

Generating political priority for public health causes in developing countries: Implications from a study on maternal mortality

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Why do some serious health issues—such as HIV/AIDS—get considerable attention and others—such as malaria and collapsing health systems—get very little? Why and under what conditions do political leaders consider an issue worthy of sustained attention, and back up that attention with money and other resources? In this CGD Brief, visiting fellow Jeremy Shiffman, an associate professor of public administration at the Maxwell School of Syracuse University, discusses nine factors that influenced the degree to which national leaders in five countries made one public health issue—maternal mortality—a political priority.¹ Pregnancy-related complications are the leading cause of mortality globally among adult women of reproductive age, with more than half a million deaths annually.² But in some countries maternal health has become a priority and maternal deaths have fallen, while in other countries this has not yet occurred. Drawing on his comparison of these countries, Shiffman offers recommendations for public health priority-setting in developing countries.³ His bottom line: attaining public health goals is as much a political as it is a medical or technical challenge; success requires not only appropriate technical interventions but also effective political strategies.

Factors that shaped political priority in five countries

Development communities in rich and poor countries have long been concerned about the minimal attention many political leaders in developing countries give to serious public health problems. Developing country officials often have different priorities than international actors, and efforts to make their priorities converge are complicated by the fact that there is little systematic research on what sparks political priority in the first place.

For different reasons Guatemala, Honduras, India, Indonesia and Nigeria have attracted considerable attention from researchers concerned with maternal mortality reduction.

Honduras is one of only a handful of developing countries to have experienced a documented significant decline in maternal mortality since the advent of the Global Safe Motherhood Initiative launched in 1987.⁴ Its Central American neighbor, Guatemala, provides an interesting contrast; though it is wealthier than Honduras and has received significant assistance from donors for safe motherhood initiatives, it still has a higher maternal mortality ratio (number of maternal deaths per 100,000 live births—the most commonly used maternal mortality indicator). Indonesia has been the focus of extensive safe motherhood research because of its long-standing problem with maternal mortality and a unique initiative begun in 1989 to place midwives in each of its more than 60,000 villages to address this problem. India and Nigeria rank first and second globally in numbers of maternal deaths annually, together contributing approximately one-third of the international total.²

What is political priority?

Political scientists have long been concerned with how political agendas are set by policymakers. We know priority is present when:

- National political leaders publicly and privately express sustained concern for the issue;
- The government, through an authoritative decision-making process, enacts policies that offer widely embraced strategies to address the problem; and
- The government allocates and releases public budgets commensurate with the problem's gravity.

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Levels of political priority for maternal mortality reduction vary: in Honduras political priority was very high, in Indonesia high, in India moderate (with a recent rise) and in Guatemala and Nigeria low.

Nine factors shaped the degree to which maternal mortality reduction emerged on the national policy agendas of these countries (Table 1). These may be divided into three broad categories: transnational influence, domestic advocacy and national political environment (see Figure 1).

TRANSNATIONAL INFLUENCE

A group of international advocates and organizations were the first to put maternal mortality reduction on the global agenda. To influence national political systems to embrace the cause they:

Promoted global norms Advocates promoted a global norm that death from pregnancy-related complications was unacceptable, and they pushed governments to embrace this norm. An international meeting in 1987 in Nairobi, Kenya had significant norm-shaping power. This gathering launched the Global Safe Motherhood Initiative that aimed to lower maternal deaths by at least half by the year 2000, and contributed to the initiation of national campaigns in each of the five countries.

Provided resources International actors backed up these efforts with the provision of financial and technical resources. Donors, including the World Bank, the United States Agency for International Development (USAID), the United Nations Population Fund and the World Health Organization (WHO), provided each of the five countries with significant financing and technical assistance for maternal mortality reduction.

DOMESTIC ADVOCACY

While international actors put the issue on the global agenda, they could not institutionalize the cause in the political systems of the countries by themselves. National adoption and sustainability required domestic advocacy. Five factors in this category shaped political priority:

Unity among advocates The degree of cohesion among national policy communities was a critical factor in their success. Maternal mortality policy communities formed in each of these five countries, grouping ministry of health doctors, parliamentarians, obstetrician-gynecologists, health-focused nationals employed by donor agencies, and other individuals and groups. The level of unity among advocates directly affected the success of their agenda: in Indonesia and Honduras these networks coalesced, pushing their governments to act. In Nigeria and Guatemala networks struggled to come together and had limited agenda-setting influence.

Political champions The success of the maternal mortality campaign also depended on the existence of public health leaders willing to make the cause a personal priority. In Indonesia Dr. Abdullah Cholil, the assistant minister of women's roles, considered to be among the most effective leaders in the social development sector of the Indonesian bureaucracy, developed the idea of a national campaign to raise attention to the plight of pregnant women. He single-handedly convinced President Suharto to take a direct role in the campaign and generated additional budgetary appropriations for maternal mortality reduction. In contrast, in Guatemala, India and Nigeria, while a number of capable individuals in government and civil society have promoted safe motherhood, no individual has emerged as a recognized leader of the safe motherhood policy community,

nor has anyone played the political mobilization role that Cholil did in Indonesia.

Evidence The availability of clear indicators to demonstrate the existence of a problem was vital to gaining support. In Guatemala and Honduras studies revealing far higher maternal mortality levels than expected helped spark national efforts to address the issue. In Indonesia the decision of Cholil to launch a campaign was a direct result of his alarm over a high maternal mortality ratio reported in the 1994 Indonesian Demographic and Health Survey. At local government levels in Nigeria, where no indicators were available, leaders were able to ignore the issue, claiming that no one had presented them any evidence that a problem existed.

Focusing event The organization of large-scale focusing events brought visibility to the issue, and shaped safe motherhood promotion in all five countries. The Nairobi conference was the first example of such an event. Soon after, in 1988, Indonesia's first national seminar on safe motherhood was held, with President Suharto delivering the keynote address. In 1990, after the Nairobi conference, Nigerian attendees organized a national safe motherhood conference, convened by the Society for Obstetrics and Gynecology of Nigeria. A formal Central American launch of the international safe motherhood initiative was held in Guatemala City in 1992 and attended by Honduran and Guatemalan delegates. In 2000, the White Ribbon Alliance of India, a grouping of organizations promoting safe motherhood in the country, organized a march led by a parliamentarian (who was also a movie star) to the Taj Mahal—a monument built to commemorate the death of an emperor's wife in childbirth. The event generated national media coverage on the country's high levels of maternal death.

Practical policy solutions Another key to success were clear policy alternatives, proposals that policymakers could understand and that convinced them that something could be done. In Indonesia, Ministry of Health doctors carried out a program to place one midwife in nearly all of Indonesia's 68,000 villages to ensure women had access to effective pregnancy care. The village midwife proposal was the lynchpin in convincing President Suharto to prioritize the issue. But globally, the safe motherhood movement lost momentum in the 1990s as a result of internal disagreements on intervention strategies (although recently these disagreements are being transcended). Advocates were also criticized for lacking evidence to back up their proposed interventions and for their use of unclear terminology surrounding interventions.⁵ These difficulties may have resulted in reduced leverage to convince policymakers to prioritize the cause.

NATIONAL POLITICAL ENVIRONMENT

National political and social environments shaped the efforts of international and domestic advocates. Many factors were influential, including the low value placed on women's lives and endemic corruption. Two, however, were particularly critical:

Political transitions altered public priorities by giving new actors agenda-setting power. In 1999 Nigeria experienced a transition to a semi-democratic political system after decades of military-authoritarian rule. This transition created the political space for reproductive health advocates to mobilize to press the government to take action on maternal mortality. Under the previous system the government faced no such pressure and largely ignored the issue. In Indonesia public sector decentralization may have hurt safe motherhood. Indonesian political champions

had convinced Suharto to prioritize safe motherhood, and he used the authoritarian political infrastructure to push sub-national governments to prioritize the issue. In 1998 Suharto fell from power and the country democratized, and in 1999 political and financial power was decentralized to district governments. As a result, the capacity of the central government, including the Ministry of Health, to command district governments to implement its priorities weakened substantially.

Competing health priorities also influenced policy attention. In India, until recently maternal mortality reduction took a back seat to population control, child mortality reduction and polio eradication. Only in India's most recent national health programs has maternal mortality reduction received prominence alongside these other health goals. Nigeria has faced a similar problem with respect to HIV/AIDS. This cause has become a funding priority for donors. Attention to maternal mortality and other reproductive health causes have suffered as NGOs pursue AIDS money and local governments receive signals from the center to prioritize this health cause over others that are just as serious.

These nine factors bear a striking similarity to the elements of success that Ruth Levine and the What Works Working Group identified in *Millions Saved: Proven Successes in Global Health*.⁶ The initial report identified 17 sustained, large-scale successful health interventions (recently expanded in an updated edition to 21 cases). Examples include smallpox eradication, HIV/AIDS prevention in Thailand and tuberculosis control in China. Although the study uses slightly different terminology, it also points to the influence of six of the nine factors identified here: resource provision, policy community cohesion, political champions, credible indicators, focusing events and clear policy alternatives.

The What Works Working Group also identified factors not mentioned in this study, including the existence of effective systems to deliver technology at an affordable price; NGO pressure; community participation; and good management on the ground. They did not emphasize three factors from this study: norm promotion, political transitions and competing health priorities. The similarities between the two studies are more striking than the differences. The differences that do exist are most likely due to divergences in case selection, and to different outcomes of interest. The Working Group was interested in explaining demonstrated public health impact; the maternal mortality study focused on the narrower subject of political priority generation—itsself one among several determinants of public health impact.

Figure 1. A broad look at factors that shape political priority

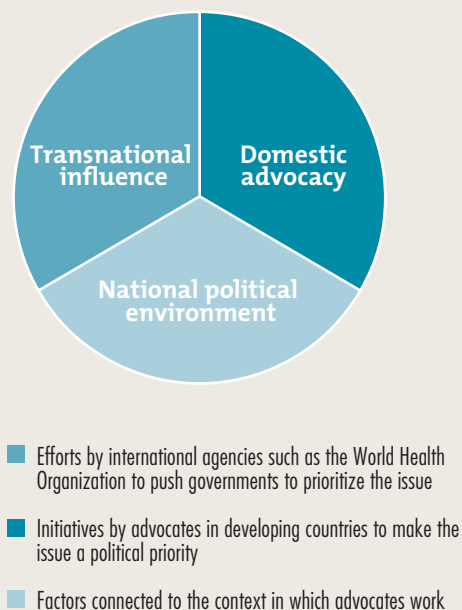


Table 1. Factors influencing the degree to which maternal mortality reduction appeared on national policy agendas

FACTOR	CATEGORY	DESCRIPTION	POSITIVE OR NEGATIVE INFLUENCE?
Norm promotion	Transnational influence	Efforts by international agencies to establish a global norm that maternal death is unacceptable	+
Resource provision	Transnational influence	Provision of financial and technical resources by international agencies to address maternal mortality	+
Policy community cohesion	Domestic advocacy	The degree to which national safe motherhood advocates coalesced as a political force pushing the government to act	+
Political champions	Domestic advocacy	The presence of respected and capable national political champions willing to promote the cause	+
Credible indicators	Domestic advocacy	The availability and strategic deployment of evidence to demonstrate the presence of a maternal mortality problem	+
Focusing events	Domestic advocacy	The organization of forums to generate national attention for the cause	+
Clear policy solutions	Domestic advocacy	The availability of clear policy solutions to demonstrate to political leaders that the problem is surmountable	+
Political transitions	National political environment	Political changes, such as democratization, that positively or adversely affected prospects for safe motherhood promotion	+ or -
Competing health priorities	National political environment	Priority for other health causes that diverted policymaker attention away from maternal mortality reduction	-

Generating Political Priority

What can development communities do to achieve national health objectives? While each country context is different, there are systematic features to the agenda-setting process that increase the likelihood national advocates will be effective in moving political elites to action.

National health advocates are more likely to be effective if they:

- **Unify:** Coalesce into unified policy communities, using their political power to press national leaders to act
- **Find a leader:** Bring into their communities respected political champions with track records in placing public health issues on national agendas
- **Have evidence:** Develop credible indicators and deploy these strategically so that political leaders become aware of the problem and cannot plausibly deny its existence
- **Organize a big event:** Convene large-scale focusing events such as national forums to generate widespread attention to the issue
- **Present practical solutions:** Present leaders with clear policy solutions proven to be effective so that they come to believe the problem can be surmounted
- **Understand country context:** Understand the distinct characteristics of their political environments and use an intuitive understanding of agenda-setting mechanisms to develop political strategies appropriate to the national context

Conclusion: Know your limits

Development communities from rich countries can influence health priorities in poor countries, but must reflect upon the extent to which they should exercise that power, and also understand its limits. At the global level they have the capacity to shape norms through support of international conferences and other activities, and at the national level, to facilitate priority through the provision of resources and technical assistance. Often, though, they seek to impose their priorities upon developing countries without considering local interests and the considerable national political maneuvering that must take place in order to institutionalize a health cause as a domestic priority. It is rare that overseas donor or health network officials have the legitimacy or expertise to pursue such political maneuvering successfully. That capability, if it exists, almost always resides in the hands of domestic bureaucrats and political officials.

It must also be remembered that international donor prioritization and resources, and effective medical and technical interventions, while critical, are far from sufficient for achieving health objectives. Attaining public health goals is as much a national political as it is a medical or technical challenge. Policy communities in settings with significant public health problems need to develop careful political strategies to ensure that their national leaders give these issues the attention and resources they deserve.

Endnotes

1. This research is the result of a collaboration with public health researchers in Guatemala, Honduras, India, Indonesia, and Nigeria. We interviewed a total of 124 persons in these countries, including ministers of health, parliamentarians, donor officials and NGO heads. We also reviewed several hundred government, donor and NGO documents.
2. UNICEF, UNFPA, WHO. *Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA*. Geneva: WHO, 2004.
3. Complete research results are reported in Shiffman J. *Generating political priority for maternal mortality reduction in 5 developing countries*. *Am J Public Health* 2007; 97, pp. 796-803.
4. Danel I. *Maternal mortality reduction, Honduras, 1990-1997: a case study*. Washington, DC: World Bank, 1998.
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6. Levine, Ruth and the What Works Working Group, With Molly Kinder. 2004. *Millions Saved: Proven Successes in Global Health*. Center for Global Development: Washington, DC.

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