

Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries

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I conducted case studies on the level of political priority given to maternal mortality reduction in 5 countries: Guatemala, Honduras, India, Indonesia, and Nigeria.

Among the factors that shaped political priority were international agency efforts to establish a global norm about the unacceptability of maternal death; those agencies' provision of financial and technical resources; the degree of cohesion among national safe motherhood policy communities; the presence of national political champions to promote the cause; the deployment of credible evidence to show policymakers a problem existed; the generation of clear policy alternatives to demonstrate the problem was surmountable; and the organization of attention-generating events to create national visibility for the issue.

The experiences of these 5 countries offer guidance on how political priority can be generated for other health causes in developing countries. (*Am J Public Health*. 2007;97:796–803. doi:10.2105/AJPH.2006.095455)

There is a strong emphasis on health in the Millennium Development Goals (MDGs; poverty alleviation objectives agreed to by United Nations [UN] member countries).¹ Goals 4, 5, and 6 are concerned with child mortality, maternal mortality, HIV/AIDS, and malaria.² In 2003, a High Level Forum—a venue for dialogue among senior policymakers from governments, aid agencies, foundations, and other organizations—formed to find ways to accelerate the slow progress toward the realization of the MDGs regarding health.^{3–5}

Many factors undoubtedly stand behind this slow progress, including insufficient donor resources, lack of consensus on intervention strategies, and weak health systems. Another potential contributor, one that has attracted little research attention, may be the difficulty in generating national political support for particular health goals. Even if national policymakers recognize the existence of health problems, have sufficient donor resources, and are cognizant of MDGs, there is no guarantee they will prioritize these issues or take action. Policymakers in developing countries are burdened with thousands of issues and have limited resources to deal with them, as well as conflicting political imperatives. Goals targeting improved health must compete for policy attention and resources in these difficult political circumstances.

What are the barriers to political attention for health? How does a lack of political support affect the achievement of health goals? How can such support be generated? Political scientists have referred to these issues as challenges in agenda setting and generating political priority,^{6,7} ensuring that political leaders consider an issue to be worthy of sustained attention and will back up that attention with the provision of financial, human, and technical resources commensurate with the severity of the problem. We know priority is present when: (1) national political leaders publicly and privately express sustained concern for the issue; (2) the government, through an authoritative decisionmaking process, enacts policies that offer widely embraced strategies to address the problem; and (3) the government allocates and releases public budgets commensurate with the problem's gravity. Agenda setting is the first stage of the public policy process during which some issues are given attention by policymakers and others receive minimal attention or are neglected completely. Scholars have identified systematic features in the agenda-setting process that shape the likelihood that any given issue will receive policy attention.^{6,8,9}

Drawing on this political science scholarship, I examined the state of political priority for maternal mortality reduction in 5 developing countries that have attracted considerable

attention from safe motherhood researchers: Guatemala, Honduras, India, Indonesia, and Nigeria (Table 1). The MDGs call for a decrease in the world's maternal mortality ratio by 75% from 1990 levels by the year 2015. With an estimated 585 000 maternal deaths in the year 1990,¹⁰ and little evidence of decline since then,¹¹ much change is needed over the next decade if the maternal health goal is to be achieved. Between 2003 and 2006, I prepared individual studies for each country on agenda setting for this cause.^{12–16} I bring together results from these 5 studies to draw out implications for health priority generation in other resource-poor countries.

METHODS

I used a process-tracing methodology in each of the 5 studies, a qualitative case study research strategy commonly employed in political science.¹⁷ Process tracing uses multiple sources of information to minimize bias, establish common patterns of causality, and reveal social and political processes—the major goal of this research.¹⁷ Process tracing in particular and case study methodologies more generally have received increasing attention in political science inquiry in recent years because of their unique capacity to consider political and social phenomena in their real-life context, with particular attention to historical influences.¹⁸ More commonly used methodologies in public health and medical research, including randomized controlled experiments, structured surveys, and statistical analysis of health service utilization, do not normally have these advantages.^{17,18}

In the study for each country, I investigated the same 2 questions: to what extent is maternal mortality reduction on the national policy agenda, and what factors have facilitated or obstructed political priority for the cause? Drawing from existing public policy research, the studies were exploratory in

nature, investigating these 2 questions to identify which factors may be at work in each country. A limitation of the case study approach is the difficulty of controlling for confounding influences on the outcome of interest. As such, inferences in this study must be understood as propositions that require further research, ideally in comparative context.

Each country was selected because of the significant attention it has attracted in safe motherhood scholarship and because of its potential to reveal underlying dynamics of agenda setting for maternal mortality reduction. Honduras is 1 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 in 1987.¹⁹ (This has been confirmed by 2 reliable reproductive age mortality surveys, the gold standard in maternal mortality measurement that documents every maternal death over the course of a year.^{20,21}) Its Central American neighbor, Guatemala, provides an interesting contrast—despite its greater wealth than Honduras and its receipt of significant donor resources for safe motherhood, it has a higher maternal mortality ratio and there is no firm evidence of maternal mortality change over the same time period.¹⁴ 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 a midwife 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.¹¹ If maternal mortality does not decline significantly in these 2 countries, it is unlikely the MDG concerning maternal health can be achieved.

I used 5 kinds of data collection methods for each country's study: interviews with officials involved in safe motherhood policy, observation of implementation sites, government reports and documents, donor agency reports, and published research on safe motherhood. I identified key individuals involved in safe motherhood policymaking and implementation, and I conducted between 20 and 30 semistructured interviews in each country. These key individuals were identified through



As part of a Unicef-funded Safe Motherhood program, Arik Dhelbeny, 18 years old and 6 months pregnant, attends a prenatal check-up in Rumbek Hospital, Southern Sudan. Photograph by Georgina Cranston. Available at <http://www.Galbe.com>.

consultation of national safe motherhood meeting reports; review of government, donor and nongovernmental organization (NGO) documents; and by asking interviewees whom they considered to be most centrally involved in safe motherhood.

Across the 5 countries, I carried out a total of 124 interviews, of which 75 were conducted jointly with research collaborators. Interviewees included former ministers and secretaries of health, maternal and child health division heads, officials in other government ministries and agencies, parliamentarians, bilateral donors, multilateral agency representatives, NGO officials, and academics. Most interviews lasted between 1 and 2 hours. The interviews were not transcribed, but I took detailed notes during each. Although there were some common questions asked of most interviewees, including their assessment of the state of political priority for the cause, I did not employ a uniform survey instrument, because each interviewee had unique knowledge about safe motherhood in his or her country. Instead, I asked each interviewee open-ended questions in an exploratory way to elicit that unique knowledge.

In addition to the interviews, multiple documents were carefully read and cross-checked to develop a history of safe motherhood initiatives in each country, to evaluate the state of political priority for maternal mortality reduction, and to facilitate analysis of the factors that shaped the level of priority. Documents included demographic and health and other surveys; government policy documents, health reports, and technical guidelines on obstetric care; documents from bilateral and multilateral donors; national government development plans; reports from foundations and NGOs; and published research on safe motherhood and maternal mortality. These documents were gathered from libraries in government, NGO, and donor offices; direct solicitation from interviewees; research libraries in the United States; and Web-based searches. In addition, villages, local health centers, and hospitals where safe motherhood activities were being implemented were observed.

Once all the material had been collected, interview notes and documents were reviewed and facts were checked across multiple sources to develop a history of safe

TABLE 1—Safe Motherhood and Economic Indicators, by Country: Mid-1990s to Early 2000s

Indicator	Honduras ^{21, 52, 53}	Guatemala ^{54, 55}	Indonesia ⁵⁶	India ^{57, 58}	Nigeria ^{39, 59, 60}
Maternal mortality ratio ^a	108	153	307	540	704
Percentage of women delivering in health institutions	62	42	40	35	33
Percentage of women delivering with medical attendants	56	41	66	42	35
Most common biomedical causes of death	Hemorrhaging, hypertension, infection	Hemorrhaging, infection, hypertension	NA	Hemorrhaging, anemia, infection	Hemorrhaging, infection, unsafe abortion
GDP per capita (purchasing power parity in 2005) in US \$ ^b	2800	5200	3700	3400	1000

Note. GDP = gross domestic product; NA = not available.

^aNumber of maternal deaths per 100 000 live births. The Honduran and Guatemalan maternal mortality ratios are highly reliable because they are population figures derived from reproductive-age mortality surveys—the gold standard in maternal mortality measurement—that investigate every death over the course of the year and therefore do not require confidence intervals. The Indonesian, Indian, and Nigerian maternal mortality ratios are estimates from representative surveys.

^bGDP per capita is 2005 estimate as reported in the Central Intelligence Agency *World Factbook*.⁵¹

motherhood policy attention in each country. Interview notes were compared with one another and with written documents to verify and extract information on major developments in the history of attention to safe motherhood in each country and to facilitate the development of propositions with regard to which factors may have shaped this attention. This comparison and cross-checking of information from interviews was crucial because respondents often did not remember accurately when particular developments occurred. Individuals involved in safe motherhood in each country also reviewed their country's case study reports to check for factual accuracy.

RESULTS

The 5 countries varied considerably in the degree to which the cause of maternal mortality reduction had received political priority (indicated by the 3 criteria in the introductory section). In Honduras, political priority was very high; in Indonesia, high; in India, moderate (with a recent rise); and in Guatemala and Nigeria, low.^{12–16} In Honduras, safe motherhood became one of the country's foremost health priorities, and between 1990 and 1997, the country experienced a 40% decline in its maternal mortality ratio,^{20, 21} one of the most significant reductions in such a short time span ever documented in the developing

world. In Indonesia, priority for safe motherhood rose from near obscurity to national prominence over the period 1988 to 1997 and received the direct attention of President Suharto, although after his fall from political power it declined. Nominally on the policy agenda in India since independence, maternal mortality reduction took a backseat to other health causes for several decades, but in 2005, it rose to receive meaningful national political attention. Until 2000, the cause received no significant attention in Guatemala and Nigeria, and it remains a neglected issue.

Nine factors, each identified in previous research on agenda setting, shaped the degree to which maternal mortality reduction emerged on the national policy agendas of these 5 countries (Table 2). These can be divided into 3 categories: transnational influences, domestic advocacy, and the national political environment.

Transnational Influences

It was a group of international advocates and organizations that first put safe motherhood on the global agenda. They used several mechanisms to influence national political systems to embrace the cause.

Norm promotion. International relations scholars, particularly those who emphasize the role of ideational factors in politics, argue that countries form their policy preferences not simply through national political processes, but also through participation in the international political arena, which helps shape societal norms and therefore policy preferences.^{7, 22} For instance, officials from

TABLE 2—Factors Influencing the Degree to Which Maternal Mortality Reduction Appeared on National Policy Agendas: Guatemala, Honduras, India, Indonesia, and Nigeria, Early 1990s to Mid-2000s

Factor	Category	Description
Norm promotion	Transnational influence	Efforts by international agencies to establish a global norm concerning the unacceptability of maternal death
Resource provision	Transnational influence	The offer of financial and technical resources by international agencies to address maternal mortality
Policy community cohesion	Domestic advocacy	The degree to which national safe motherhood promoters coalesced as a political force pushing the government to act
Political entrepreneurship	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 alternatives	Domestic advocacy	The availability of clear policy alternatives to demonstrate to political leaders that the problem is surmountable
Political transitions	National political environment	Political changes, such as democratization, that positively or adversely affect prospects for safe motherhood promotion
Competing health priorities	National political environment	Priority for other health causes that divert policymaker attention away from maternal mortality reduction

international organizations involved in health seek to persuade national officials to prioritize particular health causes such as HIV/AIDS prevention.²³ Also, national health officials influence one another at international conferences and other forums.

The international shaping of norms was an influential force in the decisions of countries to first take up the cause of maternal mortality reduction. A 1985 *Lancet* article titled “Maternal mortality—a neglected tragedy. Where is the M in MCH?” played a key role in bringing the issue of maternal death to the attention of international health officials.²⁴ An international meeting in 1987 in Nairobi, Kenya, also was influential and launched the Global Safe Motherhood Initiative that aimed to lower global maternal deaths by at least half by the year 2000. Thereafter, the Inter-Agency Group for Safe Motherhood formed to focus global attention on the issue, bringing together multiple international agencies.²⁵ A series of UN-sponsored international conferences throughout the 1990s reaffirmed the global commitment to reduce maternal mortality by 50%. Most recently, maternal mortality reduction received a place in the MDGs, and a partnership for maternal, newborn, and child health formed, linking formerly separate initiatives.

These international initiatives created concern among many national health officials about the problem of maternal mortality. Officials from Guatemala, Nigeria, Indonesia, and India attended the Nairobi conference, and officials from all 5 countries participated in regional conferences on safe motherhood as follow-up to this meeting. By the early 1990s, all had launched new national safe motherhood activities.^{12–16}

Resource provision. International relations scholars have identified several other forms of transnational influence on the policy preferences of countries.²⁶ One mechanism is compulsion, such as the leverage the International Monetary Fund wields when it threatens to deny loans to countries that face severe financial crises if they do not adopt structural adjustment programs. Another mechanism is resource provision: the enticement of financial and technical assistance from the International Monetary Fund and other organizations to governments if they agree to adopt particular priorities and policies.

Compulsion does not seem to have been at work with respect to safe motherhood. The enticement of resources, however, did shape the behavior of these 5 countries and provided material backing for the norm-promotion efforts of international actors. In Honduras, the US Agency for International Development (USAID) provided US\$57.3 million to the health sector between 1988 to 2000, a large portion directed toward maternal mortality reduction.²⁷ The UN Fund for Population Activities, Pan American Health Organization, and the World Bank also provided safe motherhood financing and technical assistance in the early 1990s.¹³ A primary financier for safe motherhood in the early 1990s—the USAID’s MotherCare program—made Guatemala one of its focal countries.¹⁴ In Indonesia, the World Bank offered support for a safe motherhood program through a US\$104 million loan to support a national population program covering the period 1991 to 1996.²⁸ In the early 1990s, at least 6 other donor agencies also began safe motherhood projects.¹² In Nigeria, the Department for International Development is funding a 7-year project with a main concern for safe motherhood.²⁹ USAID, World Health Organization, UNICEF, the UN Fund for Population Activities, the World Bank, and the MacArthur and Packard Foundations are also funding safe motherhood activities.¹⁵ In India, the 1992 Child Survival and Safe Motherhood program received US\$214.5 million from the World Bank and US\$67.8 million from UNICEF,³⁰ and donors have offered extensive financing since 1997 for both phases of the government’s Reproductive and Child Health Program, whose aims include maternal mortality reduction.³¹

Domestic Advocacy

Transnational actors brought the issue of maternal mortality to the global agenda but could not institutionalize the cause in national political systems on their own. National adoption and sustainability required domestic advocacy.

Policy community cohesion. Political scientists have argued that the structure and organization of policy communities shape how successful they will be in influencing national priorities.^{6,32}

Policy communities are networks of actors from different types of organizations—government agencies, legislatures, NGOs, and others—committed to common causes. Among the factors that shape their degree of influence are their levels of moral authority, knowledge, and coherence.³³

Safe motherhood policy communities formed in each of these 5 countries, consisting of Ministries of Health doctors, parliamentarians, obstetrician-gynecologists, health-focused nationals employed by donor agencies, and other individuals and groups. All held moral authority by virtue of their commitment to a humanitarian cause: reduction of maternal death levels. Because the group was largely composed of medical experts, all also held knowledge-based authority, and policymakers deferred to them on technical issues about safe motherhood. The communities differed, however, in degree of coherence. Some coalesced into tight networks, transforming their moral and knowledge-based authority into political influence and pushing their governments to act.^{12,13} Others struggled to come together and therefore had limited agenda-setting influence.^{14–15}

In Honduras, for instance, a highly effective working group formed in 1990 that became the unofficial center for national safe motherhood efforts.¹³ Meeting regularly over several years, the group included members of the Ministry of Health’s division of maternal and child health, Pan American Health Organization, USAID, the UN Fund for Population Activities, UNICEF, and other donors and agencies. The group produced a national plan of action for maternal mortality reduction for the period 1991 to 1995. Members also traveled to each of the country’s regions, facilitating the development of local action plans and mobilizing regional health bureaucracies in service of safe motherhood. In Guatemala and Nigeria, by contrast, cohesive networks have yet to form, and linkages among safe motherhood promoters remain informal.^{14,15}

Political entrepreneurship. Public policy scholars have found that individual national political entrepreneurs also shape agenda setting.^{6,34} These political entrepreneurs are politically influential and particularly capable individuals willing to exert effort to advance a cause. Not just any person can play such a role, however.

Research has shown that effective political entrepreneurs possess certain distinct features: they are knowledgeable about the issue, they are persistent, they have excellent coalition-building skills, they articulate vision amid complexity, they have a credibility that facilitates the generation of resources, they generate commitment by appealing to important social values, they are aware of the critical challenges in their environments, they infuse colleagues and subordinates with a sense of mission, and they are strong in rhetorical skills.¹²

Policy communities were more effective where political entrepreneurs for safe motherhood emerged to lead them. Indonesia's safe motherhood policy community had particularly effective leadership.¹² In 1995, the Assistant Minister of Women's Roles, considered to be among the most effective leaders in the Indonesian bureaucracy in the social development sector, came up with 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, generated additional budgetary appropriations for maternal mortality reduction, and mobilized provincial and local governments to address the issue. Ministry of Health doctors also played key entrepreneurial roles, sparking a flurry of activities inside the Ministry of Health in follow-up to the Nairobi conference.

In Guatemala, India, and Nigeria, a number of capable individuals in government and civil society had promoted the safe motherhood cause. In Guatemala, the former vice-president of parliament collaborated with the UN Fund for Population Activities to secure the passage of a reproductive health bill. In India, the former Secretary of Health and Family Welfare actively promotes the issue as head of an NGO. In Nigeria, the House Chairwoman for Women Affairs and Youth Development is leading an effort for a bill on maternal mortality reduction. However, in none of these 3 countries has any individual emerged as a recognized leader of a safe motherhood policy community, nor has anyone played the political mobilization role that the Assistant Minister of Women's Roles did in Indonesia.

Credible indicators. Agenda-setting scholars have demonstrated that among the factors that shape whether an issue rises to the attention of

policymakers is the presence of a clear indicator to highlight the issue, such as a maternal mortality ratio to indicate maternal death levels.^{6,35} These make a difference because they have the uniquely powerful effect of giving visibility to that which has remained hidden, serving not just monitoring purposes, the way they are traditionally understood, but also as catalysts that may provoke political elites to act. Where no such indicators are available, policymakers may ignore the issue either because they are unaware of the existence of a problem or are unconvinced in the absence of evidence that any problem exists.

In Guatemala and Honduras, maternal mortality studies sparked national efforts to address the issue, and in Indonesia, such a study contributed to rekindling an existing initiative. In Guatemala, a midlevel official in the Ministry of Health responded to a Central American regional call for action on safe motherhood by organizing a national mortality survey for women of reproductive age.³⁶ Completed in 1991, the study found a maternal mortality ratio of 248 deaths per 100 000 live births, far higher than health officials expected, prompting the Minister of Health to declare maternal mortality reduction a priority issue.³⁶ A former Honduran Ministry of Health official working for the Pan American Health Organization led the organization of his country's first mortality survey study for women of reproductive age in 1990. The research revealed a maternal mortality ratio of 182, nearly 4 times the previously accepted figure.²⁰ The official and his colleagues actively publicized the study's results. By the end of 1990 a new health minister had commented in the national media on the study, noting that the country had a serious problem with maternal mortality.³⁷ In Indonesia, the decision of the Assistant Minister of Women's Roles to launch a campaign was a direct result of his alarm over a high maternal mortality ratio of 390 reported in the 1994 Indonesian Demographic and Health Survey.^{12,38}

The absence of credible evidence has contributed to inertia in Nigeria. Although reliable data exist to confirm a national maternal mortality problem,³⁹ there are no disaggregated data for Nigeria's 36 states or 774 local governments. In a federal political system where the national government has little control over

the policy priorities of states and local governments, the absence of subnational data has contributed to a situation in which most state governors and local government heads are unaware of problems in their own areas and avoid acting on maternal mortality.¹⁵

Focusing events. Focusing events—large-scale happenings such as crises, conferences, and discoveries that attract notice from wide audiences—also have agenda-setting power.⁹ They function much like indicators, bringing visibility to hidden issues.

Focusing events helped put safe motherhood on the global agenda and shaped promotion of the issue in all 5 countries. The international Nairobi conference was the first example of such an event. In 1988, soon after this conference, Indonesia's first national seminar on safe motherhood was held, with President Suharto delivering the keynote address.⁴⁰ 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 Global Safe Motherhood Initiative was held in Guatemala City in 1992 and attended by Honduran and Guatemalan delegates.⁴¹ In 2000, the White Ribbon Alliance of India, a group of organizations that promoted 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 a sultan's wife in childbirth. The event generated national media coverage of the country's high levels of maternal death. Most recently, New Delhi hosted the 2005 World Health Day, whose theme was maternal and child health. Prime Minister Manmohan Singh met with leaders of several United Nations agencies and spoke publicly about maternal mortality specifically.

Clear policy alternatives. Agenda-setting researchers have found that policymakers are more likely to act on an issue if they are presented with clear proposals that convince them that a problem is surmountable.^{6,32} If policy communities have not generated clear and widely accepted proposals, policymakers are unlikely to pay attention to their concerns, because political elites prefer to allocate resources toward problems they believe can be effectively addressed.

The rise of the safe motherhood cause on to the Indonesian policy agenda was facilitated by just such a proposal. A village midwife program, begun in 1989, reflected a concern that women in rural Indonesia had poor access to medical care during their pregnancies. The Ministry of Health managed to place a midwife in most of Indonesia's 68 000 villages to ensure that pregnant women could get both prenatal and delivery assistance.¹² This program drew the attention of President Suharto, who at one point intervened directly to hasten its implementation.¹² It is not yet clear whether this program has reduced maternal mortality; however, policy-makers perceived that it would and were therefore willing to devote resources to the program, giving the village midwife program an agenda-setting effect.

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). One of the more contentious debates was whether scarce resources should be concentrated on ensuring the presence of skilled attendants at all births or on making emergency obstetric care available for women who experience complications at delivery.^{25,42} Also, international safe motherhood promoters were criticized for lacking evidence to back up their proposed interventions and for their use of unclear terminology surrounding interventions.⁴³ Another problem has been a difficulty in measuring maternal mortality and connecting process indicators to health outcomes. These difficulties may have resulted in reduced leverage to convince national policymakers to prioritize the cause.

National Political Environment

The quality of political advocacy by international and national safe motherhood promoters influenced the degree to which the issue received policy attention in these 5 countries. The political and social environments in which these advocates worked and over which they had little control also shaped policy attention. Many such factors were influential, including cultural barriers that place low value on women's lives, the ethnic composition of societies, civil strife, weak national health infrastructures, federalist political structures (espe-

cially in India and Nigeria) that give national governments little control over subnational politics, and endemic corruption. Two factors, however, were particularly critical: political transitions and competing health priorities.

Political transitions. Political scientists have found that major political transitions and reforms such as democratization and public sector decentralization alter public priorities by giving new actors agenda-setting power, and by changing the processes by which public policies are made and implemented.^{44,45} The same reform may have the opposite effect on the prioritization of any given issue, depending on the context.

In Nigeria, democratization facilitated policy attention for safe motherhood.¹⁵ In 1999, the country experienced a transition to a semi-democratic political system after decades of military-authoritarian rule, creating the political space for social issues, such as maternal mortality reduction, to appear on the national agenda. Under a democratic political system, the government has faced increased pressure to be accountable to its constituents, with direct impact on safe motherhood. One manifestation has been the creation of a national poverty alleviation program, entitled National Economic Empowerment and Development Strategy, which has become an overarching national framework for social change and which explicitly lists maternal mortality reduction as an objective. Another indicator is a public budget line devoted to safe motherhood, the first time such an appropriation has been made.

In Indonesia, by contrast, democratization and a subsequent reform—public sector decentralization—may have hurt safe motherhood.⁴⁶ Indonesian political entrepreneurs had convinced Suharto to prioritize safe motherhood, and the president and these entrepreneurs used the authoritarian political infrastructure to push subnational 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. Few district heads now view maternal mortality reduction as a priority, preferring to devote resources to

more visible causes that gain them votes and political capital, such as road construction.

Competing health priorities. Most health sectors in developing countries are strapped for resources, and health causes must compete against one another for scarce funding. Donors contribute to this competition by providing limited funding for health, and by promoting health causes that recipient governments may not consider to be priorities.⁴⁷

In India, until recently, maternal mortality reduction took a backseat to population control, child mortality reduction, and polio eradication.¹⁶ In 1946, prior to independence, a commission established a plan for a national primary health care system, creating a cadre of maternal and child health 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 family planning program with its own administrative structure and introduced population control targets, creating incentives for maternal and child health workers to focus primarily on contraception promotion.⁴⁸ In the 1980s, these workers took on additional roles, promoting immunization and polio eradication. It is only in India's most recent national health programs that maternal mortality reduction objectives have gained prominence alongside population control and child mortality goals.

Nigeria has faced a similar problem with respect to HIV/AIDS. This cause has become a funding priority for donors, particularly the United States through the president's Emergency Plan for AIDS Relief program, making Nigeria a focal point in the fight against the disease. Donors even convinced the government to establish a special commission explicitly devoted to control of the disease.⁴⁹ Attention to maternal mortality and other reproductive health causes has suffered as NGOs pursue AIDS money and local governments receive signals from the political center to prioritize HIV/AIDS over other problems that are just as serious.

CONCLUSION

Findings from the case studies indicate that the level of political priority for maternal mortality reduction varies considerably across the

5 countries and that 9 factors may stand behind this variance and help explain how the issue emerged on the global health agenda in the first place. Transnational actors first put maternal mortality reduction on the global agenda, promoting a norm that maternal death was unacceptable and generating the interest of national health officials with financial and technical resources to address the problem. National advocates then achieved varying degrees of success in promoting the cause. They were most successful when they formed cohesive policy communities, were led by respected national political entrepreneurs, deployed credible indicators to show a serious problem existed, organized focusing events such as national forums to promote visibility for the cause, and developed clear policy alternatives to demonstrate to national leaders that the problem was surmountable. Many factors in their political environments shaped the effectiveness of their efforts, but 2 were key: major political reforms, including democratic transitions and public sector decentralization that altered the policymaking process, and the degree of resource competition with other priorities, such as population control and HIV/AIDS.

The replicated case study methodology imposes limits on inferring causality and generalizing results. In-depth exploration of these countries facilitated the development and examination of propositions that concern the generation of political priority. In the absence of additional comparative inquiry, one cannot be certain that the factors identified were the primary forces at work nor of their causal weight. Also, each of these 5 countries has unique political and socioeconomic circumstances, so one must be cautious in generalizing to other settings. Another limitation of this study is that it focuses on the agenda-setting stage in the public policy process but not on implementation. The appearance of an issue on a national policy agenda is only 1 of multiple factors that stand behind policy effectiveness and is hardly enough to ensure that the political system will carry out plans or that these plans will be successful in reducing maternal mortality. Implementation, like agenda setting, is a politically infused process, and implementation bottlenecks may emerge at all levels of the system. The subject of implementation has received little attention in

public health scholarship on the developing world⁵⁰ and, like agenda setting, requires considerably more research.

These limitations notwithstanding, 3 implications emerge from this study for achieving national health objectives. First, the case studies support findings from prior public policy research about systematic features to the agenda-setting process that increase the likelihood that national advocates will be effective in moving political elites to action. Specifically, national health advocates are more likely to be effective if they:

1. Coalesce into unified policy communities, translating their potential moral and knowledge-based authority into political power and pressing national political officials to act.
2. Bring into their communities respected and well-connected national political entrepreneurs with track records in placing public health issues on national agendas.
3. Develop credible measures that mark the severity of this problem, and make political leaders aware of these measures so they cannot plausibly deny that a problem exists.
4. Organize large-scale focusing events such as national forums to generate widespread attention to the issue.
5. Present leaders with clear policy alternatives proven to be effective, so that policymakers come to believe the problem can be surmounted and know what they are expected to do.

Second, the case studies point to the distinctiveness of national circumstances and the need to consider these in political strategy development. Safe motherhood emerged—or failed to emerge—on national agendas because of country-specific combinations of factors. Although there were regularities to the process including the centrality of credible evidence and the power of political entrepreneurship, generating priority for the cause was not formulaic, and some factors were at work in certain countries but not others. Successful policy communities understood the distinct characteristics of their political environments and used an intuitive understanding of agenda-setting mechanisms to develop political strategies appropriate to the national context.

Third, the case studies demonstrate that international donor prioritization and resources, and effective medical and technical interventions, although critical, are far from sufficient for achieving health objectives. Attaining the goal is as much a national political challenge as it is a medical or technical challenge. Policy communities in settings with significant health problems need to develop careful political strategies to ensure that their national leaders give these issues the attention and resources they deserve. ■

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Contribution

The author conceptualized, carried out, and wrote the results of the comparative study.

Human Participant Protection

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