16] Already low levels of pregnancy care utilization have deteriorated in recent years: only 32.6% of all women delivered in health facilities over the five year period preceding the 2003 Nigerian Demographic and Health Survey, compared to 37.3% in the three year period preceding the 1999 survey. A decline also occurred for deliveries in the presence of medically-skilled attendants, from 41.6% to 35.2%.

The dismal state of the health sector in the country contributes to these adverse maternal health outcomes. A recent Nigerian government document acknowledges that "the health system in Nigeria and the health status of Nigerians are in a deplorable state"[17] and notes numerous problems, including low motivation for health professional workers, an annual budget preparation process the report calls a 'ritual', a culture of corruption and little consultation between Federal and State health authorities and between the Federal Ministry of Health and other ministries. External evaluations of the system and health sector statistics back up this assessment. In 2000 the World Health Organization ranked the performance of Nigeria's healthcare system 187th among 191 United Nations member states.[18] In 2002 general government per capita expenditure on health amounted only to five dollars, far below the World Health Organization's minimum recommendations, and health spending constituted only 3.3% of total government expenditures.[19]

The opening of a policy window

Prior to 2000 safe motherhood received some policy attention in Nigeria but was never institutionalized as a political priority. High maternal mortality in Nigeria first received international notice through a 1985 paper by obstetrician and gynecologist, Kelsey Harrison, in the *British Journal of Obstetrics and Gynaecology*.[20] This paper provided one of the impetus for convening an international safe motherhood conference

in Nairobi, Kenya in 1987, which launched a global safe motherhood movement. Harrison and other Nigerians attended, returning with a commitment to achieving in their country the objective agreed to at the conference: a reduction in the number of maternal deaths by half by the year 2000. The Federal Ministry of Health subsequently established a national safe motherhood committee, and the Society for Obstetrics and Gynecology of Nigeria (SOGON) heightened efforts to promote maternal mortality reduction. Also, Columbia University established the Prevention of Maternal Mortality Network, conducting formative research. However, these initiatives were not scaled up, and under the military government safe motherhood activities in Nigeria stagnated.

The situation changed in 2000, when a policy window opened for safe motherhood. After that year the government inserted explicit maternal mortality reduction objectives in its national poverty reduction plan, the Federal Ministry of Health began championing the cause, National Assembly members drafted reproductive health and safe motherhood legislation, and donors increased assistance for safe motherhood. Seven factors contributed to the opening of this window: the democratic transition, growing civil society attention to the cause, the accumulation of evidence on the state of maternal mortality in the country, the emergence of new leadership in the Federal Ministry of Health, the pressure of the MDGs, the new availability of donor resources and the emergence of champions inside the House and Senate.

The first factor was Nigeria's transition to a democratic political system in 1999 after decades of military-authoritarian rule, which created the political space for social issues, such as maternal mortality reduction, to appear on the national agenda. Under the military regime, with predatory governance and constricted space for social groups to mobilize, the possibility for prioritization of these kinds of causes was minimal. In 1998 military dictator Sani Abacha died suddenly. General Adbdulsalami Abubakar succeeded him and facilitated a transition to democracy. Flawed but peaceful elections were held in

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late 1998 and early 1999, and in May 1999 Olusegun Obasanjo was sworn in as president.[21] Obasanjo was re-elected in 2003, marking the first time in Nigeria's four-decade history that a civilian government completed passage from one administration to another.[22] Under a democratic political system the government has faced increased pressure to be accountable to its constituents. One manifestation has been the creation of NEEDS - a poverty alleviation program that has developed into an over-arching national framework for social change - which explicitly lists maternal mortality reduction as an objective. Another indicator of accountability and responsiveness is the growing percentage of federal government recurrent expenditures being directed toward health, which in 1999 was 1.95 percent and by 2002 had risen to 5.84 percent.[23]

Second is the growing concern among civil society organizations for the problem of maternal mortality. SOGON now holds an annual conference in which safe motherhood receives prominence. In 2003, it received funding from the MacArthur Foundation to conduct training and advocacy in six states of the country. The Campaign for Unwanted Pregnancy and Ipas have spearheaded efforts to make the sensitive issue of safe abortion a subject of public discussion, and to improve the quality of post-abortion care in the country.[24,25] The Association for Reproductive and Family Health, the Planned Parenthood Federation of Nigeria and Pathfinder International Nigeria have worked throughout the decade to expand reproductive health services for Nigerian citizens. CEDPA has been organizing committees at the national and state levels for safe motherhood advocacy. The National Council of Women's Societies, the umbrella group for all women's groups in the country, has called for free maternal health services to all women of reproductive age and the reform of existing laws on abortion. The Nigerian Partnership for Safe Motherhood (NPSM) has been established to link organizations advocating for safe motherhood.

Third is the recent accumulation of credible evidence concerning the high level of maternal mortality and dismal state of maternal health facilities. It has long been known that maternal mortality in Nigeria is high; however, the Multiple Indicator Cluster Survey of 1999, noted above, provided reliable evidence confirming the persistence of the problem. Also, in 2003 with support from the United Nations Population Fund, officials in the Federal Ministry of Health produced a study on the alarming state of obstetric care facilities across the country,[26] presenting the results directly to the Minister of Health and publicizing results in a dissemination seminar. The World Health Organization's ranking of Nigeria's healthcare system performance as one of the worst in the world in 2000[27] also served to awaken health and other political officials, and was in part a spur for a major government health sector reform plan,[16] now being supported by a US$ 127 million World Bank loan[28] and African Development Bank and DFID assistance. That plan notes that Nigeria's maternal mortality levels are among the highest in the world and includes a specific commitment to maternal mortality reduction.

Fourth, over the past half decade commitment to the cause inside the Federal Ministry of Health has increased dramatically. The Ministry produced a national reproductive health policy in 2001[29] and a national reproductive health strategic framework in 2002 with specific maternal mortality reduction aims.[30] In 2001 the government convened a national meeting on the subject, and with UNICEF support produced national guidelines for women's health services.[31] A revision of the government's National Policy on Population for Sustainable Development in 2004 explicitly called for a reduction of the MMR to 75 by the year 2015.[32] Also, the Ministry established a multi-sectoral National Commission on Safe Motherhood. In 2004 for the first time the Ministry secured a budget for reproductive health with specific funding for safe motherhood. In 2005 the Federal Ministry of Health launched a birth preparedness plan. The present Minister of Health now publicly champions the cause. At the last few

meetings of the National Council of Health maternal mortality reduction has been high on the agenda, and at the forum state commissioners of health have adopted a zero tolerance policy on maternal mortality.

Fifth, the inclusion of maternal health in the Millennium Development Goals has contributed to prioritization of safe motherhood by the Nigerian state. In response to the international consensus, the government established a presidential commission on the achievement of the MDGs and established an MDG office within the Ministry of State. In 2005, supported by the World Health Organization the government adopted a roadmap to attain the maternal and child health MDGs.[33] In addition, the health sector reform program noted above invokes the MDGs as a basis for a commitment to maternal mortality reduction in Nigeria. Furthermore, donors providing funds to the Nigerian health sector, including DFID, the UN agencies and the World Bank, have geared financing and programs toward the achievement of this goal.

Sixth, an increase in available donor resources has also enhanced the possibility for maternal mortality reduction. DFID is funding PATHS, a seven-year project whose aim is to strengthen Nigerian health systems at the state level, and which has a focal concern on safe motherhood.[34] In addition, DFID is launching a £100 million project over five years to support the efforts of UN agencies in Nigeria in achieving the health MDGs, including the maternal mortality reduction objective.[35] In its most recent country strategic plan USAID has pledged more than $10 million to safe motherhood initiatives. The UN agencies – in particular the WHO, UNICEF and UNFPA – are supporting safe motherhood initiatives in Nigeria. The World Bank has approved several loans for governance and health sector reform that make financing available to state governments, some of which is being applied specifically toward achieving the MDGS and in particular maternal mortality reduction. Among the performance indicators for the national health sector reform loan is a decrease in the reported maternal mortality rate.[36] International

foundations, including the MacArthur and Packard Foundations, have supported NGOs and civil society leaders in maternal mortality reduction.

Seventh, champions for the cause recently have appeared in the National Assembly. The Chairwomen of the House and the Senate Committees on Women Affairs and Youth Development are leading efforts to generate bills on maternal mortality reduction and reproductive health. In August 2005 the House Chairwoman led a hearing at the National Assembly on maternal mortality and reproductive health that included representatives from a number of Nigerian civil society organizations, international donor representatives, foundations and Federal Ministry of Health officials. The group secured support for a bill, now being drafted, from the President of the Senate and the Speaker of the House.

The nascent state of political priority

While a window has opened, political priority for safe motherhood remains nascent. Three problems persist. First, the network of safe motherhood champions in government and civil society has yet to come together as a cohesive and powerful agent of change pushing the political and social systems to action. Second, the Nigerian government provides minimal financial resources for maternal mortality reduction. Third, with only a few exceptions state and local governments pay virtually no attention to the issue.

An informal network of individual champions for safe motherhood in government, NGOs and donor agencies exists. Attempts have been made to formalize connections. For instance, as noted above, at the initiative of Federal Ministry of Health a National Safe Motherhood Committee formed several years ago. However, the network remains a loose collection of individuals and organizations with a shared concern, rather than a potent, unified political force pushing the state to take action. Also, while tactical

documents do exist for safe motherhood advocacy at a national level, there is no evidence that the network functions with any over-arching strategy.

Another issue is the dearth of federal budgetary resources for maternal mortality reduction. While in 2004 for the first time the federal government provided a line item allocation for reproductive health, a portion of which was directed toward safe motherhood, the total amount for safe motherhood released is only around US $800,000, hardly enough to deal with a crisis of national scope. Also, safe motherhood faces competition for scarce health resources with other reproductive health causes, particularly HIV/AIDS. HIV/AIDS receives much greater funding and attention than safe motherhood from both the government and donors, and has a national government commission explicitly devoted to control of the disease. Despite the high burden of maternal mortality and morbidity, safe motherhood has no equivalent body. The availability of HIV/AIDS funding and the establishment of the commission may be influencing lower levels of government and NGOs to concentrate limited resources on this cause, crowding out attention to other reproductive health problems including safe motherhood.

A third issue concerns the position of sub-national governments and social institutions. Generating meaningful political priority for safe motherhood in Nigeria is dependent upon gaining the active support of state and local level political, social and religious leaders. In unitary political systems such as China's and Vietnam's where regional governments are legally subordinate to the national government, sub-national level support follows more easily from national level priority because central government officials may have the political, financial and legal authority to shape the policy priorities of regional governments. In Nigeria, however, the federalized nature of the political system circumscribes the power of the national government. Federal level officials can only encourage and provide incentives; they cannot commandeer. The complex, under-

funded and institutionally weak nature of the Nigerian healthcare system, where federal, state and local officials all share authority for healthcare and responsibilities are overlapping and poorly defined, makes policy coordination all the more difficult in the country.

Circumscribed federal power is one reason that despite the commitment of officials in the Federal Ministry of Health to maternal mortality reduction, priority for this cause is minimal among Nigeria's 36 state and 774 local governments. Few governors, or even state commissioners of health, place safe motherhood at or near the top of their policy agendas, and virtually no local government heads do. Another reason for this situation is that they face minimal political costs if they ignore the issue. Governors are not held accountable for high levels of maternal deaths in their states, and are rarely pressed to pay attention to the issue by the publics they are elected to serve. Even in those states where they have been pushed by social advocates to prioritize safe motherhood, they prefer to devote public budgets to causes that are politically more visible, such as building roads.

A few exceptions to this lack of state level attention do exist, however. In each case policy priority was initiated by a state commissioner of health who actively championed the cause, gaining the governor's commitment and taking the case for safe motherhood to other officials in state and local government and the state assembly. In Anambra the state house of assembly approved a bill in 2005 guaranteeing free maternal health services to pregnant women.[37] The state commissioner of health, who is an obstetrician-gynecologist and SOGON member, played a central role in its development and adoption, testifying in the state assembly and eventually securing passage of the bill. In Kano, a heavily Islamic state in the north governed by shariah law and with a population suspicious of reproductive health initiatives, the state government includes in its budget a line item for free maternal health services. The former state commissioner of

health along with a senior obstetrician-gynecologist, also a SOGON member, played central roles in creating this positive environment for maternal health. In Jigawa, state and local budgets have provided funds for the upgrading of obstetric care facilities in hospitals, the recruitment of obstetricians-gynecologists and the provision of ambulances at the local level to transport pregnant women experiencing delivery complications to health facilities. The former executive secretary for primary healthcare, who subsequently became state commissioner for health, stood behind these initiatives. Priority for safe motherhood in Jigawa received a further boost when the DFID-funded PATHS program supported maternal mortality reduction in the state as part of a wider health sector reform program.

Challenges in Nigeria

Advocates face many challenges in institutionalizing political priority for safe motherhood in Nigeria, but three are key: bringing about coalescence of the existing network of champions; developing strategies to increase federal budgetary resources; and promoting attention for the cause at state and local government levels.

The first challenge is to transform the existing network of champions into a potent political force. The network has many capable individual members, but remains loose, has no over-arching strategy and does not act in unison. Network members have numerous responsibilities within their own organizations, and these organizations themselves have multiple mandates, making it difficult to bring about this coalescence. Developing a unified community and common political strategy for safe motherhood promotion in the country is possible but would be a time and resource intensive task, and would require a leader or set of leaders to appear, backed by a supportive organizational structure. The effort to generate a national bill on reproductive health, led by the House Chairwoman for Women Affairs and Youth Development, has brought some Nigerian

safe motherhood champions together in a common undertaking. This initiative may be a spark that leads to coalescence of this community, but this remains to be seen.

The second challenge is to generate significant federal budgetary resources for the cause. The minimal amount the national government has devoted to the cause raises questions about the meaningfulness of its commitment. HIV/AIDS has begun to attract significant federal resources, so it is by no means impossible for other health causes including maternal mortality reduction to be funded. These budgetary circumstances for safe motherhood may improve as the federal government, in accordance with NEEDS and in response to national legislative and international pressure to achieve the maternal mortality reduction aims of the Millennium Development Goals, may augment funding for the cause. The key to actualization of this possibility will be pressure on the federal government from the community of safe motherhood advocates. This speaks back to the first challenge: to bring about the coalescence of the network of safe motherhood promoters into a tighter political force, speaking with a unified message and placing pressure on the state to act.

The third challenge is to generate meaningful political priority in state and local governments. With only a few exceptions priority at these levels is minimal. This challenge has several components. First is generating reliable information on the scope of the problem so that officials come to understand a problem exists. There is sufficient national level information to confirm a country-wide maternal mortality crisis. Reliable local and state level data are scarce, thereby making it plausible for sub-national officials to deny they have a problem or to argue that other priorities are more pressing. Investing in more local studies to document the state of maternal healthcare facilities and the size of local maternal mortality problems would not only have informational value; it would also serve as a tool for political advocacy. Second is re-orienting the political calculus of these officials, recognizing that they operate as much from political self-interest as from a

desire to promote social welfare. Many see little political value in making safe motherhood a policy priority, preferring to devote resources to other causes that they understand to be more visible and that they therefore perceive will generate greater political capital for themselves. The challenge for safe motherhood advocates is to frame the issue in such a way as to convince governors and other elected officials that they can gain political support by acting on the problem and that they will lose political support by ignoring it. Third is encouraging the diffusion of policy attention among state level officials themselves. In some countries, political priority for safe motherhood has emerged primarily through top-down mechanisms as national political leaders have pushed subordinates to prioritize the cause.[3] In other countries priority has emerged primarily from bottom-up as civil society organizations, particularly public health communities, have pressed governments to act.[38] The dynamic of safe motherhood priority generation in Anambra, Kano and Jigawa states suggests yet another possibility, complementary to both: horizontal diffusion. State commissioners for health and other state-level policy champions in government and civil society could influence one another by sharing ideas about their initiatives. The federalized nature of the Nigerian political system that limits the possibility for top-down priority generation makes horizontal diffusion a particularly critical strategy.

INDIA

Studies consistently find a national maternal mortality ratio for India between 400 and 600 deaths per 100,000 live births, lower than Nigerian figures but given the country's population size making India the largest contributor globally to maternal deaths in childbirth. The Indian National Family Health Survey estimated a maternal mortality ratio of 540 for the period 1998 to 1999, with a rural figure of 619 and an urban figure of 267.[39] These numbers were higher than those reported in the 1992-93 National Family

Health Survey, which found an MMR of 437,[40] although one cannot infer a rise in levels given wide confidence intervals for these estimates. As in Nigeria, there are large variations across states. The 1998 MMR estimate from the Registrar General of India for Tamil Nadu, for instance, was 79, while that for Uttar Pradesh 707.[41] National statistics indicate that the leading biomedical causes of maternal death are hemorrhaging (29.6%), anemia (19.0%) and sepsis (16.1%).[42] The 1998-99 survey indicated low use of maternal health services: 65.4% of Indian women deliver at home, and only 42.3% deliver in the presence of medically-skilled attendants.

National policy papers have included formal commitments to maternal mortality reduction for nearly a quarter century. As Mavalankar has noted, in 1983 the Government of India made a pledge to attempt to reduce the maternal mortality ratio to below 200 by the year 2000. [43] Maternal mortality reduction commitments were reiterated in a 1992 Child Survival and Safe Motherhood Program[44]; a 1996 Reproductive and Child Health Program[45]; a 2000 National Population Policy[46]; a 2003 National Health Policy[47]; the Tenth Five Year Plan covering 2002 to 2007[48]; a second phase of the Reproductive and Child Health Program launched in 2005[49]; and most recently, a National Rural Health Mission established by the Congress Party-led government.[50]

The problem has been in carrying out these plans. Competing health priorities, a weak national health infrastructure and a federal system that permits states to disregard these pledges have precluded effective action. As one respondent notes: "There are lovely documents with the best intellectual inputs, then it goes to this mysterious place to be implemented."

In 1946, prior to independence, a commission established a plan for a national primary healthcare system, focusing on maternal and child health and creating a cadre of MCH workers. From the beginning, these workers emphasized the health of children rather than mothers. Maternal health work was further diluted in 1966 when the

government established a vertical family planning program and introduced population control targets, creating incentives for MCH workers to focus primarily on contraceptive use promotion.[51] In the 1980s these workers took on additional roles, promoting immunization and polio eradication. Amidst these multiple population control and child health priorities, maternal health promotion took a back seat.

The 1992 Child Survival and Safe Motherhood program (CSSM) was the first national government effort to back a maternal mortality reduction commitment with substantial financing.[52] The government provided US\$ 495.8 million for the CSSM, while the World Bank contributed an additional \$214.5 million and UNICEF \$67.8 million.[53] Roughly half of these contributions were to go to safe motherhood. The program's core strategy for maternal health was the establishment of first referral units at the community level where mothers could receive comprehensive obstetric care.

Program evaluations concluded that the CSSM's contributions to safe motherhood were minimal. The World Bank's 1997 implementation completion report noted that only approximately 600 of 1700 planned first referral units were functional.[54] A 1999 study of 760 of these units indicated that only 48% had an obstetrician-gynecologist and only 22% an anesthesiologist.[55] There was a rise from 1992-93 to 1998-99 in the percentage of women delivering in health facilities, but this was due to an increase in private facility use and cannot be attributed to the CSSM.[56]

Following CSSM the government carried out another national reproductive health initiative, the Reproductive and Child Health Program (RCH I), begun in 1997, which had a planned budget of \$1.2 billion of which \$309 was to come from the World Bank and \$250 million from the European Commission.[57] RCH I continued efforts to upgrade first referral units, but evaluations of the program indicate limited success in this regard. A second phase (RCH II) has just been initiated that includes a scheme to stimulate demand for institutional deliveries by providing women below poverty line with financial

assistance for costs including transport and caesarean sections.[58] The planning of RCH II involved far greater consultation and coordination among the Government of India and donors, and with state governments, many of which have produced their own implementation plans. Most recently, with the return to power of a Congress Party-led government, a new national program with a primary healthcare emphasis is being launched, the National Rural Health Mission (NRHM). Seeking to raise national funding for health from 0.9% of GDP to two to three percent, it may encompass RCH II and introduce a new initiative – rural voluntary female community workers called ASHAs (accredited social health activists) who will receive financial incentives for taking women to deliver at health facilities.[59] In 2005, approximately 100,000 were trained. Recently, the Mission and its maternal mortality reduction aims received support when New Delhi hosted the 2005 World Health Day, whose theme was maternal and child health. Prime Minister Manmohan Singh met with leaders of several UN agencies and spoke about maternal mortality specifically. Later in the year he commented publicly about India's 'atrociously high infant mortality rate and maternal mortality rate,'[60] a comment that contributed to the decision to hold National Planning Commission health division meetings in October of this year on high maternal and child mortality.

Even with these multiple national initiatives over the past decade, all the major implementation bottlenecks remain, including lack of skilled medical personnel at facilities; difficulties in keeping doctors – particularly specialists – at post; weak blood supplies; pressure on health workers to emphasize health goals other than maternal mortality reduction – particularly family planning and immunization; the ability of states to ignore national priorities given the country's federalized political structure and the fact that the national government provides only a small percentage of total public funds for health; and ongoing preferences by Indian women to deliver at home in the absence of skilled attendants.

IMPLICATIONS FOR OTHER HIGH MATERNAL MORTALITY COUNTRIES

The Nigerian and Indian cases suggest several points concerning the generation of political priority for safe motherhood in other high maternal mortality countries.

Translating network moral authority into political influence

National safe motherhood policy communities - networks of advocates in government, civil society, academia and donor organizations concerned with reducing maternal mortality - possess moral authority that potentially can be translated into political influence. This moral authority derives from network involvement in a problem of a humanitarian nature, and network expertise on solutions. The extent to which this moral authority will translate into political influence will, to some degree, depend on the initiative and creativity of members of the community itself. Networks that lack leadership, are fragmented, and do not position safe motherhood in a way that appeals to the interests of political leaders, may fail to leverage this authority. Networks that develop effective leadership, create institutional structures that allow members to work in unison, and frame the cause in a politically strategic way may find that they have the power to move national leaders to act.

Securing adequate national budgetary appropriations

Bilateral and multilateral donors are increasingly willing to fund safe motherhood, particularly since maternal mortality reduction has made it on to the MDG agenda. Such funding is essential for resource-strapped health systems in poor countries. However, it also carries the danger that national governments in developing countries will perceive safe motherhood to have adequate international funding and fail to appropriate domestic budgetary resources for the cause. National appropriations, not donor funds, leadership pronouncements or policy documents, are the primary indicator of meaningful domestic

priority for the cause. One of the core challenges for national safe motherhood policy communities is to press their political leaders to appropriate and release public budgets for safe motherhood that are commensurate in size with the severity of the maternal mortality crises in their countries, just as has occurred in a number of countries for other health causes, such as HIV/AIDS prevention and control.

Generating sub-national as well as national political support

Safe motherhood policy communities must do more than convince national political leaders to act. They must also persuade sub-national leaders – governors, chief ministers and others – that this is a cause worthy of attention and resources. In federal political systems such as Nigeria's and India's, sub-national attention is particularly critical since the authority of national over sub-national governments is legally circumscribed. Even in unitary political systems such as China's, where sub-national governments derive their authority from and are legally subordinate to national governments, sub-national attention does not follow immediately from national priority. Political scientists have long recognized that national leaders in developing countries frequently are unable to exert power over lower level governments, even where they have legally-derived authority.[61,62] This struggle is particularly acute in the world's poorest states, precisely where maternal mortality is highest. Safe motherhood advocates must therefore develop sub-national as well as national political strategies.

Surmounting implementation barriers

Reducing maternal mortality is an implementation problem, and implementation, like agenda-setting, a political challenge. The political problems of prioritizing safe motherhood are not solved once international actors have approved pronouncements such as the MDG maternal mortality reduction goals, donors have backed these commitments

with funding, national governments have articulated maternal mortality reduction goals, and national legislators have appropriated and released the funds to pursue these goals. Governors, chief ministers and state health secretaries must still mobilize their bureaucracies to act. Corruption and the misappropriation of these resources must be addressed. Health workers must be given incentives to carry out their maternal health tasks. Doctors must stay in their rural posts. All of these are examples of politically-influenced implementation challenges that safe motherhood policy-makers and advocates must address to reduce maternal mortality.

Identifying safe motherhood as a political as well as a medical challenge

Perhaps the fundamental point for scholarship is that safe motherhood researchers have focused more on the medical and technical dimensions of the problem – such as which obstetric care interventions are most effective – than its political dimensions. Maternal mortality reduction is as much a national political as a technical/medical challenge. Even if researchers identify effective interventions, there is no guarantee political leaders will pay any attention. Maternal mortality is one among thousands of issues such leaders confront each year, and they have scarce resources to deal with the many problems they face. Maternal mortality reduction will become their priority only if safe motherhood advocates develop and carry out effective national and sub-national political initiatives to convince these leaders of the worthiness of the cause. The future of maternal mortality reduction in nation-states such as Nigeria and India depend upon more than the articulation of global commitments such as the MDGs and the provision of donor resources: this objective requires the development and implementation of national and sub-national political strategies.

Acknowledgements

References

[1] World Health Organization, UNICEF. *Revised 1990 Estimates of Maternal Mortality: A New Approach by WHO and UNICEF*. Geneva: WHO and UNICEF, 1996.

[2] AbouZahr C. Safe motherhood: a brief history of the global movement 1947-2002. *Br Med Bull* 2003; **67**:13-25.

[3] Shiffman J. Generating political will for safe motherhood in Indonesia. *Soc Sci Med* 2003; **56**:1197-1207.

[4] Shiffman J, Stanton C, Salazar AP. The emergence of political priority for safe motherhood in Honduras. *Health Policy Plan* 2004; **19**:380-390.

[5] Adamu YM, Salihu HM, Sathiakumar N, Alexander GR. Maternal mortality in northern Nigeria: a population-based study. *Eur J Obstet Gynecol Reprod Biol* 2003; **109**:153-159.

[6] Roberts H. Reproductive health struggles in Nigeria. *Lancet* 2003; **361**:1966.

[7] Adamu et al., 2003.

[8] WHO, UNICEF, UNFPA. *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA.* Geneva: World Health Organization, 2005.

[9] Shiffman J, Ved R. The state of political priority for maternal mortality reduction in India. Working paper, 2006.

[10] Shiffman J, Okonofua F. The state of political priority for safe motherhood in Nigeria. Working paper, 2005.

[11] Yin R. *Case Study Research: Design and Methods* (2nd ed.). Thousand Oaks, California: Sage, 1994.

[12] Federal Office of Statistics (FOS), United Nations Children Fund (UNICEF). *Multiple Indicator Cluster Survey 1999.* Lagos, Nigeria: FOS and UNICEF, 2000.

[13] National Planning Commission (NPLC), UNICEF. *Child Survival, Protection and Development in Nigeria: Key Social Statistics*. Abuja, Nigeria: NPLC and UNICEF, 1998. As reported in Fatusi A. *Maternal Mortality Situation and Determinants in Nigeria. A Review Commissioned by Federal Ministry of Health.* Abuja, Nigeria: Federal Ministry of Health, 2004.

[14] Fatusi A, Ijadunola K. *National Study on Essential Obstetric Care Facilities in Nigeria*. Abuja, Nigeria: Federal Ministry of Health and UNFPA, Nigeria, 2003.

[15] National Population Commission [Nigeria]. *Nigeria Demographic and Health Survey 2003*. Abuja, Nigeria: National Population Commission, Federal Republic of Nigeria and MEASURE DHS+ ORC Macro, 2004.

[16] National Population Commission [Nigeria]. *Nigeria Demographic and Health Survey 1999*. Calverton, Maryland: National Population Commission and ORC/Macro, 2000.

[17] Federal Ministry of Health. *Health Sector Reform Program, 2004-2007*. Abuja, Nigeria: Federal Ministry of Health, 2004.

[18] World Health Organization. *World Health Report 2000 – Health Systems: Improving Performance*. Geneva, Switzerland: World Health Organization, 2000.

[19] World Health Organization. World Health Organization health statistics for 2002. World Health Organization. 2002. Available: http://www3.who.int/statistics (Accessed 20 December 2005).

[20] Harrison KA. Childbearing, health and social priorities: a survey of 22,774 consecutive hospital births in Zaria, northern Nigeria. *Br J Obstet Gynaecol* 1985; **92 (suppl. 5)**:3-13

[21] Lewis PM. Nigeria: elections in a fragile regime. *J Democr* 2003; **14**:131-144.

[22] Lewis PM, 2003.

[23] Nigerian Central Bank. *Nigerian Central Bank Annual Report Statement of Accounts*. Abuja, Nigeria: Nigerian Central Bank, 2004.

[24] Oye-Adeniran B, Long C, Adewole I. Advocacy for the reform of the abortion law in Nigeria. *Reprod Health Matter* 2004; **12**:209-217.

[25] Ipas. Ipas Nigeria Country Report. Available: htttp://www.ipas.org (Accessed 15 July 2005).

[26] Fatusi A, Ijadunola K. *National Study on Essential Obstetric Care Facilities in Nigeria*. Abuja, Nigeria: Federal Ministry of Health and UNFPA, Nigeria, 2003.

[27] World Health Organization. *World Health Report 2000 – Health Systems: Improving Performance*. Geneva, Switzerland: World Health Organization, 2000.

[28] World Bank. *Health Systems Development Project II.* Washington, DC: World Bank, 2002.

[29] Federal Ministry of Health. *National Reproductive Health Policy and Strategy*. Abuja, Nigeria: Federal Ministry of Health, 2001.

[30] Federal Ministry of Health. *Nigeria National Reproductive Health Strategic Framework and Plan, 2002-2006*. Abuja, Nigeria: Federal Ministry of Health, 2002.

[31] Federal Ministry of Health, UNICEF. *Women and Children Friendly Health Services Initiative in Nigeria: National Guidelines*. Abuja, Nigeria: Federal Ministry of Health and UNICEF.

[32] Federal Government of Nigeria. *National Policy on Population for Sustainable Development*. Abuja, Nigeria: Federal Government of Nigeria, 2004.

[33] World Health Organization. *Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Africa*. World Health Organization, 2005.

[34] Duby F. *Resource Materials for Better Health: Round Table Report Safe Motherhood, Report on Conference in Cross Rivers State*. PATHS and DFID, 2004.

[35] DFID. *Project Concept Note: Strengthened UN Programme in Support of Health MGDs, Nigeria*. DFID, 2005.

[36] World Bank. *Health Systems Development Project II*. Washington, DC: World Bank, 2002.

[37] Anambra State of Nigeria. *Law/2005/04: A Law to Confer certain Reproductive Rights on Women and to Provide for Related Matters*. Enacted by the Anambra State House of Assembly on March 17, 2005.

[38] De Brouwere V, Tonlet R, Van Lerberghe W. Strategies for reducing maternal mortality in developing countries: What can we learn from the history of the industrialized West? *Trop Med Int Health* 1998; **3**:771-782.

[39] International Institute of Population Services. *National Family Health Survey (NFHS-2) 1998-99.* Bombay: International Institute of Population Services, 2000.

[40] International Institute of Population Services. *National Family Health Survey 1992-93* Bombay: International Institute of Population Services, 1995.

[41] Registrar General of India. *Sample Registration Bulletin* (33:1 April 2000) New Delhi: Office of the Registrar General. As reported in Mavalankar D. "State of Maternal Health," in Dadhich JP, P Vinod, eds. *State of India's Newborns Report.* New Delhi: National Neonatology Forum and Saving New Born Lives – Save the Children, 2005.

[42] Registrar General of India. *Sample Registration Bulletin* (33:1 April 1999) New Delhi: Office of the Registrar General. As reported in Mavalankar D. "State of Maternal

Health," in Dadhich JP, P Vinod, eds. *State of India's Newborns Report.* New Delhi: National Neonatology Forum and Saving New Born Lives – Save the Children, 2005.

[43] Government of India, Ministry of Health and Family Welfare. National Health Policy 1983. As reported in Mavalankar D. "State of Maternal Health," in Dadhich JP, P Vinod, eds. *State of India's Newborns Report.* New Delhi: National Neonatology Forum and Saving New Born Lives – Save the Children, 2005.

[44] World Bank. *Implementation Completion Report: Child Survival and Safe Motherhood Project.* World Bank, 1997.

[45] Government of India. *Reproductive and Child Health Programme: Implementation Issues.* New Delhi: Department of Family Welfare, Ministry of Health and Family Welfare, 1998.

[46] Government of India, National Commission on Population. *National Population Policy 2000.*

[47] Government of India, Ministry of Health and Family Welfare. *National Health Policy 2002.*

[48] Government of India, Planning Commission. *Tenth Five Year Plan (2002-2007), Vol. II, Chapter 2.*

[49] Government of India, Ministry of Health and Family Welfare, *RCH II, Programme Implementation Plan,* Ministry of Health and Family Welfare, 2005

[50] Government of India, Department of Family Welfare, Ministry of Health and Family Welfare, *National Rural Healthcare Mission,* 2005.

[51] Mavalankar, *State of Maternal Health.*

[52] World Bank. *Implementation Completion Report: Child Survival and Safe Motherhood Project.* World Bank, 1997.

[53] World Bank. *Implementation Completion Report.*

[54] World Bank. *Implementation Completion Report.*

[55] International Institute of Population Sciences. *Facility Survey (under Reproductive Health and Child Project) Phase I.* Mumbai: IIPS, 2001, as reported in Mavalankar, *State of Maternal Health Services.*

[56] Mavalankar, *State of Maternal Health.*

[57] Government of India. *Reproductive and Child Health Programme.* New Delhi: Department of Family Welfare, Ministry of Health and Family Welfare. As reported in Mavalankar, *State of Maternal Health.*

[58] Government of India. *RCH II Document 2, The Principles and Evidence Base for State RCH II Programme Implementation Plans (PIPs).* New Delhi: Government of India, 2005.

[59] Government of India, Department of Family Welfare, Ministry of Health and Family Welfare, *National Rural Healthcare Mission*, 2005.

[60] *Times of India*, October 1, 2005.

[61] Migdal JS, Kohli A, Shue V, editors. *State Power and Social Forces: Domination and Transformation in the Third World*. Cambridge, England: Cambridge University Press, 1994.

[62] Zartman W, editor. *Collapsed States: The Disintegration and Restoration of Legitimate Authority*. Boulder: Lynne Rienner, 1995.