The state of political priority for safe motherhood in Nigeria

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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. In this article, we assess the state of political priority for maternal mortality reduction in Nigeria, which has more maternal deaths in childbirth than any country except India. We also identify challenges that advocates face in promoting priority. We find that after decades of neglect, a policy window has opened for safe motherhood in Nigeria, giving hope for future maternal mortality reduction. However, priority is as yet in its infancy, as advocates have yet to coalesce into a potent political force pushing the government to action. The case of Nigeria suggests that there is an urgent need for safe motherhood policy communities in countries with high maternal mortality to transform their moral and technical authority into political power, pushing policy-makers to action. We offer a number of suggestions on how they may do so.

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 (MMR) by 75% from 1990 levels by the year 2015. With an estimated 585 000 maternal deaths in childbirth in the year 1990,[1] and only a limited decrease as of 2000,[2] much change is needed over the next decade if the maternal health MDG is to be achieved.

Since the launch of a global safe motherhood initiative at a conference in Nairobi, Kenya, in 1987, advances have been made in medical and technical research on maternal mortality. Researchers have identified the leading biomedical causes of maternal death in childbirth,[3] refined means of measuring maternal mortality[4] and accumulated evidence concerning which health services are needed to prevent maternal death in childbirth.[5] One critical concern, however, is underemphasized in research and remains poorly understood: what causes governments to pay attention to the issue of maternal mortality reduction in the first place? Even if we know the biomedical causes of maternal mortality, can ascertain that levels remain high and are able to identify effective interventions, there is no guarantee that political leaders will take action, as they are burdened with thousands of issues to consider each year and have limited resources to deal with these problems. Political scientists have termed this the challenge of generating political priority: ensuring that political leaders consider an issue to be worthy of sustained attention, and back up that attention with the provision of financial, human and technical resources commensurate with the severity of the problem.

In this study, we consider the state of political priority for safe motherhood in a country that may have the most serious maternal mortality crisis in the world: Nigeria. Despite having only 2% of the world's population, Nigeria contributes 10% of the world's maternal deaths.[6] Each year, as many as 60 000 Nigerian women die due to pregnancy-related complications.[7] Globally, only India has a larger number of maternal deaths from pregnancy-related complications, and that is only because it has a population eight times the size. Using a qualitative case study methodology commonly used in political science inquiry, process tracing, we conducted interviews in 2004 and 2005 with 28 individuals in Nigeria in government, civil society, the donor community and academia, all centrally involved in safe motherhood policy formulation and implementation. We also reviewed multiple documents, including health surveys, government policy documents, donor reports

and research on Nigerian safe motherhood. We analysed the interviews and documents to develop a history of safe motherhood efforts in the country, assess the state of political priority for the cause, identify factors that have shaped the level of priority and determine challenges advocates face in enhancing political attention. In the sections that follow, we report on the results and draw out the implications for generating political commitment for safe motherhood in other countries with high maternal mortality.

The opening of a policy window for safe motherhood in Nigeria

Nigerian safe motherhood advocates confront adverse social, health and political conditions that create high maternal mortality levels, even by sub-Saharan African standards, and that make their work particularly challenging. A 1999 study estimated a MMR of 704 deaths per 100 000 live births.[8] A 2003 study revealed that only 4.2% of public facilities met internationally accepted standards for essential obstetric care.[9] Approximately two-thirds of all Nigerian women deliver outside of health facilities and without medically skilled attendants present.[10,11] The health sector as a whole is in a dismal state. In 2000, the World Health Organization ranked the performance of Nigeria's healthcare system 187th among 191 United Nations member states.[12] These poor maternal health outcomes and the weak performance of the health system must be understood in the context of the country's long-standing problems with governance. Nigeria has a history of military authoritarian rule, only recently replaced by a fragile democracy, and corruption in the political system is endemic.[13] Social development, including the promotion of the health of Nigerian citizens, has been more a rhetorical than a real aim of the state.

Prior to 1999, safe motherhood received some policy attention in Nigeria but was never institutionalised as a national concern. The situation changed in that year when a policy window opened for safe motherhood with a move to democracy. Subsequently, priority for the cause grew. Seven factors contributed to this increasing prioritisation: the democratic transition itself, 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 mobilise, the possibility for prioritisation of these kinds of causes was

minimal. Flawed but peaceful elections were held in late 1998 and early 1999, and in May 1999, Olusegun Obasanjo was sworn in as president.[14] Obasanjo was reelected in 2003, marking the first time in Nigeria's four-decade history that a civilian government completed passage from one administration to another. Under a democratic political system, the government has faced increased pressure to be accountable to its constituents. One manifestation has been the creation of the National Economic Empowerment and Development Strategy (NEEDS), a poverty alleviation programme that has developed into an overarching national framework for social change, which explicitly lists maternal mortality reduction as an objective.

Second is the growing concern among civil society organisations for the problem of maternal mortality. The Society of Gynecology and Obstetrics of Nigeria (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 against 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 postabortion care in the country.[15,16] 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 has been established to link organisations 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, a 1999 survey noted above provided reliable evidence confirming the persistence of the problem.[8] Also, in 2003 with support from the United Nations Population Fund (UNFPA), officials in the Federal Ministry of Health produced a study on the alarming state of obstetric care facilities across the country,[9] presenting the results directly to the Minister of Health and publicising 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[12] also served to awaken health and other political officials.

Fourth, over the past half decade, commitment to the cause inside the Federal Ministry of Health has increased dramatically, a function of the emergence of new leadership in the Ministry committed to the cause, as well as pressure on these leaders from civil society organisations and international MDGs to address the problem. The Ministry produced a national reproductive health policy in 2001[17] and a national reproductive health strategic framework in 2002 with specific maternal mortality reduction aims.[18] In 2001, the government convened a national meeting on the subject, and with United

Nations Children's Fund (UNICEF) support produced national guidelines for women's health services.[19] A revision of the government's National Policy on Population for Sustainable Development in 2004 explicitly called for a reduction of the MMR by 75% by the year 2015.[20] Also, the Ministry established a multisectoral 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.

Fifth, the inclusion of maternal health in the MDGs has contributed to prioritisation 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 road map to attain the maternal and child health MDGs.[21] In addition, a health sector reform programme invokes the MDGs as a basis for a commitment to maternal mortality reduction in Nigeria.[22] Furthermore, donors providing funds to the Nigerian health sector, including the British Department for International Development (DFID), the United Nations agencies and the World Bank, have geared financing and programmes towards the achievement of this goal.

Sixth, an increase in available donor resources has also enhanced the possibility for maternal mortality reduction. DFID is funding Partnerships for Transforming Health Systems (PATHS), a 7-year project whose aim is to strengthen Nigerian health systems at the state level, and which has a focal concern on safe motherhood.[23] In addition, DFID is launching a £100 million project over 5 years to support the efforts of United Nations agencies in Nigeria in achieving the health MDGs, including the maternal mortality reduction objective.[24] In its most recent country strategic plan the United States Agency for International Development has pledged more than $10 million to safe motherhood initiatives. The United Nations agencies, in particular the World Health Organization, 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 towards achieving the MDGs and in particular maternal mortality reduction. International foundations, including the MacArthur and Packard Foundations, have supported nongovernmental organisations (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, securing support for a bill from the President of the Senate and the Speaker of the House.

The nascent state of political priority for safe motherhood in Nigeria

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 formalise connections. For instance, as noted above, at the initiative of the Federal Ministry of Health, a National Safe Motherhood Committee formed several years ago. However, the network remains a loose collection of individuals and organisations 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 the national level, there is no evidence that the network functions with any overarching 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 towards 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. Early in his administration, President Olusegun Obasanjo gave HIV/AIDS programming priority, raising levels of government funding for the disease and urging states and local governments as well as donor agencies and NGOs to do the same. The government created a special commission (National Action Committee on AIDS, NACA) explicitly devoted to control of the disease. The result has been a dramatic increase in funding of HIV/AIDS programmes, and a greater commitment from government and donor agencies to control the disease in Nigeria. Funding for HIV/AIDS in Nigeria comes from governments at all levels, international donor agencies (the World Bank, the United States, the Gates Foundation, the Global Fund and the Ford Foundation, among others), private sector firms and NGOs. Recent estimates indicate that

funding provided by international donor organisations to HIV/AIDS comprises 6% of Nigeria's entire health spending.[25] Despite the high burden of maternal morbidity and mortality, safe motherhood has no equivalent commitment or specific national implementing committee. The increased availability of HIV/AIDS funding and the establishment of NACA have influenced 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 subnational governments and social institutions. Generating meaningful political priority for safe motherhood in Nigeria is dependent on gaining the active support of state- and local-level political, social and religious leaders, as the federalised nature of the political system circumscribes the power of the national government. Federal-level officials can only encourage and provide incentives; they cannot commandeer. This 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 state and local governments. Another reason for this situation is that local officials 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 prioritise 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.[26] The state commissioner of health, who is an obstetrician and gynaecologist 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 included in its budget a line item for free maternal health services. The former state commissioner of health together with a senior obstetrician and gynaecologist, 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 and gynaecologists 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 health care, who subsequently became state commissioner for health, stood behind these initiatives.

Challenges in generating priority for safe motherhood in Nigeria

Advocates face many challenges in institutionalising 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 overarching strategy and does not act in unison. Network members have numerous responsibilities within their own organisations, and these organisations 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 organisational 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 MDGs, may augment funding for the cause. The key to actualisation of this possibility will be pressure on the federal government from the community of safe motherhood advocates.

The third challenge is to generate meaningful political priority in state and local governments. 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 nationwide maternal mortality crisis. Reliable local- and state-level data are scarce, thereby making it plausible for subnational officials to deny they

have a problem or to argue that other priorities are more pressing. Second is reorienting the political priorities of these officials, recognising 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 prioritise the cause. In other countries, priority has emerged primarily from bottom-up as civil society organisations, particularly public health communities, have pressed governments to act.[27] 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 federalised nature of the Nigerian political system that limits the possibility for top-down priority generation makes horizontal diffusion a particularly attractive strategy.

A number of safe motherhood policy communities in developing countries have effectively surmounted these challenges. In Honduras and Indonesia, cohesive safe motherhood policy communities formed, led by highly effective political champions who promoted the maternal mortality reduction cause.[28,29] Both policy communities used evidence from credible studies to convince national political leaders of the severity of the problem, organised national forums to raise visibility for the issue and presented leaders with coherent policy alternatives on how to address the crisis, leading to the mobilisation of national and international resources for the cause. In Honduras, this political activism contributed to a decline in the MMR of 40% between the years 1990 and 1997, and in Indonesia, these champions moved the safe motherhood cause from near obscurity to national-level prominence over the years 1989–97.

Implications for other high maternal mortality countries

The Nigerian case suggests 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 organisations 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, that are fragmented, and that do not position safe motherhood in a way that appeals to the interests of political leaders, may fail to take advantage of this authority. Networks that develop effective leadership, that create institutional structures that allow members to work in unison, and that develop a convincing case for prioritizing safe motherhood, 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 subnational as well as national political support

Safe motherhood policy communities must do more than convince national political leaders to act. They must also persuade subnational leaders, governors and others, that this is a cause worthy of attention and resources. In federal political systems such as Nigeria's and India's, subnational attention is particularly critical since the authority of national over subnational governments is legally circumscribed. Even in unitary political systems such as China's, where subnational governments derive their authority from and are legally subordinate to national governments, subnational attention does not follow immediately from national priority. Political

scientists have long recognised that national leaders in developing countries frequently are unable to exert power over lower level governments, even where they have legally derived authority.[30,31] This struggle is particularly acute in the world's poorest states, precisely where maternal mortality is highest. The need to engage subnational leaders is particularly critical in an era of health sector decentralisation, where more and more health decision-making power is being handed over to district-level governments.[32] Safe motherhood advocates must therefore develop subnational as well as national political strategies.

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

Safe motherhood research has focused more on the medical and technical dimensions of the problem, such as which obstetric care interventions are most effective, than its political dimensions. Safe motherhood policy networks must recognise that maternal mortality reduction is as much a national political as a technical/medical challenge. Even if researchers identify effective interventions, there is no guarantee that 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 subnational political initiatives to convince these leaders of the worthiness of the cause.

Conclusion

The MDG maternal mortality reduction objectives will be achieved only if the governments of countries with particularly high numbers of mothers dying in childbirth make the cause a national political priority. In Nigeria, a country with one of the world's most serious maternal mortality problems, a network of capable safe motherhood champions exists, and a policy window recently has opened for the cause. However, this network has yet to capitalise on its potential power, and political priority remains low. The future of Nigerian safe motherhood may depend considerably on the effectiveness of this network in transforming itself into a potent political and social force, pressing national and subnational governments to act. Similarly, the future of safe motherhood in other countries may depend on the formation and mobilisation of their national networks and the recognition that reducing maternal mortality is not just a technical or medical challenge but also a political one.

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Conflict of interest

The views presented represent those of the authors alone, who take responsibility for all errors. ■

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