

What Are Maternal Health Policies in Developing Countries and Who Drives Them? A Review of the Last Half-century

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Summary

This paper examines maternal health policies in developing countries and identifies contributions made by policy makers, health professionals and users. It starts by reviewing the broader health systems within which maternity services sit, and the specific maternity-service configurations that appear to lead to low maternal mortality. Next, it lays out the main actors (politicians and policy makers, health professionals and women's groups) operating internationally. This is followed by presenting the maternal health policy agenda at the international level and discussing the ideological paradigms that influenced these policies. Mention of the main actors (as above but including and organised groups of service users) at the national level is more superficial, but examples of the impact of various actors on national-level maternal health policies are given. The overall aim is to better understand how policies have developed and to suggest lessons and ways forward for the future.

Introduction and Rationale

Each year around 585,000 women die and many more encounter serious problems in childbirth (WHO 1996, AbouZahr 1998). Furthermore, around 120 million women have unwanted pregnancies and 20 million have unsafe abortions (Ashford 1995). Maternal deaths affect hundreds of thousands of families and communities; several million children are left motherless each year, and an estimated one million young children die soon after the deaths of their mothers. Adding maternal morbidity to mortality, the 1993 World Bank's assessment of the global burden of disease estimated that 18 percent of the disease burden of women aged 15-49 was due to maternal causes, making these the leading cause of ill-health in this age group (World Bank 1993, AbouZahr 1998). The vast majority of these problems occur in low-income countries, where poverty increases sickness and reduces access to care (WHO 1996). They also occur within a context of gender-based economic, political and cultural discrimination and neglect of women's rights to equal status and equitable access to services.

Perhaps the most compelling reason to address maternal mortality is that it is largely avoidable, and the technical interventions needed are well understood (WHO 1994, Starrs 1998). What is less clear is how to create an enabling environment to implement these obstetric care interventions (Koblinsky *et al.* 1999). This paper examines the history of maternal health policies in developing countries, and looks at the roles played by the main actors involved in influencing these policies. The paper starts by reviewing the broader health systems within which maternity services sit, and the specific maternity-service configurations that appear to have led to low maternal mortality. Next, it lays out the main actors (the politicians and policy makers, health professionals and women's groups) operating internationally, and presents the international maternal health policy agenda. It also discusses the ideological paradigms that have influenced these policies. Presentation of the main actors (politicians and policy makers, health providers and organised groups of women's rights activists and consumers), at the national level is by necessity more superficial, but examples of the impact of various actors on national-level maternal health policies are given. The overall aim is to better understand how policies have developed and to suggest lessons and ways forward for the future.

Health System Solutions

This section of the paper considers the main types of national health systems through which specific services can be delivered and characterizes specific features relating to maternity care, particularly delivery services. It aims to provide a backdrop for interpreting policies and policy shifts.

Preventing the bulk of maternal deaths requires curative care, i.e. using clinical services to treat conditions as they arise to prevent them from leading to death (WHO 1991). By the early 1990s these were identified and labelled essential obstetric care (WHO 1991). The main challenge for countries is to organise maternity health services so as to deliver these relevant preventive and curative interventions, particularly around the time of labour and delivery when most deaths occur. Most effective interventions require skilled, often specialized, personnel.

The features of maternity care services are largely determined by the characteristics of the national health systems within in which they are imbedded. National health systems comprise five main interacting components as shown in Figure 1: resources, organization, management, economic support, and, delivery of services (e.g. maternity care) (Roemer 1991). The components are in turn affected by a great multiplicity of social influences that can be grouped as economic, political and cultural.

(Roemer 1991) presents the national health systems of the world in a matrix based on the first two, the economic status of the country according to annual GNP (grouped as affluent and industrialized, developing and transitional, very poor, or resource (oil) rich) and its health policy orientation (grouped as entrepreneurial, welfare oriented, comprehensive, or socialist)². Examples of very poor countries with the above four health policy orientations respectively are Nepal, India, Sri Lanka, and China. During the 1980s, most very poor countries were categorized as having welfare-oriented health policies (Roemer 1991). In more recent years, very poor and transitional countries have been pressurized by the economic policies and structural adjustment programmes of the IMF and the World Bank to further reduce government expenditure and to rely more on private services and markets, thus moving more strongly to entrepreneurial and welfare-oriented health policies. In Zimbabwe for example, progressive erosion of the general standard of health services has been associated with a rising maternal mortality ratio (CSO 1995).

² Health systems with an entrepreneurial orientation have very strong private markets and intervention by government or other entities is minimal. Private care dominates, and government programmes, planning and regulation tends to be weak. Access to health care is uncertain and is the individual's responsibility. In welfare systems, the government and others intervene in the private market, typically by organizing the financing of private care (industrialized countries) or by major efforts to bring services to rural populations (transitional and very poor countries). In comprehensive-type health systems, governments carry this even further by allowing all or nearly all the population equal entitlement to complete health services. There are relatively few examples of very poor countries with comprehensive services. Finally in socialist health systems, market intervention is carries to its furthest point. There is virtually no private health care and the government collectivizes financing, and takes control of human and physical resources (Roemer 1991).

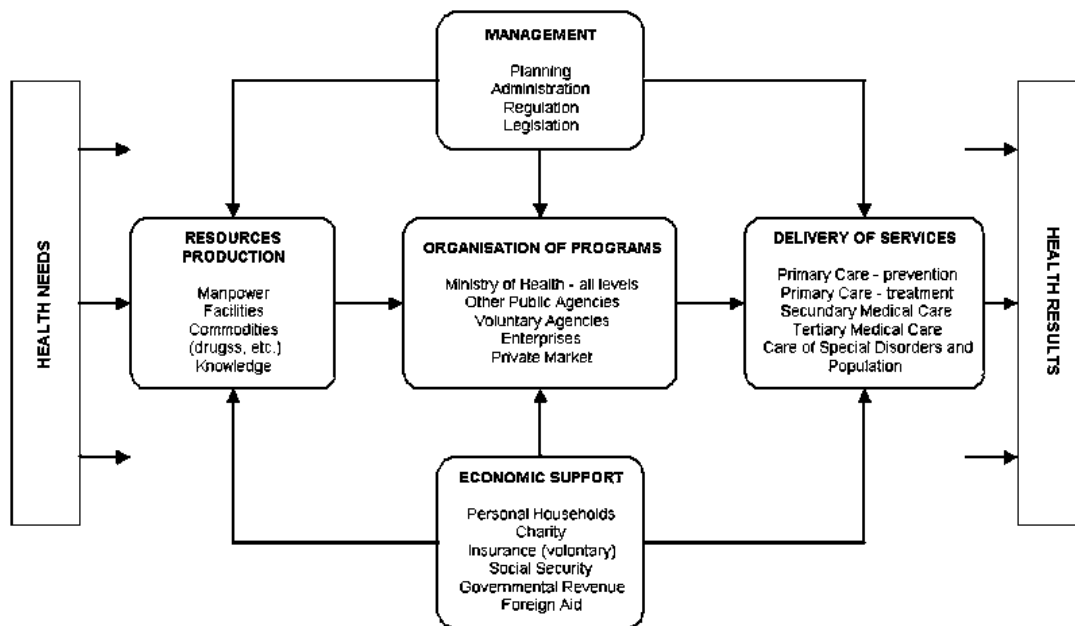


Figure 1. The five main interacting components of national health systems (taken from Roemer 1991)

Within the context of their national health systems, maternal health programmes need to find ways to decrease the gap between women and services so that both respond rapidly and appropriately to the obstetrical complications that cause death. Most countries appear to have developed a least minimal infrastructure for providing antenatal care, but a far bigger challenge is posed by delivery care services. We identify four basic models for organizing maternity care services. These can be described based on where women deliver and who delivers them (Figure 2) (Koblinsky *et al.* 1999). The differences in cost and constraints of the four models, in terms of type of staffing, training, up-grading of skills, type and number of health facilities, supervision, regulation, and fulfilment of mothers' wishes, have not been quantified or described and thus are poorly understood) (Koblinsky *et al.* 1999). Nevertheless the evidence unearthed suggests that where non-professionals (i.e. TBAs or relatives) carry out home deliveries, maternal mortality ratios are usually staggeringly high (often between 500-1000 per 100,000 - e.g. the Gambia) and never fall below 100 deaths per 100,000 women (e.g. rural China and Forteleza, Brazil). When a professional (midwife or doctor) linked up with a strong referral system carries out deliveries, maternal mortality ratios can be reduced to 50 per 100,000 or below, irrespective of whether births takes place at home, in health centres or maternity homes, or in hospitals. However, even where all births take place in a hospital (the fourth and arguably most advanced model), mortality is not necessarily reduced to fewer than 100 per 100,000 (e.g. Mexico City and Former Soviet Union) (Koblinsky *et al.* 1999).

Figure 2. Safe Motherhood Care: required features of service delivery models

Models	Features of service delivery	Maternal mortality ratios/100,000 by country
Non-professional delivery at home	<ul style="list-style-type: none"> • Non-professional recognises complications • Access to EOC organised by family or non-professional • Functioning EOC available 	Rural China: 115 Forteleza, Brazil: 120
Professional delivery at home	<ul style="list-style-type: none"> • Professional recognises complications, provides basic EOC • Access to EOC organised by family or provider • Functioning EOC available 	Malaysia (1970-80s): 50 Netherlands (1983-92): 7
Professional delivery in limited EOC facility (health centre)	<ul style="list-style-type: none"> • Professional recognises complications, provides basic EOC • Facility organises access to EOC • Functioning EOC available 	Malaysia (1985-1990s): 43 Sri Lanka: 30
Professional delivery in full EOC facility (hospital)	<ul style="list-style-type: none"> • Professional recognises complications • Professional provides basic and comprehensive EOC 	UK: 9 USA: 12 Mexico City: 114

EOC = essential obstetric care

A key feature of countries that have lowered maternal mortality to a level of < 100 per 100,000 appears to be that the large majority of births are delivered by professional skilled birth attendants. Where women are geographically isolated, strategies used to increase access to professional care include obligatory rural postings or incentives to health staff in rural areas, use of maternity waiting homes (homes located close to a referral facility where pregnant women can go near term)³ and delegation of life-saving skills to lower level staff⁴.

Where professionally trained birth attendants cannot conduct most deliveries, the appropriate organization of services is not clear. If referral services are accessible and functioning, prenatal screening based on poor obstetric history and identification of present medical problems or complications carried out by a trained nurse-midwife with women and their TBAs in the community, may contribute to reducing local, hospital-based maternal mortality [e.g. Nigeria (Brennan 1989) or Ethiopia (Poovan *et al.* 1990)]. TBAs and families can identify early signs of complications during labour and delivery and refer women successfully for treatment [e.g. Indonesia (Alisjahbana 1991) and Guatemala (Schieber 1991)]. In Forteleza Brazil (Koblinsky *et al.* 1999, Janowitz *et al.* 1985) such a TBA based system functioned, but with extraordinary inputs in terms of supervision, referral and free emergency care at the referral hospital. More commonly the necessary supervision and the required linkages to referral services are not available. In such instances, in Indonesia and the Gambia for example, trained TBAs alone, without the support of skilled back-up services, do not decrease the maternal mortality ratio (Alisjahbana 1991, Greenwood *et al.* 1987, Greenwood 1991). Rural China poses an intriguing exception in that it appears to achieve relatively low maternal mortality without a strong referral system or free tertiary level care (Koblinsky *et al.* 1999); much more effort is needed to understand how China is able to achieve such low mortality in its rural areas.

³ The national programmes of Cuba and Mongolia have used maternity waiting homes. In Ethiopia, projects with maternity waiting homes contributed to reducing maternal mortality when communities participated in their planning, development and management (Poovan *et al.* 1990). This approach was also used historically in the USA (e.g. in Alaska and Kentucky) and in Australia.

⁴ In Zaire, delegation of certain life savings tasks (manual removal of the placenta and Caesarian section) to trained midwives located close to women saved lives, especially in emergency situations (White *et al.* 1987).

International Maternal Health Actors and Policies

This next section reviews the main international actors in maternal health and the main positions they adopted vis-à-vis maternal health over time. This is followed by a review of the main international maternal health policies and the roles played by the various actors in getting them on the policy agenda. Besides the economic status of the country and configuration of the health system described in section II above, Lush and Campbell (2000) identify four ideologies have influenced maternal health policies: family planning, primary health care (PHC), neo-liberal economics and women's status. These are described in some detail in Annex 1, but their impacts on policy development in maternal health at various points in time are touched on briefly below.

International Actors

In the first half of the 20th century, there were approximately 60 nation states, and many of the countries now classified as developing countries, especially the poorest, were colonies or protectorates (Zapata & Godue, 1997). The main international actors in health were the colonizing countries, a few international organizations (e.g. the International Sanitary Conference, or the Pan American Sanitary Bureau), foundations (e.g. the International Health Commission of the Rockefeller Foundation) and missions. Most tropical medicine or international health efforts were geared around war and trade (Zapata & Godue, 1997) and oriented around the protection of the colonizing population and its workforce (Jolly 1997).

During this period, little attention was given to maternal health internationally, except occasionally where colonized populations appeared to be declining, as for example in Fiji (Jolly 1997, Jolly 1997b) and Tanganyika. By the start of the 20th century, however, (Manderson 1997) shows how in Malaya for example, English colonists wives' concern with their own maternity flowed over into concerns with the maternity and mothering of other women, and services were developed in response, in this case by the colonial government. In other settings, such services were largely provided by missions⁵ [see for example in Africa (Chintu & Susu 1994, Beinart 1992, Vaughan 1991) or in Papua New Guinea (Denoon 1989)].

The WHO was founded in 1948 to promote and protect the health of all people. It was built on the premise of building sovereign nation states and intended to function as an inter-governmental institution. In the report of the first 10 years of WHO, maternal and child health is a clearly identified area of action and a chapter is devoted to it (WHO 1958). The major thrust in the 1950s was providing technical support to training sufficient number of personnel (including domiciliary training for midwives in order to raise the standards of home births), creating administrative divisions of maternal and child health within national health systems, and integrating maternal and child health services with general health services.

International co-operation in maternal health started somewhat later, mostly in the mid-1960s, when Western donor countries and international agencies first started to fund maternal and child health (MCH) programmes of national Ministries of Health. However, in the report of WHO's second 10 years (1958-67) overlapping this period, maternal health features much less than previously (WHO 1968).

By the 1970s, the family planning movement influenced those involved in maternal health. WHO clearly adopted and prioritised a family planning strategy (WHO 1974). For other actors too, such as UNICEF or USAID, the focus and funding of MCH was actually geared to child health and family planning (Rosenfield & Maine 1985). WHO remained a key actor in maternal health the late 1970s and early 1980s as a new health-care ideology was promoted for developing countries. This involved switching towards PHC and the proposal of "Health For All by the Year 2000" (WHO 1978). WHO's approach to maternal health in the mid-1980s

⁵ Jolly (1997) reports that Fijian women who trained as midwives in mission hospitals saw themselves as much servants of God as of science.

advises training TBAs as one of the most cost-effective strategies to reduce maternal mortality and morbidity (Belsey 1985). TBA training programmes also drew considerable support and funds from UNICEF, UNFPA and USAID, among others, especially since the latter two agencies had a further interest in using TBAs as family planning workers.

During the same period, the international women's health movement, which had emerged in the 1970s in the industrialised West, started leading global campaigns for women's rights and to expand the interest in women's health beyond family planning. Government donor agencies, such as the Swedish Agency for Research Co-operation with Developing Countries (SAREC), foundations and NGOs also supported research and activities in women's health [for example, see the (World Federation of Public Health Associations 1986) or (Bergstrom *et al.* 1993)]. The Women in Development programme within USAID also supported research-based activities on women's health issues through an NGO, the International Centre for Research on Women (ICRW). Indeed USAID also initiated some funding of maternal health programmes through what were to become the MotherCare projects, despite lacking a congressional mandate, on the strength of advice by their technical staff, many of who were women who identified with the aims of the women's movement. The World Bank also played an important role: in the 1980s, they attempted to counterbalance the child survival work that had been led with strong support by USAID, UNICEF and, to a lesser extent, WHO, and to redress the balance in favour of adult health (Reich 1995).

Finally, in 1985, two academics from Columbia University, (Rosenfield and Maine 1985) wrote a highly influential paper that galvanised interest and put the issue of maternal mortality on the international health policy agenda. They argued that MCH programmes focused almost exclusively on child health, assuming that "whatever is good for the child is good for the mother" (Rosenfield & Maine 1985 : p 83), and called on obstetricians and the World Bank to take the lead in maternal health policy. The first international conference devoted to maternal mortality (Safe Motherhood Conference, Nairobi, Kenya, 10-13 February 1987) was sponsored by the World Bank, WHO and UNFPA and led to the launch of the Safe Motherhood Initiative (SMI).

International agencies involved in the SMI coalition included five UN agencies (WHO, UNDP, World Bank, UNFPA, and UNICEF) and two NGOs (the Population Council and IPPF). Family Care International, another NGO, also came to be involved in organising the first national conferences on safe motherhood. USAID was not a SMI coalition member but was influential through its MotherCare I demonstration projects and research support. Other, mainly research, activities were also launched in response⁶. In 1987 the international women's movement also launched a day of action focussed around maternal mortality (te Pas 2000). The success of this event led to a 10-year campaign co-ordinated by the Women's Global Network for Reproductive Rights (WGNRR)⁷ to reduce maternal mortality that ended in 1996 (te Pas 2000).

International funding of safe motherhood in 1990 showed that of total external assistance a mere 0.2 percent to safe motherhood (although a further 16 percent went to MCH services which would mainly have targeted child health) (Zeitlin *et al.* 1994) reflecting a low priority by donors. Indeed it was not until the mid-1990s that international actors funded large-scale programmatic activity. Here the main actors were USAID projects with MotherCare II, and more recently the Maternal and Neonatal Health project, and the World Bank. The UK's Department for International Development (originally ODA) also supported large programmes

⁶ These include the Columbia University Prevention of Maternal Mortality Network in West Africa, funded initially by the Carnegie Foundation (Lucas 1997); the London School of Hygiene and Tropical Medicine Methods for Measuring Maternal Health Programme, supported by Ford Foundation and the UK Overseas Development Administration (now DFID) (Graham & Campbell 1990); and Uppsala University International Maternal Health Care training programme, supported by the Swedish Agency for International, Technical and Economic Co-operation (BITS) (Bergstrom *et al.* 1993).

⁷ But involving women's groups from many developing countries, with strong representation from Latin America, the Philippines, and India.

in Nepal and Malawi, and in some countries UNICEF and UNFPA⁸ also pay considerable attention to maternal health and contributed through national programmes. UNDP appears to have dropped out of the SMI for reasons that are unclear. The International Federation of Gynaecologists and Obstetricians, FIGO, has also started several projects, supported by national societies from industrialized countries. Most recently, in 1999, the Bill and Melissa Gates Foundation has contributed to work in maternal mortality reduction, via Columbia University and Family Care International.

International Policies

The early international maternal health policies adopted are best summarised by the report of the 1950 WHO Expert Committee on Maternity Care that stated '*In the implementation of a programme of maternity care, expenditure for adequate training of personnel should take precedence over other expenditures if, in fact, a choice has to be made*' (WHO 1958). WHO assigned teaching staff to medical and midwifery schools, and in-service training was organised. Efforts were made to include domiciliary training of midwives to raise the standards of home births and many fellowships were awarded for academic study and study tours (WHO 1958). UNICEF assisted by providing equipment and in developing training courses for traditional birth attendants. A 1954 WHO Expert Committee on Midwifery Training described the different types of personnel required, their characteristic functions and their training requirements (WHO 1958).

These policies were translated into activities in various countries. For example, in Kabul Afghanistan, WHO assisted in establishing a maternity hospital, a domiciliary midwifery service and antenatal care, staffed by the first trained midwives to give service in the history of the country (WHO 1958). MCH services were seen as creating appreciation among the national populations for curative and preventive health services and hopes were expressed that such services, particularly the rather limited MCH services in rural areas, would become the nucleus for more comprehensive health services. By the mid 1950s, WHO was also proclaiming the desirability of integrating MCH activities into general public health and medical services where these existed (WHO 1958).

By the 1960s, WHO seems to have lost its focus on maternal health and its policies were less clearly articulated. For example, its summary of the second 10 years (WHO 1968) has no specific chapter heading on maternal and child health, but seems instead to concentrate instead on an expanding range of issues. At national level though, training activities appeared to continue as in the first 10 years. For example, Zambia opened community and professional midwifery schools in 1967 and 1969 respectively with support from WHO (Chintu & Susu 1994). A lack of data may have exacerbated the neglect of maternal health (Graham & Campbell 1992): maternal mortality in the industrialised countries was plummeting, while data from very poor countries was virtually non-existent.

The 1970s saw more reliable maternal mortality estimates for developing countries that made the very high rates in developing countries evident (Vaughan 1987) and the production of one of the first WHO documents to focus exclusively on maternal health (WHO 1974). WHO's document (1974) clearly describes a maternal health strategy that prioritises family planning as a way of improving maternal health. It argues that maternal morbidity and mortality and foetal perinatal and infant mortality increase with repeated pregnancies and calls for integration of family planning into already existing MCH and family health programmes. This shows the influence of the strong international family planning agenda (see annex 1). At the same time, the 1974 WHO document also makes the statement that '*the training of traditional*

⁸ UNFPA health programmes typically adopt a reproductive health strategy. In some settings, for example Morocco, the UNFPA reproductive health programme includes a major safe motherhood initiative. Overall though, our perception is that this is an exception; for example in a joint UNFPA/EU reproductive health programme in six Asian countries, only 11 out of 40 NGO projects mentioned any aspect of maternal health. In three countries, there was no mention of safe motherhood activities at all, in two countries there was a minimal mention, and only one country, Nepal, had safe motherhood components in most projects.

birth attendants for home deliveries is recommended rather than trying to persuade rural women to go to hospitals or trying to train enough professional midwives'. This policy shift may have been a pragmatic response to the growing observations that professional midwives and obstetricians were reaching very few women and that hospitals gobbled up huge portions of national health budgets but it was also clearly thought that training TBAs could improve equity in access to health care, one of the key features of the PHC ideology that was emerging at this time (see annex 1).

By the late 1970s and early 1980s, implementing PHC for maternal health in a cost constrained environment translated into a limited set of activities, none of which were particularly effective. The promotion of minimally-trained multipurpose workers at the community level, including traditional and volunteer health cadres that did not need government salaries, was a development very much in harmony with the thrusts of both primary health care and cost-containment. As part of this trend, support for the training of traditional birth attendants (TBAs) increased, whereas training of specialist cadres, those most necessary for preventing maternal deaths, decreased. For example, in the mid 1970s, the Bangladesh government discontinued training women who were in effect specialist community midwives and replaced them with family welfare visitors who were eventually to prioritise the delivery of contraceptives at the community level (Sherrat 1999). Similarly, in Egypt, midwifery schools were closed in the 1970s, and the current shortage of trained personnel with midwifery skills is a consequence that many other countries share today (Kwast 1992).

The influence of PHC and cost containment on the policy focus in maternal health can also be seen in the emphasis on antenatal care (as a preventive rather than costly curative service that could be delivered by relatively untrained health workers), and risk approach (as a way to rationally triage resources in poor environments by paying attention to those in greatest need) (Backett *et al.* 1984). These factors combined, meant that TBA training and antenatal care came to be thought of as the most cost-effective solutions to the problem of maternal mortality and morbidity until the mid to late 1980s (WHO 1974, Belsey 1985), though they came to be discredited by the 1990s. Global indicators for 'Health for All by the Year 2000' included measures of the proportion of the pregnant population receiving antenatal care, and the proportion delivered by trained attendants (including trained traditional attendants), that reflected these policies. In the poorest countries, coverage of professional delivery care services remained severely restricted; levels of maternal mortality remained very high.

In the early and mid 1980s, the women's movement activities to draw attention to women's health status brought the issue of maternal health successfully to the attention of major international institutions like the WHO and the World Bank. They made a public outcry about the high levels of maternal mortality in the developing world at the Mexico City Population Conference of 1984, and the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women in Nairobi in 1985. The women's movement was also an important influence leading to the 1987 Safe Motherhood Conference in Nairobi. The latter highlighted the persisting tragedy of maternal death in developing countries and set itself a target to halve maternal deaths by the year 2000 (Mahler 1987). The international women's movement's own campaign to prevent maternal mortality and morbidity also had similar goals (te Pas 2000).

Unfortunately, although the women's movement advocated for maternal health, it was never as specific in its demands for delivery services as it was in its demands for abortion services. For example, (Correa's 1994) book on feminist perspectives on reproductive health makes only mentions abortion as a cause of maternal mortality. Women's groups may have been fearful of focussing too much on women's traditional value as mothers (Jolly 1997). In her analysis of the contribution of the international women's movement to safe motherhood, (te Pas 2000) suggests that factors responsible for this included the diverse nature of the movement membership, their reluctance to being co-opted by engaging too closely with governments an international players like the World Bank. She also points out that the SMI had also failed to pay much attention to the question of how services could be best organised. For their part, some SMI advocates distanced themselves from the feminist agenda and attempted to focus on the technical aspects of Safe Motherhood, rather than diluting it by

addressing women's status and living conditions more broadly: 'SMI is not the women's initiative. It is not intended to meet all of women's medical and social needs' (Law *et al.* 1991). In 1996, the WGNRR decided to end its campaign on maternal mortality, replacing it with two campaigns: one on abortion and the other opposing cuts in health budgets and the World Bank (te Pas 2000).

Women's groups also promoted maternal health within the context of the 1994 ICPD. The 1993 Women's Declaration on Population Policies published prior to the ICPD incorporated previously separate areas of health, including maternal, into the definition of reproductive health. This was despite relatively little involvement of the international maternal health policy community in defining the reproductive health agenda (those involved were mainly concerned with ensuring that maternal health was part of this agenda for advocacy purposes and in the hope of attracting greater financial resources). At ICPD, women's groups saw maternity services as a core element of a comprehensive reproductive health care package. However a conflict remained over how the new ICPD agenda was to be funded (Murphy & Merrick 1996).

Policies within the international Safe Motherhood Initiative evolved slowly over time. Until the early 1990s, the SMI struggled to clarify the paradigms for providing maternal health services. Strong arguments were also made against exclusive reliance on the high risk screening approach and the value of TBA training. Maine 1991 cogently articulated the case for services at the referral hospital level. In an UNDP document with Law and colleagues (Law *et al.* 1991) also argued for a strong focus on maternal mortality and away from maternal health. In 1994, WHO articulated its policies in the form of the Mother -Baby package (WHO 1994), which included four pillars: antenatal care, clean safe delivery, EOC and family planning. The international SMI was not much influenced by the debates within ICPD. Perhaps the most significant shift in policy has occurred with respect to the call that all women have access to a skilled attendant. At the 1997 technical meeting of the SMI in Sri Lanka, Koblinsky and colleagues presented case studies of developing countries that had successfully reduced maternal mortality. In most of these countries skilled attendants were involved. The 1997 Technical conference document (Starrs 1998) presents a broad spectrum of policies⁹, including one reflecting a growing consensus on the need for skilled attendant for all births. The 1999 World Assembly adopted this goal. The maternal mortality target was also shifted to reducing the maternal mortality ratio by 75% by 2015' (DFID 1999).

⁹ Other policies include three messages aimed at changing the political environment by advancing safe motherhood through human rights; empowering women; and clarifying safe motherhood as a vital social and economic investment, and six messages aimed at the design and implementation of programmes: delaying marriage and first birth; acknowledge that every pregnancy faces risk, improving access to quality maternal care; preventing unwanted pregnancy and addressing unsafe abortion; the importance of measurement; and the power of partnerships (Starrs 1998).

National Maternal Health Actors and Policies

It is not possible to review the main actors and policies within individual developing countries in the format used in the previous section for international actors. National players parallel the main groups seen internationally. They include politicians and national level policy makers, members of the national ministries of health, professional groups of doctors and midwives, traditional birth attendants, women's and service users' groups. Examples given of the roles they have played in getting various issues on the policy agenda. Some examples are also used from industrialised countries as these are better documented in the literature.

Industrialised Countries

It is difficult to summarize national policies with respect to childbirth. In the West, the development of life-saving technologies occurred at a time when childbirth was professionalised and was becoming increasingly institutionalised (see figure 3). The 1950s and 1960s saw rapid and considerable falls in maternal mortality and maternal deaths ceased to be a big public health concern (Loudon 1992). The concerns in the late 1960s, 1970s and 1980s shifted to perinatal mortality and to issues related women's satisfaction with birth and iatrogenic medical practices.

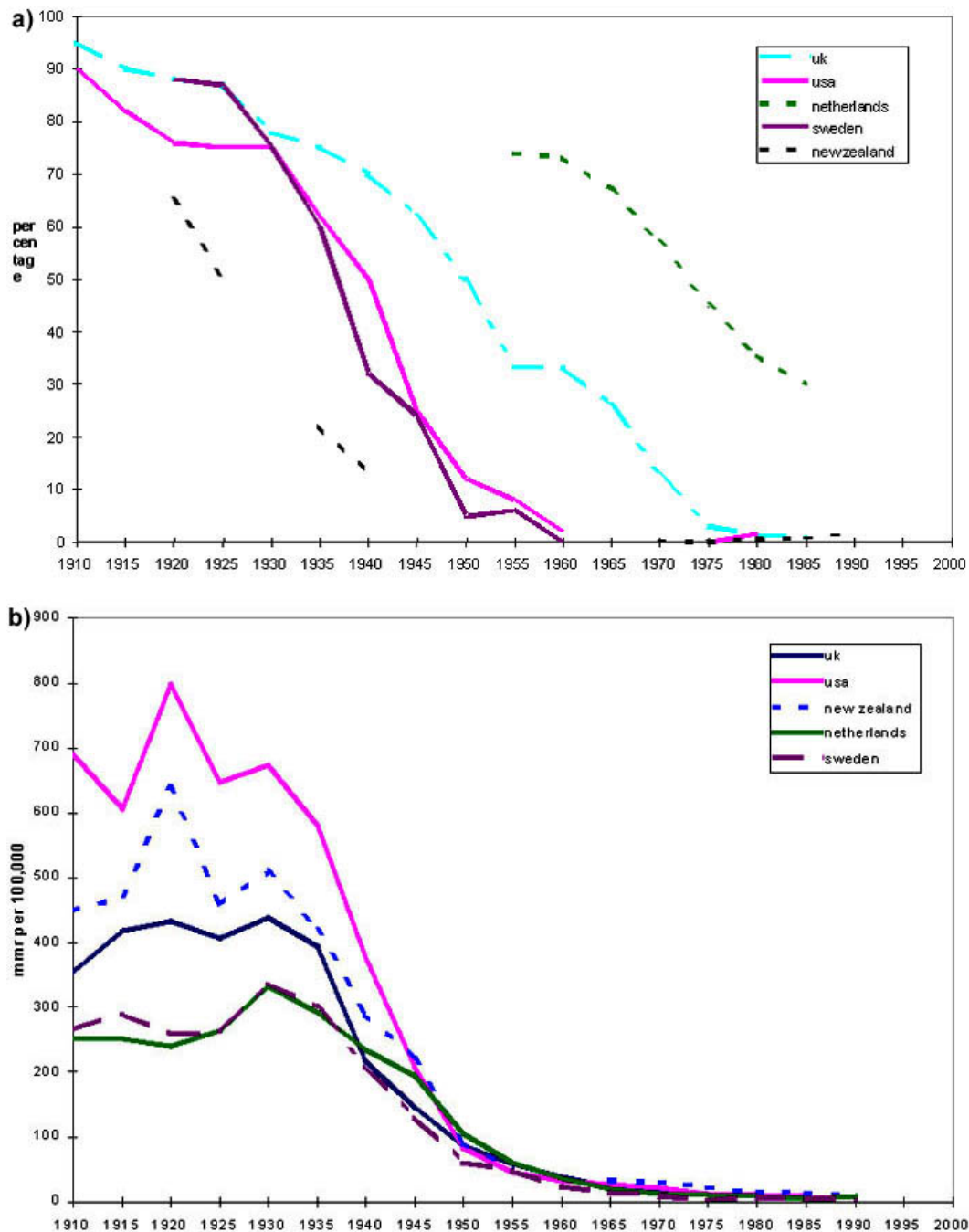


Figure 3. Percentage home deliveries and maternal mortality ratios for selected industrialised countries. a) Percentage home deliveries; b) Maternal Mortality Rates 1910-1990

Governments and Politicians

Although (Loudon 1992) and (Maine 1991) present the declines in maternal mortality as stemming largely from medical advances (including sulpha drugs and antibiotics to treat infection, better medical management of hypertensive diseases of pregnancy and better blood transfusion technology), (De Brouwere and colleagues 1998) convincingly identifies other factors. These include early awareness of the problem, recognition that the deaths were avoidable, and mobilisation of health professionals and the community. They also identify the political contribution to policies that enabled medical advances to be delivered to the population at large, namely by making sure that modern obstetric care [skilled birth attendants were available to all (De Brouwere *et al.* 1998)]. Similarly, (Williams 1997), in her history of

maternity care services in the UK in 20th century, provides a rich documentation of the roles of both government and politics in promulgating specific forms of delivery care. She also shows the appeals made to individual women by political parties (e.g. an election poster in 1929 stating 'Women if you want...Medical Care for Mothers and Babies...Vote Conservative'). Even in the USA, with its entrepreneurial health system characterised by negligible government inputs, (Margolis and colleagues 1997) argue that Congress passed the Maternity and Infancy Act in 1921 because of international comparisons showing the poor standing of the US, and fear of a feminized voting block backlash (women had just been given the vote).

Ministries of Health and Health Professionals

In industrialised countries with comprehensive health systems, national ministries of health have played a key role in organizing services. Child-bearing was increasingly institutionalised in most countries in Europe, although some, such as the Netherlands, set about deliberately maintaining home births with midwives (Van Alten *et al.* 1989, Treffers *et al.* 1990).

In other instances, health professionals have come to the fore as key policy actors. For example, national organizations of midwives have supported policies which retain their professional control as autonomous providers for normal births. In the USA, private markets and the medical profession were much more influential in setting policies than the government. The American Medical Association's political efforts to exclude midwives and the black medical schools from delivery have been well-documented (Margolis *et al.* 1997). Earlier, the AMA actively attempted to restrict government control of services (Margolis *et al.* 1997). More recently, insurance companies and HMO have also played key roles in such issues as the length of hospital stay after normal delivery (Kotagal *et al.* 1999). Professional bodies have also been influential in determining standards of practices, as for example with the Confidential Enquiry into Maternal Deaths, conducted by the UK Royal College of Obstetrics and Gynaecology.

Women's Groups

Women's groups and users groups have also had an influential role in affecting maternity care policy in later years. In the UK for example, groups like National Childbirth Trust (NCT), Association for the Improvement in Maternity Services (AIMS) Maternity Alliance, and historically, the National Birthday Trust have used a variety of advocacy tools to effect enormous changes in the quality of maternity care delivery in the last 40 years - not least by the skilful use of the media to disseminate and publicise their own and other relevant research findings. For example, The Changing Childbirth policy adopted in the UK government in the 1990s was developed in close concert with the NCT among others. Such user and/or women's groups also occasionally provide services, although they tend to be allied to but not directly maternity care services. For example the NCT provides antenatal care and breastfeeding support classes while in the USA, the Jane Collective in Chicago taught women to become lay abortion providers, at a time before abortion was legal.

Developing Countries

Apart from the literature on maternal health services during colonial administrations cited earlier, there is a limited literature on developing countries' maternal health policies prior to the second half of the 20th century. Kuhnke 1990 however, provides a rich description of Muhammed Ali's 19th century attempts to bring midwifery care to Egypt as a response to the problem of under-population. For most countries though, the concept of national policies only becomes meaningful after the end of the Second World War. In countries other than the West, national policies in this period seem to have depended to a great extent on the prevailing political systems and the allegiances held by governments in the Cold War (Zapata & Godue 1997). In general, socialist countries prioritised health care as a human right and made maternal health facilities widely available, including community programmes in the rural areas and, in many cases, abortion services (e.g. Soviet Union, Cuba, Sri Lanka, Kerala). In the Western-oriented developing countries, maternal health, and access to health-care in

general, was less of a priority to policy-makers and donors. Increased training of doctors and midwives and building of large hospitals was probably as much part of a general bid to increase human resources and develop rather than as a deliberate maternal health strategy (Rosenfield & Maine 1985).

Governments and Ministries of Health

Some countries did institute successful maternal health programmes, largely through governments and Ministries of Health. These examples of success include China, Malaysia, Sri Lanka, and more recently Iran. These countries boasting low mortality rates share a number of common features that could feed into policy agendas elsewhere. These include strong political support from health ministries and central government and long-term planning, often over 20 to 50 years. There is also efficient co-ordination between all levels of care from non-professional attendance at home to top medical care in hospitals. Accountability of local officials - crucial as a management tool in China and Malaysia and free referral to specialist and essential obstetric care was provided in Fortaleza Brazil, Malaysia, and Sri Lanka. Equity for rural populations was also a major policy thrust, but apparently not at the cost of good quality. In parts of Africa by contrast (Kasonde 1994) states that 'The historical background of inequity in most countries led them to emphasise equity even at the risk of reducing the quality of services'.

Health Professionals

It has not been possible to date to review literature on the contribution of professional groups in developing countries in setting maternal policies. Groups like the UK Royal College of Obstetricians play a role in framing the issues, largely by convening meetings (Philpott 1979). There are also several examples in the literature of where professional groups, normally doctors, have obstructed delegation of responsibility to other cadres. Also, in some countries, midwives and other staff do not have legal cover (Kasonde 1994).

Women and User's Groups

An international workshop¹⁰ on grassroots advocacy for maternity services determined that the majority of NGO's in developing countries were involved in a variety of activities that were allied, but secondary, to the provision of functioning delivery care services. These included providing training for traditional birth attendants, antenatal and post-partum care, fertility and abortion services, breastfeeding counselling, community education and sensitisation of health workers and service providers. However, after 10 years of the Safe Motherhood Initiative, experience suggests that such activities in isolation have had a limited impact on reducing maternal mortality, and that improvements in the availability and quality of delivery care are still desperately needed. Few of the NGOs interviewed were actively engaged in service delivery or advocacy activities directly focussed on reducing maternal death. One successful example of the latter though was a coalition of groups of activists and policymakers that worked to change abortion law in South Africa. There were fewer instances of advocacy to lobby for access to delivery care, although Ghana and Nepal provided some examples.

By and large though, most examples of NGO or women's activists organizing for maternity care services have been about getting more humane, responsive services. For example Anganen women in Papua New Guinea who were contacted by a Catholic mission in the mid 1960s willingly shifted from delivering alone to birthing with nuns in the aid post. Yet in the 1970, they staged mass protest with hundreds of women demanding that their placentas be returned. A compromise was reached in that a few inches of umbilical cord were given to new mothers (Merrett-Balkos 1997). In Brazil, groups such as Grupo Curamin and SOS corpo have also worked towards more 'humanized childbirth' services and have also been working

¹⁰ Feb 14-17 2000, London School of Hygiene & Tropical Medicine, UK. 15 representatives of NGOs in Ghana, Bangladesh, Philippines, Nepal, India, South Africa, Guatemala and the UK attended.

with TBAs to demand government reimbursement for delivery services provided. Another Brazilian group has supported legal action in cases of malpractice.

Finally, in developing countries individual, unorganised, users have played an important part. The shift to specialist care in hospitals tends to be demand-driven by, rather than stemming from proactive policy initiatives. In the urban areas of many countries, women are choosing to deliver in hospital, even though their rural counterparts deliver at home alone or with relative or TBAs.

Conclusions

In summary, this paper argues that much known about the technical interventions needed to reduce maternal mortality, but there has been much less study of the features of health systems that promote maternal health. There is some evidence to back the assertion that skilled attendants are a requirement but more data are needed on enabling factors such as resource requirements. Also there needs to be further study of exceptions such as rural China. It is relatively easy to assess the main actors and policies that have influenced international maternal health, but the role of the medical professionals and the reasons for the apparent shift in WHO's policies in the 1960 needs more attention though. In developing countries, more exhaustive case-study reviews of the key players and policies are needed.

Examples should be chosen from countries that developed their own policies as well as those that appeared to go along with international recommendations.

Two surprising features of international policy making for maternal health emerge: how the process of global agenda setting was driven by a relatively small set of international actors with particular ideologies; and second, how, despite relatively simple and cheap technologies being available, this process of agenda setting in fact limited the effectiveness with which appropriate interventions were implemented, largely because the health systems context was not addressed (Lush & Campbell 2000).

At the national level, policies were mostly driven by and politicians and the Ministries of Health, although less is understood of the details of how these policies happened. In general, and unlike the history in the West, service users, women's groups and democratic politics appear to have played a lesser role.

The way forward. Much more research is needed. However, it seems possible to identify a unique window of opportunity to improve maternity care services for women by working with advocates for service users and the sector wide approaches (SWAps) currently being promoted for health. The international Safe Motherhood Initiative has mainly worked with health services and medical care providers. This is an uphill battle given the entrenched and fossilised nature of many health services. A co-ordinated global campaign by grass roots organisation to tackle the access to and quality of maternity care services in poor countries (along the lines of the breastmilk network IBFAN) may be successful. Many NGOs perceive themselves as being well placed to advocate for appropriate delivery care services to be made universally accessible (Peattie & Campbell 2000).

There are also real opportunities to be had for the Safe Motherhood Initiative by linking it to activities that seek to improve the health sector as a whole. Creating a functioning health system appears to be the most obvious way to provide an enabling environment for maternity services. Most of the inputs needed to improve essential obstetric care already exist as integral parts of district health-systems even if some do not function well, or need updating. Currently donors are interested in SWAps, which are seen to present a major opportunity for donors to support policies leading to development of effective and efficient health systems. (Cassels 1997). There are two main reasons to promote safe motherhood within SWAps (Goodburn & Campbell 2001).

First, considerable donor resources are invested in 'health services' and the health sector generally (Zeitlin *et al.* 1994). For this reason, it may make better tactical sense for maternal health to link-up with, and tap into, the greater funds available for health sector development rather than to compete with an articulate and large constituency for family planning funds. Second, safe motherhood's dependence on the health system configuration means that health sector reforms have huge implications for safe motherhood. For example, the introduction of user fees has been associated with reduced use of maternity care in some situations and an increase in others (e.g. see Borghi 2000 in this conference). Many proposed solutions, such as insurance schemes, fail to cover precisely those interventions that are life-saving [for example, in Yunnan, China, an insurance scheme covered antenatal and

postnatal, but not delivery, care (Kaufman *et al.* 1997)]. Linking safe motherhood to SWAps at an early stage can mean the implications for proposed solutions for maternal health can be tested and considered. It also provides an opportunity to test the robustness of SWAps against a few agreed clinical priorities.

In conclusion, long term, sustainable and affordable improvements in safe motherhood are dependent on policies that improved functioning of health systems as a whole. Gains in countries such as Malaysia, Sri Lanka and Iran were achieved by making maternity care a core activity guiding changes in their health services. Efforts to achieve this in other developing countries need pragmatic support, and SWAps and consumer advocacy are compatible with a focus on maternal health services.

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Annex 1. Ideologies that Have Influenced Maternal Health Policies

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Developments in maternal health have been guided by particular ideological paradigms which have been adopted to varying degrees. Beyond the obvious role played by economic rationales, the most prominent of these have been, first, the need to prioritise interventions that are appropriate for delivery at basic PHC facilities and, second, the desire to address health problems through improving the status of women. To some extent this has been based on political expediency and presentation rather than technical or scientific evidence, a process that has led to problems with implementing effective health programmes at national level.

Family Planning

Family planning policy from the 1950s to the late 1980s was driven by a macro-economic agenda of concern over the impact of rapid population growth on developing economies. This concern led to the development of vertically funded and managed family planning programmes, heavily prioritised by international donors, in particular, the United States Agency of International Development (USAID) (Finkle & McIntosh 1996), UNFPA, a number of international family planning NGOs, including the Population Council. The Human Reproduction programme within WHO was also started in the mid 1960s. Large US-based foundations, such as Rockefeller and Ford also took a significant interest in population issues (Finkle & McIntosh 1996).

Primary Health Care

PHC, since its origins in the 1960s and 1970s was guided by five principles: equitable distribution; community involvement; focus on prevention; appropriate technology; and a multi-sectoral approach (Walt & Vaughan 1982). It was grounded in a broad theory of development that rejected economic modernisation as the only means to human well being and placed good health firmly at the centre of an economic growth-equity-productivity nexus. Furthermore, in the Alma Ata declaration of 1978, the international public health community committed to comprehensive PHC as part of a broader political and economic development agenda (WHO 1978).

During the 1980s, PHC ideals ceded to selective care based on what were perceived to be cheap service packages (Walt 1998) (see below). The failures of PHC therefore came under intense scrutiny, especially the unrealistic nature of the original objectives, given levels of public sector expenditure, and the difficulties of ensuring equitable resource allocation (Chen 1986, Rifkin & Walt 1986, McPake *et al.* 1993, Collins & Green 1994, Kalumba 1997). Ironically, many of the PHC concepts were absorbed by those drafting the ICPD Programme of Action (Chapter eight starts with a discussion of PHC (para. 8.1)), apparently ignoring 20 years of PHC experience, which suggested that a comprehensive approach was difficult to implement in practice, given low levels of funding (Walt & Vaughan 1982).

Neo-liberal Economic Policies

The global trend towards neo-liberal economic policies also influenced policy-making at Ministries of Health of developing countries. In the 1980s, cost-effectiveness of health interventions became a priority, necessary for the structural adjustment programmes that the IMF and World Bank recommended to the indebted developing countries. Limiting the costs of healthcare spending was considered essential in globalised competition (Zapata & Godue

¹¹ Based in Lush L and Campbell 2000. International co-operation for reproductive health: too much ideology? In press.

1997) and comprehensive PHC pared back. This shift also reflected the growth in influence and financial commitment of richer and more economically-motivated international actors, such as the World Bank (Walt 1998).

More recently, major reforms were initiated in many low income countries to try to increase efficiency in health service financing, expand access to primary level services and improve quality of care (Berman 1995, Janovsky 1996). As part of this effort, international donors emphasised basic packages of care that were considered to be cheap and cost-effective and should therefore be available to all. Two of the top five most heavily promoted cost-effective address preventing unwanted pregnancy and preventing maternal mortality (World Bank 1993).

Tinker states for example that maternal health interventions are cost-effective (3\$ per woman and \$230 per death averted) (Tinker 1997, Jowett & Ensor 1999).

Women's Status

Women's status in low-income countries and its relationship with poor health outcomes has long been a cause for concern among Western women's groups and increasingly among low-income country women's groups themselves (Kabeer 1994). There is also a well-documented inter-action between poverty and gender, whereby poor women often live in extremely vulnerable situations (Folbre 1983, Boserup 1989, Oppenheim Mason 1993).

There is considerable debate remains over what the goal with respect to women's status is and what should be the means of achieving it (van Staveren 1994, Basu 1997, Oppenheim Mason 1993, Agarwal 1994). Nevertheless, during the 1980s, improving gender equality and women's rights became a central tenet of women's health activists' arguments (Lane 1994), some going as far as saying that meaningful improvements in reproductive health could only be achieved by improving women's status.