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**SAFE MOTHERHOOD: THE MAKING OF A
GLOBAL HEALTH INITIATIVE**

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London School of Hygiene & Tropical Medicine

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Declaration by the candidate

I hereby declare that the work presented in the thesis is my own.

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Abstract

Launched in 1987, the Safe Motherhood Initiative has brought together UN agencies, donors, NGOs and academics to galvanise a political, financial and public health response to women's pregnancy-related death and ill health in low-income countries. This thesis presents an historical ethnography of the 'making' of this policy community over the past twenty years, as one of many so-called global health initiatives that populate the global health field. Compared with its competitors, the Safe Motherhood Initiative is often depicted as weak and in need of urgent revival. Drawing on in-depth interviews with over seventy actors within the field, participant observation and document review, I explore how safe motherhood practitioners have come to understand the problems that are credited for the field's stymied status, and how their 'diagnoses' and situational analyses have informed their subsequent practices.

My findings demonstrate that the Initiative has continually had to reposition itself in response to broader ideological, institutional and epistemological struggles. An impulse for self-preservation within a competitive global health field favouring disease-specific approaches has been in tension with safe motherhood practitioners' fundamental conviction that comprehensive, socially-based policy change is needed to reduce maternal mortality. In order to pursue their common policy objectives and to secure their survival as an expert group, safe motherhood practitioners have sought to enhance the credibility of their policy proposals, establish new institutions and funding mechanisms, elaborate advocacy campaigns and pursue more sophisticated research to demarcate their practices as scientific, rather than ideologically driven. However, the benefits of such 'self-management' practices remain to be established. In conclusion, I challenge the widespread, if implicit, assumption that the success of a single advocacy issue, as measured through the rise of a global health initiative and growing political commitment to the specific issue, will necessarily lead to health improvement.

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Acronyms

AMDD	Averting Maternal Death and Disability
DALY	Disability-adjusted life years
DfID	Department for International Development
ESRC	Economic and Social Research Council
EmOC	Emergency Obstetric Care
FCI	Family Care International
FIGO	International Federation for Gynaecologists and Obstetricians
GAVI	The Global Alliance for Vaccines and Immunisation
GHI	Global Health Initiative
GOBI	Collective term for growth monitoring, oral rehydration therapy, breastfeeding, and immunisation
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
LAG	(Safe Motherhood) Inter-Agency Group
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IMCI	Integrated management of childhood illnesses
IMPACT	Initiative for Maternal Mortality Programme Assessment
IPPF	International Planned Parenthood Federation
LSHTM	London School of Hygiene and Tropical Medicine
MAP	World Bank's Multi-Country AIDS Programme
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MMR	Maternal mortality ratio
NGO	Non-governmental organisation
NORAD	Norwegian Directorate for Development Assistance
Pepfar	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PMNCH	Partnership for Maternal, Newborn and Child Health
RCT	Randomised controlled trial
RPMM	Regional Prevention of Maternal Mortality Network
SAPs	Structural Adjustment Programmes
SWAPs	Sector-wide approaches
TBA	Traditional Birth Attendant
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Project
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

Chapter 1

1. INTRODUCTION

...you know, maternal health has had a very sad history, as you probably know better than I do, and the Safe Motherhood Initiative – that’s what it was called – in ’87 was full of hope and fell flat, flat, flat... Now, part of that was context. A lot of global health fell off the agenda in the late ’80s early ’90s... But, as far as I am concerned, it was a disaster, that whole effort, despite quite good intentions. The question is, can this constituency, this community, get its act together and push a little bit more effectively...

So started my interview with a senior policy advisor for the World Health Organisation (WHO) in 2005, during which we discussed the current position of the Safe Motherhood Initiative within the global health field. Launched at an international UN-sponsored conference in Nairobi, Kenya in 1987 (Starrs 1987), the Safe Motherhood Initiative is a policy community consisting of multilateral and bilateral agencies, academics, professional organisations for healthcare providers and a range of international advocacy NGOs. Ever since its formation it has aimed to galvanise a political, financial and public health response to women’s pregnancy-related death and ill health, an important public health problem in low- and middle-income countries.

Today, the Safe Motherhood Initiative co-exists with about one hundred other ‘global health initiatives,’ such as Roll Back Malaria, Stop TB and the Child Survival Initiative (WHO 2008). While the term is loosely defined, global health initiatives are often identified by several common characteristics. This includes their focus on specific diseases or on selected interventions, commodities or services and their ability to generate substantial funding, including from private sources (World Health Organization Maximizing Positive Synergies Collaborative Group 2009). Global health initiatives often invest directly in low-income countries, including through partnerships with NGOs and civil society, and their activities tend to be oriented towards the achievement of health and development ‘targets,’ especially those associated with the Millennium Development Goals (MDGs).¹ This is certainly the case with regard to safe motherhood: MDG 5 calls for improved maternal health

¹ The MDGs are a list of eight goals that UN member states and leading development agencies strive to achieve by 2015 (United Nations 2009).

and sets the target of a three quarters reduction of the maternal mortality ratio (MMR) by 2015, from 1990 levels.²

Global health initiatives constitute an ever more important part of the international health landscape. Increasingly they control financial resources (McCoy et al. 2009; Ravishankar et al. 2009), set the terms of debate, and occupy important positions in global health policy debates (Lee and Goodman 2002). Despite their proliferation and apparent success, some authors have described such initiatives as characteristic of a deeply fragmented and indeed “over-populated” global health architecture (McCoy 2009). Within this architecture, a multitude of diverse players exist in parallel and overlapping coalitions, alliances and partnerships and work towards different, often disease-oriented goals, largely in competition with one another (Buse and Walt 2000a; Walt 2005). This notwithstanding, a small number of global health initiatives dominates the international health scene. Examples of these more powerful initiatives include the Global Fund to Fight AIDS, Tuberculosis and Malaria (often referred to simply as the Global Fund); the Global Alliance for Vaccines and Immunisation (GAVI); the US President’s Emergency Plan for AIDS Relief (Pepfar); and the World Bank Multi-Country AIDS Program (MAP) (Lancet 2009a). The Global Fund and others like it have been revered for their contribution to global health (Lancet 2005), and have received a good deal of academic attention. Much less attention, however, has been paid to the plight of those initiatives that struggle to make their way within this increasingly competitive global health field (Walt 2005; Béhague and Storeng 2008).

The Safe Motherhood Initiative comprises one such arena of struggle. Though maternal health has an MDG of its own, the initiative itself is most certainly not among the more powerful group of global health players. Indeed, it is frequently depicted as weak and struggling for influence, success and funding (AbouZahr 2003; Starrs 2006). It has been estimated, for example, that donor spending on activities related to maternal, newborn and child health combined represented just 2% of gross aid disbursements to developing countries in 2004 (Powell-Jackson et al. 2006), and this at a time when other major, new disease-targeted global health initiatives have

² The MMR is the number of maternal deaths per 100,000 live births, and is a measure of the risk associated with each pregnancy (obstetric risk). The WHO defines a maternal death as the “death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (WHO 2004).

been seen as playing a major role in bringing about a four-fold increase in development assistance to the health sector between 1999 and 2005 (OECD 2008; Ravishankar et al. 2009). The Global Fund in particular was in 2008 described as the single most important agency for health assistance in terms of the number of country partners and the diversity of recipients (it having agreed US\$ 11 billion in grants with 136 countries within its first decade) (Banati and Moatti 2008).

While the Global Fund claims to have saved 4,000,000 lives,³ the relatively limited improvement in maternal health statistics since the Safe Motherhood Initiative was launched has often been seen as a sign of the Initiative's failure. The latest global estimates suggest that maternal mortality accounts for approximately 536,000 deaths of women each year, for example: a figure that has remained remarkably constant since the first global estimates were published in 1986 (WHO/UNICEF/UNFPA/World Bank 2007).⁴ While it may be true that a handful of countries in Asia and Latin America have succeeded in reducing their maternal mortality ratios, the maternal health situation in Sub-Saharan Africa is worse than it was twenty years ago and remains dismal in South Asia (Hill et al. 2007). The statistics are especially tragic given that most maternal deaths could have been prevented had women had access to medical interventions to treat the obstetric complications that are the main direct cause of maternal mortality (Rosenfield 1989).⁵

According to safe motherhood leaders, one of the principal reasons for such disappointing statistics has been the Initiative's inability to issue clear, evidence-based recommendations to countries on how to best organise their health systems to ensure access to life-saving care to those who need it (Starrs 2006). This perception, in turn, has prompted considerable self-criticism of the Initiative's ability to advocate for dedicated policy attention, to attract financial resources and to ensure that safe

³ <http://www.theglobalfund.org/en/>, accessed 10.11.09.

⁴ Measuring maternal mortality accurately is difficult except where comprehensive registration of deaths (with causes) exists. As a result, estimates in low-income countries are usually derived from a combination of surveys and mathematical models. Given the variety of methods used and the large uncertainty bounds around estimates discerning trends in maternal mortality is particularly complex (Ronsmans and Graham 2006).

⁵ Complications including haemorrhage, infection (sepsis), hypertensive disorders during pregnancy, anaemia, obstructive labour and complications from unsafe abortion account for around 80% of maternal deaths globally, with the remaining 20% resulting from indirect causes (pregnancy-related death in a patient with a pre-existing or newly developed health problem) (WHO 2004; WHO/UNICEF/UNFPA 2004). The distribution of causes of maternal mortality varies by region. While haemorrhage is the leading cause of maternal mortality in Africa and Asia, hypertensive disorders (including eclampsia) have been identified as the top single cause in South America. By contrast, in developed countries, the most important cause of maternal death is 'other direct causes' such as complications during interventions like caesarean section and anaesthesia (Khan et al. 2006).

motherhood remains high on the list of priorities on the broader global health agenda (Rosenfield 1997; AbouZahr 2001; Campbell 2001; Miller et al. 2003; Starrs 2006). Scholarly interest in the amount of international attention and funding directed at different global health initiatives has tended to reinforce such self-criticisms. In one such analysis of the Safe Motherhood Initiative, the political scientists Shiffman and Smith (2007:1377) argue that the Initiative has failed in its efforts to achieve political priority and that it “remains in a state of infancy even after 20 years,” in large part because of institutional weaknesses and problems in the way the issue has been publicly framed. They therefore recommend that safe motherhood advocates should build better institutions and identify champions who can drive the movement forward and take advantage of windows of opportunity for effective advocacy (Shiffman and Smith 2007). Key leaders in the field have taken this advice on board, as is reflected in the way the twentieth anniversary of the Initiative’s founding was marked in 2007. For many of the safe motherhood actors I spoke with in the course of my research, this anniversary was judged to be a critical juncture at which the movement needed to regroup and find ways to emulate its more successful competitors. According to one commentator, it offered an “unprecedented chance to redress errors of the past and take advantage of new opportunities” (Starrs 2006:1130). As the WHO representative I cited at the beginning of this chapter claimed, as the Initiative approached its twentieth anniversary the time had clearly come for this coalition of actors to, “get its act together and push a little bit more effectively.”

Such recommendations speak to some of the principal concerns within the field, but tend to inappropriately reduce the relative ‘neglect’ of maternal mortality to the Safe Motherhood Initiative’s technical failure as a global health initiative. By focusing heavily on raising funds and political will to address safe motherhood, such recommendations may not adequately address the broader challenges of improving maternal health, including challenges relating to weak and poorly-functioning health systems in low-income countries, or the potential implications of intensified competition between global health initiatives for efforts to improve health. In just the last few years, at the same time that safe motherhood experts have been pushing to attain the status of a strong global health initiative, there has been growing concern that the ‘effectiveness’ of health sector aid is in fact hampered by the competition, duplication and lack of coherence that topic-specific global initiatives generate

(Lancet 2009*a*). There are also worries that global health initiatives encourage disease-specific donor-funded ‘vertical’ programmes that weaken health systems by detracting financial and human resources from government services (Pfeiffer 2004).⁶ Nevertheless, it is often in the self-interest of global health initiatives, who are themselves dependent on donor financing, to focus on short-term performance and to see health in terms of crisis and humanitarian immediacy, rather than to pursue comprehensive change and focus on the long-term sustainability of interventions. Key players in the maternal health field are aware of the broader context that shapes the tension between disease-specific advocacy and the need for comprehensive change to health systems (Freedman et al. 2005). Indeed, this tension, together with the various activities that have been mobilised by maternal health experts in responding to it, became the central entry point for my own research.

Making sense of this tension entailed exploring first, how the actors involved in the struggle for survival and recognition have come to understand the problems that are credited for the field’s stymied status, and second, how their own ‘diagnoses’ and situational analyses informed their subsequent practices. I thus set out in this thesis to conduct an historical ethnography of the ‘making’ of the Safe Motherhood Initiative, combining ethnographic and historical approaches to uncover the complexity of this initiative’s development over the past two decades.

Three specific objectives have oriented my fieldwork and analysis. The first of these was to analyse how the enduring tension between ‘comprehensive’ and ‘selective’ or disease-specific approaches to public health has impacted on safe motherhood policy debates since the Initiative’s launch in 1987. This involves situating the emergence of the Safe Motherhood Initiative and the particular shifts in its international policy proposals within the rapidly changing context of international or global health. My second objective was to examine how research and advocacy practices have responded to, and are in part constrained by, these developments, including by dominant ideas about what constitutes evidence. Underlying these two objectives is a key theoretical concern with identifying and examining a series of ‘self-management’ techniques developed by safe motherhood leaders. By self-management

⁶ According to the WHO (2008), a health system comprises “all organisations, institutions and resources devoted to producing actions whose primary intent is to improve health. Most national health systems include public, private, traditional and informal sectors. The four essential functions of a health system have been defined as service provision, resource generation, financing and stewardship.”

I mean the range of practices and strategies that actors within the Initiative engage in to pursue their common policy objectives and to secure the survival of safe motherhood as an expert group. The third objective was to then critically evaluate the extent to which the 'self-management' practices that have been adopted are likely to ensure the survival of safe motherhood as a policy community and to translate into effective strategies for the survival of women throughout pregnancy and childbirth.

This thesis draws upon, and brings together, literature from anthropology and policy studies, as I set out below. It builds on earlier ethnographic research funded by the Economic and Social Research Council (ESRC) on the role of the evidence-based medicine movement in shaping international maternal health policy, a project of which Dominique Béhague and I were co-principal investigators (see Béhague and Storeng 2007 and Chapter 2 for details).⁷ I use a multi-method approach, which includes the review of documents (including scientific literature, policy documents and grey literature), in-depth interviews with actors from the main organisations involved in international-level work on safe motherhood (such as multilateral and bilateral agencies, academic institutions and NGOs), and participant observation in international meetings, conferences and within the academic domain.

1.1. Safe motherhood as a global assemblage

Today, global health initiatives are so pervasive that it is easy to forget that they constitute a relatively recent development that has emerged as a result of great changes within international public health. The establishment of networks such as the Safe Motherhood Initiative is emblematic, in fact, of a broader shift from 'international' to 'global' health (Brown et al. 2006). Whereas international collaboration in health in the late 19th and early 20th centuries accompanied the growth of the modern bureaucratic state and its need to protect its territorial interests against threats such as infectious disease (Weindling 1995), the term 'global health' reflects the linkages and transnational flows of people, ideas, commodities and

⁷ This project was initiated in 2004 and completed in April 2007 and aimed to examine how researchers and policy-makers in the international maternal health field engage with the ideas and values of 'evidence-based policy-making,' the extension of the basic tenets of evidence-based medicine (the explicit attempt to use science to guide and evaluate clinical practice) into public health policy. The specific objectives of this research explored first, the circulation of evidence between policy-makers and researchers; second, actors' views on the use of different kinds of evidence; third, epistemological constraints on evidence-based policy-making and, finally, how research could more effectively guide policy-making and programme development (Béhague and Storeng 2007).

ideologies that characterise health in today's interconnected world (Nichter 2008; Janes and Corbett 2009). Global health is intimately connected to issues of national security, economic development, globalisation, human rights and global governance (Fidler 2004). In this context, the Safe Motherhood Initiative must be seen to be in a process of emergence. Its development has unfolded in the midst of institutional struggles in the international health field and in response to competing framings of the idea of health itself. While these elements recur throughout the thesis, it is useful to briefly outline the main institutional struggles and ideological and intellectual developments against which the Safe Motherhood Initiative has developed.

Since the mid-1980s, international governance for health has shifted from being dominated by inter-governmental collaboration within international health organisations, to a complex structure of multiple organisational types and public private partnerships, such as the global health initiatives described above (Fidler 2007; Gostin and Mok 2009). Following its formation as the UN's specialised agency for health after the end of the Second World War, the WHO was a representative body for its member states and the undisputed leader of international health collaboration (Fee et al. 2008). However, the Safe Motherhood Initiative was in fact formed in the midst of a contest for dominance over the governance of international health, in which the WHO saw its authority threatened and gradually subsumed. This was due in part to the WHO's own economic and institutional problems, which enabled better-resourced actors, notably the World Bank, to assume a leading position in international health work (Ruger 2005; Brown et al. 2006). The rise of the World Bank as a global health actor in turn reflected a broader shift with the rise of neoliberalism as a dominant political ideology within international development assistance.⁸ Ever since the early 1980s, the WHO has had to constantly reposition itself within a shifting set of power alliances resulting from the growing involvement not only of the World Bank, but also of the private sector, including philanthropists such as the Bill & Melinda Gates Foundation (hereafter the Gates Foundation), and a growing number of civil society or non-governmental organisations (Brown et al. 2006). Over the past decade global health initiatives have become a ubiquitous feature of this landscape, and while they often incorporate the WHO and other UN agencies, they are autonomous from them and are, in fact, largely governed by donors' interests and priorities (*ibid.*).

⁸ 'Neoliberalism' denotes a form of liberalism favouring free markets (see Chapter 3).

The emergence of such an 'architecture' of competing interests has had important implications for international governance for maternal health too. Although the WHO has a constitutional mandate to protect maternal health, the weakening of its position by the mid-1980s meant that the remit for 'safe motherhood' was divided between the WHO and other UN specialised agencies, including the World Bank, and several NGOs who together comprised a Safe Motherhood Inter-Agency Group (IAG) (see Chapter 3). With time, this group has become increasingly influenced by donors and NGOs and now competes with many other disease-specific initiatives.

The institutional struggles that have characterised global health over the past two decades are underpinned by a deeper and more entrenched ideological tension between polarised framings of public health. At one end of this polarity is the view of health as a basic human right that should be available to all and collectively provided, while at the other end lies a view of health services as a product that should be provided and determined by the market place (Lee and Goodman 2002). While the WHO has often been associated with the former of these framings, the World Bank and many of today's dominant global health initiatives have been associated with the latter (Cueto 2004).

Over the past three decades, these often polarised conceptions of public health have given rise to different policy approaches to health improvement and reforms of the health sector (discussed in more detail in Chapters 3 and 4) (Standing 2002; Mills 2005). Those pursuing 'health for all' as a social good have often favoured 'comprehensive' approaches incorporating attention to social, economic and biomedical determinants of health through 'horizontal' programmes, seeing health improvement as inseparable from social and economic development. By contrast, others have favoured 'selective' or disease-specific approaches delivered through 'vertical' programmes, often with a more narrow focus on achieving measurable impact on health targets (Mills 2005; Brown et al. 2006; McPake 2008). Such vertical programmes have been encouraged in recent years by the disease-specific and target-oriented nature of the MDGs and other international health campaigns. The debate about the merits and challenges of these different approaches was formative in the creation of the Safe Motherhood Initiative and has, as this thesis will show, permeated policy debates and strategic developments within the field ever since.

Such ideological positions have, in turn, become institutionalised within different epistemological traditions and analytical approaches too. Notably, as neoliberal ideas have gained influence within the international health field, they have become reflected in the creation of normative criteria for evidence and priority-setting and resultant analytical tools, such as burden of disease and cost-effectiveness analysis. These tools are then applied in global health policy to ‘translate’ neoliberal values into decisions about the allocation of limited resources (Lee and Goodman 2002:109). The reliance on such tools is itself an expression of the more general shift towards ‘audit cultures’ within the context of Western, neoliberal societies (Lambert 2006). Anthropologist Marilyn Strathern (2000) coined the term ‘audit culture’ to describe a cultural shift characterised by a bias towards quick, visible productivity, driven by the perceived need for transparency and accountability that increases as trust in the authority of public sector institutions wanes. Audit culture, although characterised by Strathern as a quintessentially British phenomenon, has been transposed to international development work and global health policy. Mosse and Lewis (2005), for instance, show how various aspects of audit culture, such as the demand for ‘accountability’ in terms of performance indicators like the ones associated with the MDGs, have permeated the heart of international development and the management of aid. Under the guise of ‘evidence-based’ practice and the need for ‘transparency’, such demands for accountability have replaced the more explicit and now largely discredited forms of donor conditionalities associated with neoliberal structural adjustment policies of the 1990s (*ibid.*).

The rise of the evidence-based movement in medicine and its subsequent expansion to public health and, eventually, to health policy and almost all areas of social policy, can also be seen as a manifestation of this broader cultural shift (Dobrow et al. 2004; Lambert et al. 2006). Evidence-based medicine, developed primarily in the UK and the US, is an explicit attempt to use scientific knowledge, or “clinical evidence [derived] from systematic research,” to guide and evaluate clinical practice (Sackett et al. 1996:73). Evidence-based policy-making, the expansion of this paradigm from clinical practice into decision-making about policy, is said to enable policy-makers to move away from a form of health politics based on popular support or ideology, to a more legitimate approach based on scientific fact (Klein 2000). In the global health field, increasingly stringent demands for evidence to justify donor investment and government action on health can be seen as the result of an emerging

tendency to express the values of public health through technical, evidence-based goals (Walt 2008). An ethnography of the Safe Motherhood Initiative offers an interesting vantage point onto the impact of such changing epistemological frameworks on the competition for global health resources. The rise of the evidence-based medicine paradigm, for example, has been associated with acute anxieties, with key actors claiming that problems relating to measurement and the inability to prove the impact of proposed programmes have contributed to the neglect of maternal health relative to other global health issues (Béhague and Storeng 2008).

As set against this institutional, ideological and epistemological context, the Safe Motherhood initiative is perhaps best thought of as an example of what Ong and Collier (2005:13) have called “global assemblages.” Ong and Collier use the term to refer to the emergence of new social, political and epistemic configurations associated with the structural transformations and reconfigurations of society that accompany globalisation. The ‘making’ of the Safe Motherhood Initiative cannot be understood, therefore, in isolation from its institutional, political and intellectual context.

1.2. Gaps in the social science literature on global health

The rapid changes to the international health field briefly outlined above have in recent years captured the interest of scholars, including medical anthropologists, health policy analysts and historians of public health. However, as I outline below, literature in this area is in its infancy and important gaps remain in this literature on the role of global health initiatives in the broader health policy process. The actual process of policy development and, crucially, the perspectives of the actors who make up such initiatives, for instance, have received little attention. In the subsections below, I provide a brief overview of how the subfields of health policy analysis and medical anthropology have examined global health and public health policy, before discussing how these approaches have informed my own analytical approach and effort to address gaps in the existing social science literature on global health.

1.2.1. Health policy analysis

Health policy analysis is an applied multi-disciplinary, social science approach to public policy with the remit of explaining the interaction between institutions, interests and ideas in the policy process (Walt et al. 2004). The policy process can be

understood as the way in which problems, or health issues, come to be defined as ‘political’ problems, the remedies that are devised for dealing with them, the implementation of those solutions, the evaluation of the impact that the solutions have, and the way in which that evaluation itself feeds back into the process of policy formulation (Sabatier and Jenkins-Smith 1993:xi). For the past 15 years, new approaches have been developed to deal specifically with health policy analysis in, and as it pertains to, low- and middle-income countries.⁹

Until the mid-1990s, much policy analysis applied rationalist or instrumental models to understand the policy process, often considering the policy process in terms of incremental, discrete stages, and mostly focusing on the role of governments in devising policy (Buse et al. 2005). Scholars interested in international health policy found such models, developed for studying policy in the US and advanced democratic systems, inadequate for examining the policy environments of low- and middle-income countries, which tend to have weaker regulations, regulatory capacity and monitoring systems (Walt and Gilson 1994). Instead, they identified a need for attention to global decisions as well as domestic actions. As Walt and her co-authors (2008:309) argue, this is because these countries often lack purchasing power as leverage to influence types and quality of services delivery and are often dependent on external donor funds in setting the policy agenda. Health policy analysts subsequently advanced analytical models that tried to take into account the complex interplay between the actors devising policy and the context in which policy is formulated, and the power relationships that come to bear on this process (Walt 1994; Gilson and Raphaely 2008). This was a clear departure from previous approaches that focused largely on content and design of policy.

The notion of ‘policy transfer’ has been of major intellectual interest to scholars of international health policy, and is clearly of relevance to any study examining the work of global health networks such as the Safe Motherhood Initiative (Lush et al. 2003; Ogden et al. 2003; Walt et al. 2004). Policy transfer has been defined as “the occurrence of, and processes involved in, the development of programmes, policies, institutions etc. within one political and/or social system which are based upon the ideas, institutions, programmes and policies emanating from other political and/or social systems” (Dolowitz and March 1996:3). When applied to the transfer of policies from international to the national or even sub-

⁹ For the first ever review of health policy analysis in low and middle income countries see Gilson and Raphaely (2008).

national level, studies of policy transfer draw particular attention to the distinction between voluntary and coercive policy transfer. Where policy is transferred voluntarily, policy-makers learn about experiences elsewhere and choose to adapt them to their own contexts (Culpeper 1997; Killick 1998). By contrast, coercive policy transfer implies that policies are imposed, often by international organisations or donors who may influence policy choices at the national level by, for instance, tying financial or technical assistance to policy conditions (Hiscock 1995; Okuonzi and Macrae 1995; Sundewall et al. 2009). Authors have examined the effects of policy transfer on the operational implementation of policies and programmes at the district or health facility levels in specific countries, often showing how transfer that lacks local 'ownership' or that fails to take local context adequately into account can fail in implementation (Stone 1999; Gilson and Raphaely 2008).

Policy analysts have paid less attention, however, to what Walt and colleagues (2004:191) term "the bread-and-butter" work of international organisations and actors and how they devise, adopt, adapt and then promote global policies. This includes not only the role of intergovernmental agencies such as the WHO, but also that of various policy-advisors, scientists and advocacy specialists operating at the international level (Gilson and Raphaely 2008). Existing studies suggest that the role of international organisations and certain NGOs is particularly important in 'agenda-setting' and in formulating, adapting and promoting global guidelines, while international-level researchers play distinct roles in informing, evaluating and legitimating international policy (Stone 2002; Lush et al. 2003; Ogden et al. 2003; Doyle and Patel 2008). Yet, an identified gap remains in the literature, which I hope to help address, on how policy initiatives emerge and develop, and what part international organisations play in promoting such initiatives, internationally and nationally, as policies assumed to represent global "best practice" (Walt et al. 2004:191).

Those interested in the important question of how international policy agendas are established have paid particular attention to how advocates of different health issues manage to exploit 'windows of opportunity,' as mentioned above. Such analyses often draw on Kingdon's (1984) 'multiple streams' theory of agenda-setting, which conceives of the policy process as having a random character, with problems, policies and politics flowing along independent streams, which merge at particular junctures, creating windows of opportunity in which governments decide to act. For

instance, some have adapted Kingdon's framework to study health policy issues, including relating to safe motherhood (Reich 1995; Shiffman and Smith 2007). Others have emphasised the role of agenda-setting, focusing events and dedicated advocacy in these processes (Reich 1995; Birkland 1998). But a possible critique of such studies is that while it is often possible to identify the window of opportunity that gives global health initiatives the legitimacy to promote specific policies, doing so does not tell us why specific policies are selected and pushed as global best practice (Walt et al. 2004).

Frustration with applying formal policy frameworks and theories to complex policy processes has led many policy analysts to abandon strict adherence to a specific theoretical model and recognise the need for more open-ended forms of analysis, ones that can take account of the "characteristic complexity and messiness of [policy-making] processes" (Czarniawska-Joerges 1992:16). Health policy analysts have recently come to acknowledge that their approach should become more deliberative, less top-down, more sensitive to expanded networks, and more interpretive (Walt et al. 2008). In order to capture the social dynamics of policy, analysis must take into account "people's stories, their understandings, their values and beliefs as expressed through language and behaviour," argue Hajer and Wagenaar (2003:8; cited in Walt et al. 2008). In effect, such comments suggest a growing appreciation within policy studies of the potential benefits of a more anthropological approach.

1.2.2. Anthropology of global health

Within anthropology, and specifically medical anthropology, global health has also been identified as a separate sub-area of research. The approaches taken to studying it have been somewhat different from those of health policy analysts. A recent review of the literature in this area identifies interrogation, analysis, and critique of international health programmes and policies as one of four principal contributions that anthropology has made to advance understanding of global health (Janes and Corbett 2009). Other important anthropological contributions include, first, ethnographic studies of health inequities in political and economic contexts; second, analyses of the impact on local worlds of the assemblages of science and technology that circulate globally; and, finally, analyses of the health consequences of the reconfiguration of the social relations of international health development (*ibid.*).

According to Janes and Corbett (2009), anthropological critiques of health policy should emphasise the formation, dissemination, *and* local consequences of expert knowledge forms (see also Whiteford and Manderson 2000; Castro and Singer 2004). This implies a focus both on the *processes* of policy making – i.e. examining the ideological and political-economic relations that influence decision-makers and the policy-making process – and on the *consequences* of policy making – their impact on their intended beneficiaries. However, mirroring the gap identified above in the health policy literature, to date, very few anthropologists have explored in detail how “the substances of international health policy-making – knowledge, ideology, politics of representation, competing vested interests, processes of persuasion and advocacy, etc. – come to constitute it” (Janes and Corbett 2009:174). Anthropological interest in health policies has instead been directed primarily towards interrogation, analysis and critique of the consequences of such policy at the local level.

This is not to deny the importance of existing work in this area. Justice’s (1986; 1987) work on the gap between policy-making and international health programme implementation in Nepal, for instance, is a good example of early ethnographic analysis of the problems that often arise as a result of differences in culture and interpretation between international and national bureaucratic settings and those of the local villages receiving services. Anthropologists have thus shared policy analysts’ interest in the transfer of policies, but have been distinct in the localised nature of their analyses. This has particularly been the case in ethnographic studies of reproduction and childbirth. From the late 1980s onwards, the gradual medicalisation of childbirth and the wholesale export of a ‘technobirth’ model from the US to other countries reignited interest in the earlier comparative study of childbirth practices. Such studies brought specific attention to a frequent discrepancy between the biomedical ideas driving health planning and local knowledge and preferred practices in relation to childbirth, some incorporating critiques of internationally-sponsored safe motherhood programmes (e.g. Jordan 1983; Jeffery et al. 1988; Inhorn 1994; Davis-Floyd and Sargent 1996; Allen 2002; Hampshire 2003; Jenkins and Inhorn 2003). Moreover, Ginsburg and Rapp (1995) were particularly influential in bringing together a feminist critique of the control of reproduction through population policy, global planning and international development initiatives. They argued that reproduction can be seen at once as a critical site of the local/global interface, and as a site of social stratification.

In a similar vein, others have shown how structural violence – defined as a set of large-scale social forces, such as racism, sexism, political violence, poverty and other social inequalities rooted in historical and economic processes (see Farmer 1999) – become inscribed in public health problems such as high levels of maternal mortality, HIV/AIDS and tuberculosis (Scheper-Hughes 1993; Farmer 1999; Janes and Chuluundorj 2004; Pfeiffer 2004; Fassin 2007). Fassin (1992; 2001) in particular has drawn critical attention to the tendency of both social scientists and public health specialists to blame people for their health problems, or assign unhealthy behaviour to cultural factors rather than examine structural impediments to health.

‘Critical’ anthropological analyses of global health policy and programmes (e.g. Morsy 1995; Singer and Castro 2004) have often taken their cue from critical ethnographic studies of development practice more broadly, dating from the late 1980s and 1990s (see e.g. Escobar 1994; Ferguson 1994; Scott 1998). Such critical analyses of development have tended to see policy as a rationalising technical discourse concealing hidden purposes of bureaucratic power and dominance. As Mosse (1995) explains, critical anthropologists have often treated the failure of development efforts as self-evident, seeing these as interventions isolated from the history and social and political realities of the countries in which policy was implemented. Whereas earlier ethnographic work on development policy took an ‘instrumental’ perspective focusing on stated goals and planning (similarly to early health policy analysis as discussed above), critical ethnographic approaches have focused on *undisclosed* ends or effects. In particular they have drawn attention to the way in which development policy’s models mimic those of colonial rule by expanding bureaucratic power and reproducing hierarchies of knowledge – but doing so in ways that conceal subjugation (Mosse 1995; Mosse and Lewis 2005). Similarly, critical anthropologists interested in global health policy have conceived of health policy as a process that unfolds in “a world of competitive social interests, opposed class agendas, unequal genders, and overt and covert power conflicts” (Castro and Singer 2004:xiii). The anthropologist’s task is thus, according to Castro and Singer, one of uncovering how health policy may in fact reproduce ‘structural violence’ (*ibid.*)

While such critical perspectives are invaluable in drawing attention to structural impediments to health, a resultant problem is that on some levels they also ‘black-box’ the policy process itself, for instance by seeing the transfer of policy from international to local level as inherently insidious. Significantly, in *Unhealthy Health*

Policy, Castro and Singer state that their specific anthropological contribution is “to critically review the intended or unintended *negative* impact of policy on the lives and well-being of people targeted by social policies” (Castro and Singer 2004:xiii, emphasis added). On one level, such accounts deny the agency of the beneficiaries of policies, casting them as mere passive subjects. This is a critique that has been persuasively made by those arguing for a ‘critical-interpretive’ medical anthropology that seeks to incorporate the perspectives, pragmatism and resilience of sufferers into the critical analysis of structural determinants of health (Lock and Scheper-Hughes 1996; Lock and Kaufert 1998). But analyses carried out in the critical tradition can also be seen to disregard the agency of those directly involved in the policy process, including policy advisors and donors, either by ignoring these actors’ practices and intentions altogether or by treating their behaviour as inherently self-interested.

In anthropological analyses of global health policy, those formulating and promoting policy are often represented as if driven by a universalising set of assumptions, devoid of appreciation for the complexities and local implications of the advice they brandish. Nichter (2008:2), for example, draws attention to “key social representations” or “master narratives” perpetuated by global health actors that dominate health and development discourse and that tend to simplify and frame problems in a limited way. Hardon (2005), also critical of policy-makers, asserts that their work often entails a focus on “magic bullets” and oversimplified prescriptions that deny the complexity of local realities. While anthropologists may be right that global-level policy-makers simplify complex local realities through master narratives, they rarely pay corresponding attention to how such master narratives arise and what social and political struggles go into their making. The fact that policy-makers may not only create and disseminate, but also resist and modify such narratives is rarely the subject of analysis. Conversely, by contrast to their interest in documenting how individuals are constrained by poorly conceived health policy, anthropologists have paid little attention to the broader structural, political and ideological constraints operating on those formulating policy. As Fairhead and Leach (2003) note, there has been a tendency in critical anthropological analyses of science and policy towards “monolithic” structural analysis that obscures the diverse views, actions, interactions and everyday dilemmas experienced by scientists and policy-makers.

Ideally, an ethnographic study of safe motherhood – and indeed any other area of global health policy – should span the dynamic interactions between the

different levels at which policy ideas are conceived, formulated, promoted and implemented. However, there is also a clear need for in-depth study to try to understand how *global*-level policy initiatives form, the role that international actors play in this process and the way in which such actors themselves interpret the broader global health context of which they are part, as well as their own position within it. Although international-level actors do not always dictate the design of health services in low-income countries, they do create an overall policy climate within which governments develop plans for health, as well as influence the uptake, formulation, financing and implementation of policy in low-income countries (Lee et al. 2002*a*). Given the preoccupation across both policy studies and anthropology with the mismatch between global prescriptions and local realities, understanding how such global prescriptions develop is of utmost importance. It is only with greater in-depth understanding of the challenges that global health initiatives face and create that an insightful debate about whether and how global campaigns should be sustained can move forward.

My decision to conduct an ethnographic study of the transnational policy community that makes up the Safe Motherhood Initiative – rather than to examine the impact of this Initiative’s global policy recommendations in a specific country or locale (as others have done) – responds to the recent call for anthropologists to become more sophisticated in ‘studying up’ and to carry out ethnographies of multiple stakeholders in health systems, donor communities and emerging global health networks (Pfeiffer and Nichter 2008). If, as Pfeiffer and Nichter (2008) assert, a central component of anthropology’s mission is to study social organisation and the distribution of resources, then studying these within the multi-sited domain of global health seems an equally legitimate ethnographic endeavour as studying the more bounded communities in which anthropologists have been more accustomed to working.

1.3. Analytical approach

In this historically informed, ethnographic study I take the safe motherhood policy community and the global health arena within which it is situated as my ‘field site.’ This implies a focus on actors that are part of transnational networks that have, furthermore, changed over time and suggests an approach that differs from conventional ideas about what constitutes ethnography, as I reflect on in Chapter 2.

Before outlining the contents of the empirical chapters, I want to briefly set out the main elements of the analytical perspective I take. This includes, first, a focus on actors and networks; second, a focus on practices; and third, an historical perspective on the development of expert communities and global health policy.

1.3.1. Actors and networks

A starting point for my analysis is the importance of incorporating people's own understanding of their values, beliefs and histories into the analysis and to take into account the social dynamics between different actors. In order to do so, I conceive of the Safe Motherhood Initiative as a network of experts in maternal health that is relatively small (perhaps a few hundred people globally) but positioned strategically to devise and advocate solutions to maternal ill health and mortality (cf. Lee and Goodman 2002). This is a network that creates knowledge, formulates policies and advocates solutions to donors and governments in low-income countries and those charged with implementing policy at the national and sub-national levels. Their advocacy also has an internal dimension, as when representatives of UN agencies advocate for a greater focus on maternal health within their own organisations. The safe motherhood network I examine extends into universities, professional organisations for health workers and a growing number of advocacy groups and other non-governmental organisations (NGOs) operating at the international level.

Reflecting an interest in networks, over the past two decades social scientists have advanced many different theoretical formulations to capture the rise of what has been termed the 'network society' (Castells 1996). None of these formulations perfectly captures the Safe Motherhood Initiative, but they are nevertheless useful for conceptualising its social configuration. Haas' (1992:1) notion of the 'epistemic community' is perhaps particularly useful for conceptualising the safe motherhood field; Haas describes an epistemic community as "a network of professionals with recognised expertise and competence in a particular domain or issue-area." Although those who form part of such communities may have different backgrounds and disciplinary identities, Haas contends that a number of core characteristics bind them together. These include a set of normative and principled beliefs; shared notions of validity; and a common policy enterprise (*ibid.*). Control over knowledge and its diffusion is considered to be an important dimension of the power of such

communities.¹⁰ Other scholars speak of policy communities or ‘advocacy coalitions,’ useful for drawing attention to the tensions that can often be masked by the external appearance of consensus (Sabatier and Jenkins-Smith 1993; Reinicke 1999). Within such coalitions there is often a high level of agreement on policy objectives, despite internal contestation about the means to achieve the objectives (Sabatier and Jenkins-Smith 1993). The concepts of ‘transnational advocacy networks’ (Keck and Sikkink 1998) and ‘global knowledge networks’ (Stone 2002), though emphasising different aspects, help to highlight the international dimension of the Safe Motherhood Initiative and others like it.

However named, a central message to derive from the many different theories of network formation is the importance of understanding which actors actually set the terms for debates, how power is distributed between them and how networks diversify over time, in other words, their complex – and often dynamic – social configuration (Lee and Goodman 2002). Furthermore, it is necessary to be attentive to the fact that while organisational relationships between international agencies, NGOs and academic institutions clearly influence the development of policies, it is often particular individuals who form networks and who move between organisations, create links and modify existing networks (Walt et al. 2004).

1.3.2. Practices

Another crucial insight deriving from analyses of social networks is the importance of paying attention to the strategies and practices through which networks seek to come together as coherent entities. By looking at safe motherhood actors’ practices, as well as their self-representations and narratives, it becomes possible to move away from rationalist understandings of the policy process as a neat and linear process of ‘problem identification,’ ‘evidence production’ ‘formulation of solutions,’ ‘implementation’ and ‘evaluation’ – as the development of safe motherhood policy

¹⁰ Social scientists have also expanded on the traditional actor-centred perspective of anthropology to include not only human actors, but also the other elements. This notion has been best articulated as ‘actor-network theory,’ an approach to social theory that originated in the field of science studies, most usually associated with the work of Michael Callon and Bruno Latour (Latour 1983; Latour 2005). Within this theoretical perspective, networks comprise not only human actors, but also the non-human elements, ideas and technologies they deal with (Latour 2005). Originally developed to describe how scientists operate in laboratory settings, if applied to policy networks this framework can help draw attention to the strategies for relating different elements – including human actors, but also theories, ideas and practices – together into a network so that they form an apparently coherent whole. Contrary to the schematic and static notion of networks that has sometimes characterised policy analysis, it is a core part of this theory that networks are inherently transient and are therefore constantly made and remade.

has sometimes been depicted in the public health literature (Weil and Fernandez 1999). By focusing on practices as well as narratives, it becomes possible to show that the policy process is fundamentally social, characterised not just by rational consensus building but also by dispute, discussion and competition (Buse et al. 2005). Policy-making is not simply intended to extend dominance and hegemony, as some anthropologists have implied, but can rather, following Mosse (1995; 2004), be conceptualised as a process within which actors compete to win legitimacy for different policies.

As specified in the description of my research objectives above, part of that competitive work involves different forms, and varying degrees, of 'self-management,' by which I mean the range of practices that actors within the Initiative engage in to pursue their common policy objectives and to secure their own survival as a policy community. I will demonstrate that actors at times work against their own inclinations or interests in light of an understanding that such practices will ultimately prove helpful for the realisation of policy or professional objectives. Thus, various efforts to influence the policy process through research, advocacy and policy-making can be seen as part of the more deeply wired agency of the initiative's policy community.

Gieryn's (1983; 1995) notion of 'boundary work' is useful here for thinking about specific types of self-management practices that have taken on greater currency in recent years with the rise of the evidence-based movement and the emphasis that is placed on normative frameworks for priority-setting and evaluation of global health activities. Gieryn (1999:4-5) describes the term 'boundary work' as "the discursive attribution of selected qualities to science, scientific methods and scientific claims for the purpose of drawing a rhetorical boundary between science and some less authoritative residual non-science." Here I am interested in exploring in particular the way in which safe motherhood practitioners' efforts to demarcate their scientific credibility and legitimacy has become a crucial part of the competition for global health resources.

1.3.3. Historical contingency

A final element of my approach is the historical. By this I refer not simply to analysing the history of the Safe Motherhood Initiative as trajectories of events. Rather, I seek to understand how and why ideas, scientific understandings and policy

positions change over time, so as to understand the historical contingency also of current ideas.

Over time, categories change and take on new meaning. To capture such change, the philosopher Hacking (1990; 2007) writes of the importance of paying attention to communities that form around specific issues or interests, but also the diverse categories, institutions and histories that these communities come up against in practice. Crucially, Hacking draws attention to the way that traditionally accepted meanings become redefined as a result of the interaction between these diverse elements. His framework implies a 'genealogical' approach to history, building directly on the work of Foucault (1977). Such an approach involves first discerning shifts in ideas, knowledge or policy through an 'archaeological' perspective and then looking to ethnography to understand how and why these shifts have come about. For Foucault, genealogical investigation is neither a quest for origins, nor an attempt to restore historical continuity (*ibid.*) Instead, such investigation is a way to document the battle that gave rise to the dominance of one set of values over another. The intention is to say something about the causes of the transition of one way of thinking to another, rather than provide a grand scheme of progressive history.¹¹ When combined with ethnographic attention to the present, Hacking and Foucault's ideas can help to highlight how concepts, ideas and social configurations that are seen as axiomatic – such as 'evidence', for instance – have specific social, political and economic origins.

Just such processes as Hacking and Foucault describe can be discerned within safe motherhood. The insights of such authors help to show that the field did not undergo a linear history of scientific achievement. Rather, the shifts in policy, research and advocacy positions that I will discuss in this thesis came about as the result of a struggle between different visions for public health, as well as different epistemological frameworks and professional interests. In order to grasp this, we need to pay attention to the way in which disputes, discussion and competition shape policy developments and understandings of safe motherhood, at the same time as placing safe motherhood within a broader history of global health. An historically-

¹¹ A good example of the use of such an approach is provided by Simon Szreter's (2004) writing on historical anthropology in the context of demography. Szreter examines the historical and political circumstances in which categories have their provenance and reassesses their uncritical application across space and time.

informed ethnographic perspective on the formation of a contemporary global health initiative is well placed to take such an approach forward.

1.4. Outline of the thesis

The analytical approach I have sketched above is reflected in the methodology I have used, outlined in Chapter 2. That chapter starts with critical reflection on what it means to conduct an ethnography of global health initiatives and policy, before describing the specific methods used to collect and analyse the data. I then present the findings in two main parts. In *Part I*, comprised of Chapters 3-6, I address my first specific objective by examining the Safe Motherhood Initiative's own particular policy vision and the way that vision has been modified and adapted in response to a series of external pressures. In *Part II*, comprised of Chapters 7 and 8, I address the second specific objective by reflecting on the role of normative ideas about evidence and the relationship between scientific expertise and authority within global health discourse and practice. I do so by examining the practices of academics and advocacy specialists in particular – both sub-groups that play important roles within global health initiatives. In the final concluding chapter I address the third objective of this thesis, by offering a critical evaluation of whether global health initiatives are conducive to improved health systems and health outcomes.

Part I begins with Chapter 3, in which I delineate the establishment of the Safe Motherhood Initiative and analyse its original policy vision in relation to the broader debate about comprehensive and selective approaches to health – debates that came to dominate the international health community in the 1980s. I demonstrate that despite its targeted objective of improving maternal health and survival, the Safe Motherhood Initiative advocated for a comprehensive vision that did not simply address the direct causes of maternal deaths, but instead involved a combined preventive and therapeutic, social and medical approach as the best means of achieving safe motherhood. An overarching aim was to develop health systems' capacity to deliver such integrated care.

In Chapter 4 I describe and analyse the challenge of realising, or achieving uptake of, this comprehensive vision during the first ten years of the Safe Motherhood Initiative's operation. I show how during this time safe motherhood programmes in many low-income countries became reduced to donor-driven 'selective' or 'vertical' programmes, often focusing on the training of traditional birth

attendants (TBAs). In trying to account for why the Initiative's original comprehensive agenda – and especially its emphasis on health system development – was neglected, I juxtapose safe motherhood practitioners' own explanations with a broader historical perspective. By doing so, I argue that although many have faulted safe motherhood policy for lacking strategic focus and causing confusion about its priorities, the neglect of the Initiative's comprehensive agenda also related to the fact that it was incompatible with the neoliberal approach to development and international health that came to dominate international health during this period, as well as with the reality of weakened health systems.

In Chapter 5 I argue that the Safe Motherhood Initiative responded to a decade of failed implementation and changing political realities, including entrenched preference for disease-specific approaches to public health, by reformulated international safe motherhood policy recommendations. I analyse the process that saw the original social agenda de-emphasised in favour of policy targeted at averting deaths from obstetric complications. I argue that the 'branding' that went into defining a new strategic focus on professional healthcare providers and emergency obstetric care as key priorities for achieving safe motherhood was, in fact, an effort to redirect international and national policy attention onto much-neglected health system development. The ethnographic findings in the chapter also highlight the social negotiation and conceptual shifts that were necessary to achieve support within the initiative for this 'rebranded' policy vision – one that appealed to, rather than challenged, priority-setting frameworks that had become dominant in international health in the decade since the Initiative's launch.

Chapter 6 then turns to examine how the safe motherhood movement responded to a further set of challenges stemming from the fact that the global health field, by the first decade of the new century, was becoming very fragmented and competitive. Specifically, I focus on the efforts to create a Partnership for Maternal, Newborn and Child Health (PMNCH). I argue that this was at once an effort to curb extreme competition from new global health initiatives such as the Global Fund, and an attempt by international organisations and donors to comply with a new discourse within global health and development practice, which specified the need for greater aid effectiveness through 'harmonisation' and 'integration' of global health efforts. I analyse practitioners' ambivalent responses to this development, showing how the challenges of achieving 'integration' between

maternal, newborn and child health on some levels reinforced competitive tensions and gave rise to new forms of self-management of the safe motherhood community, including efforts to emulate for maternal health the process that led to the creation of the Global Fund to Fight HIV/AIDS, TB and Malaria.

Part II begins with Chapter 7, in which I trace the development of an academic subfield specialising in the epidemiology of maternal health and evaluation of safe motherhood interventions in low-income countries. I examine how research practices and priorities within this field have shifted over time in response to challenges faced by the broader Safe Motherhood Initiative, including the need to comply with narrowing definitions of what constitutes scientifically credible and policy-relevant evidence. I identify some of the challenges that researchers in international academic institutions encounter in their work. This includes, first, the difficulty of balancing both academic and donor-driven demands for 'gold standard' research with growing recognition that country-level policy-making and implementation requires other, more operational forms of knowledge. Second, it entails managing an identity sometimes torn between that of academic, policy advisor and advocate.

Chapter 8 is the final empirical chapter. In this chapter I reflect on the role that scientific authority, health statistics and evidence play in the work of advocacy specialists within the broader safe motherhood field. I show how appeals to 'objective' justifications for prioritising maternal health and for pursuing specific policies have gradually replaced more explicitly value-based argumentation. I further argue that this shift has taken place in response to advocacy groups' transnational remit, as well as in response to their perceived need for new ways to present and 'sell' safe motherhood, but may also contribute to unduly depoliticising the struggle for women's health.

In the concluding chapter I provide a review of the main findings and reflect critically on the various forms of self-management that have gone into the 'making' of the Safe Motherhood Initiative. I assess, on the basis of results from this thesis as well as evidence from studies of the broader global health field, whether such intensified issue-specific advocacy, research and policy activities are likely to be beneficial to the professional community specialising in maternal health. Finally, I reflect critically on whether the eventual 'success' of the safe motherhood advocacy coalition is likely to translate into improved health systems and ultimately, improved

survival for women. In doing this, I hope that my research will help to critically examine the widespread, if implicit, assumption that the success of a single advocacy issue, as measured through the rise of a global health initiative and growing political commitment to a specific health problem, will necessarily lead to health improvement.

2. METHODOLOGY

In this chapter I provide an overview of the methodology of the thesis. Because the empirical evidence I present is derived from an ethnographic study, I start by briefly reflecting on what is meant by ethnography in the context of my research. This is followed by an overview of the methods that I used to collect the data: in-depth interviews, participant observation and document review. In conclusion I describe my approach to analysing and interpreting the data.

2.1. Ethnography

Debates about the distinctive nature of ethnography have a long and unresolved history within anthropology. Ethnography can be thought of as a set of activities – ethnographic fieldwork comprised of, for instance, participant observation, open interviews or other qualitative field research methods – and as the product of those activities, the ethnography or a written description of the social life of particular place or community or, indeed, of an institution (Gellner and Hirsch 2001). Ethnography in both senses relies on the inclusion of the ‘native’s’ point of view, a characteristic that can be seen as one aspect of growing democratisation or critique of established relations of power. Often associated with Malinowski’s (1961 (1922)) pioneering ethnographic fieldwork of the Trobriand Islanders in the early 20th century, many anthropologists today consider participant observation, commonly thought of as total immersion in a particular social environment, to be the basis of the ethnographic method. In-depth interviews, involving face-to-face interactions with an informant selected for their particular involvement in or knowledge of a social environment, are also generally considered to be an important method (Bernard 1994). Furthermore, a key aspect of the ethnographic approach is that it should contextualise its findings, pay attention to questions of power and inequality, emphasise both what people say and do, look closely at the use of language, and be reflexive of the researcher’s ambiguous position within the research context (Bernard 1994). It is also widely agreed that what makes ethnography distinctive is its commitment to methodological ‘holism,’ which implies accepting that in principle anything in the research context

can be relevant and should potentially be taken into account (Gellner and Hirsch 2001:9). Such 'holism' is in contrast to the countervailing trend towards control, measurement and quantification of outputs that characterise some of the other main disciplines concerned with global health, including epidemiology (Janes et al. 1986; Inhorn 1995).

How we think about ethnography is clearly modified when the focus of analysis moves from the villages and relatively bounded communities that were the focus of classical ethnographic studies and onto the kind of complex transnational social configurations of which the Safe Motherhood Initiative is an example. In classical anthropological studies, fieldwork, comprising both participant observation and interviewing, was usually carried out in a discrete local community or bounded geographical area. Participant observation implied prolonged interactions and observations in face-to-face localities with the aim of understanding the total social configuration of the chosen field.

What constitutes the 'local' in the context of global health, however, is contested (Ong and Collier 2005). Janes and Corbett (2009) therefore argue that anthropologists interested in global health need to take a pragmatic view on what is understood by the 'local.' In doing so, they build on Ginsburg and Rapp's (1995:8) assertion that, "[t]he local is not defined by geographical boundaries but is understood as any small-scale arena in which social meanings are informed and adjusted." In general, though, a focus on the global level requires that anthropologists respond to Nader's (1972:289) call to "study up," or "to study the colonisers instead of the colonised, the culture of power rather than the culture of the powerless, the culture of affluence rather than the culture of poverty." An ethnographic focus on the global also inevitably implies that the field of research becomes both more complex and more unbounded. Moreover, an analytical focus on policy itself requires reconceptualising the ethnographic 'field' as a social, political or even epistemic space that is articulated through a clear set of self-identifications relating to professionalisation and embedded relations of power (rather than to a specific geographical locale) (Shore and Wright 1997:14; Wedel and Feldman 2005).

In the mid-1990s, responding to the new conditions imposed by globalisation, Marcus (1995) proposed an adaptation of long-standing models of ethnographic research labelled 'multi-sited ethnography'. Marcus' aim was to link global and local-level analyses within a single study and thereby be able to

accommodate within the analysis the effect of the “capitalist world system” on local experience (*ibid.*). The principles of multi-sited ethnography rapidly gained popularity within anthropology (see Nader 1996). Of particular interest here is the multi-sited approach developed by Fairhead and Leach (2003) to study the politics around biodiversity and conservation in Trinidad and Guinea, an analysis that paid particular attention to the interface of science and policy. For Fairhead and Leach (2003:3) a multi-sited ethnography implied a study that spanned from “international organisations and networks, through national bureaucracies, scientists and activists and their local staff and activities, to the complexities of everyday life.” Their approach highlights the importance of identifying the processes by which different strands of science and policy come to shape each other and gain authority within the broader social field of which they are part. Although my study focuses on global-level debates and traces the impacts of these debates on the everyday life of experts rather than geographically bounded local communities, it can be thought of as multi-sited in that it is attentive to the different scales, levels, sites and actors that together comprise the international or ‘global’ field of safe motherhood.

A focus on ‘global-level’ activities also alters one of the most important aspects of ethnography, namely negotiating access to informants and field sites. In conventional fieldwork sites, such as villages or other small social units, access is often negotiated through discussions with state and local bureaucracies (Gupta and Ferguson 1997). The process of obtaining access to global policy elites and to sites in which political and scientific decisions are made, however, implies different rules of interaction than those that apply when studying the intended beneficiaries of policy. Studying policy and scientific elites requires, for instance, awareness of the particular procedures that may exist within elites for establishing access, as well as how these might become muddled when an outsider takes on an ‘insider’ status through participation (Gellner and Hirsch 2001). With this in mind, I now go on to consider briefly on my own position within the ‘multi-sited’ field I have been studying, before describing the specific methods I used to collect my empirical data

2.2. Positionality

Anthropologists often reflect critically on their own positions as simultaneous participants and observers within complex social and institutional arrangements, and particularly on the resultant social obligations and ethical considerations (Gellner and

Hirsch 2001). Mosse (2006), for instance, has written instructively about the challenges of conducting research within policy communities of which one is also part, based on his personal experience of working as an advisor within a bilateral development project while also observing it ethnographically. He depicts an irresolvable tension between studying inside an organisation, and therefore accepting its aims and agenda, and studying the organisation itself. This tension, he argues, comes to the fore in particular in writing and disseminating the results of ethnographic analyses, which may be contested by informants (*ibid.*). Anthropologists and historians working with public health institutions have similarly contemplated the specific challenges of conducting ethnography within their own professional sphere, including the predicament of becoming part of the history and social processes that they are studying (Lambert 1998; Berridge 2001; Lambert and McKevitt 2002; Dehue 2004; Heckler and Russell 2008).

In keeping with such discussions, it is useful to reflect briefly on my own position during the time I conducted my doctoral research. The fieldwork and write-up of this research was part-time (from 2005 to 2009) while I worked as a research fellow in medical anthropology within an inter-disciplinary research group specialising in maternal health, at the London School of Hygiene & Tropical Medicine (LSHTM). December 2006 and January 2009 I had full funding through a doctoral fellowship from the Norwegian Research Council. My doctoral research was conducted alongside my other research within a number of large-scale, international research collaborations during this time. The first was the Immpact project (the Initiative for Maternal Mortality Programme Assessment), which ran from 2001 to 2006 as a multi-country research project to improve methods for evaluating the effectiveness of large-scale programmes designed to reduce maternal mortality and improve maternal health. This was funded by an 'alliance' of donors, including the UK Department for International Development (DfID), the United States Agency for International Development (USAID), and the Gates Foundation. The second project was the 'Towards 4+5' programme, funded by DfID until 2010, comprised of partners in the UK, Bangladesh, Burkina Faso, Ghana, Malawi, Nepal and Pakistan. This is a research consortium that aims to first, develop and consolidate the evidence base for the reduction of maternal and neonatal mortality and morbidity and second, to get evidence into policy and practice at the international and national levels. A third collaboration was an inter-disciplinary research project into the long-

term social and economic consequences of surviving severe obstetric morbidity, funded through a joint grant from the Economic and Social Research Council UK (ESRC) and the Hewlett Foundation from 2006 to 2010.

My position within this broader research environment and my participation in these specific projects both facilitated my research and bestowed upon me a specific set of responsibilities, including a responsibility to respect the confidentiality of my colleagues, some of whom became informants, as well as a need to be sensitive towards the complex motivations behind their practices and accounts. An advantage of being part of a public health research environment is that I was routinely exposed to scientific and policy debates within the maternal health field and within the public health field more broadly, including through many lectures, seminars and discussions about the challenges of managing relationships with funders and advancing professional demands. Such interactions inevitably impacted on my understanding of the issues I have chosen to emphasise and on the analytical perspective and methods I developed.

On one level, my position gave me an 'insider' status that enabled me to access research sites, to ask meaningful questions and, hopefully, to present an accurate depiction of the field's dilemmas and practices (Walt et al. 2008). I was also able to establish a broad network of contacts that facilitated my access to informants. At the same time, the fact that I was a newcomer to the field, as well as a social scientist within an expert field dominated by epidemiologists and clinical specialists, meant that I was also often an 'outsider,' perhaps permitting me to probe and be curious about questions that real 'insiders' might have taken for granted. Furthermore, the fact that I was clearly identified with the academic sphere, rather than with UN agencies, donor agencies or NGOs, influenced my interactions with informants from these other domains. This is also necessarily reflected in my analytical perspective and my decision to make research practices a central part of my analysis. I hope that the relatively long timeframe of my research means that I have been able to avoid the risk of excessively superficial and incomplete analyses associated with short time-frame research. In presenting my findings I have sought to be sensitive to the nuance and complexity of my informants' statements – both on the record and off – but I also acknowledge any shortcomings in my ability to capture the subtleties of the tensions and pressures under which my informants work.

2.3. Ethics

The LSHTM Ethics Committee approved my study, as well as the ESRC-funded research project on evidence-based policy-making upon which the doctoral research builds. In addition to complying with the Committee's principles and guidelines, I have conducted the research according to the American Anthropological Association's (1998) code of conduct for qualitative research and participant observation. This implies commitment to being open about the purposes, potential impacts and sources of support with funders, colleagues and persons studied, and providing information to relevant parties affected by the research.

An important part of ethical conduct involves obtaining informed consent from individual participants in the research. According to the American Anthropological Association (2004), informed consent includes three key components: communication of information, comprehension of information, and voluntary participation. I bore the responsibility for ensuring that participants were fully informed of the intent of my research, how the information they offered would contribute to the research and the anticipated risks and benefits they could expect to incur through their participation. This was ensured through my own oral explanation to potential participants and through an 'information sheet' approved by the Ethics Committee, which was presented to each informant prior to the interview. The sheet specified the objectives, potential risks and procedures for ensuring confidentiality. Individual participants' informed consent was documented through their signature on a consent form, also approved by the Ethics Committee (see the Appendix). Documenting informed consent for participant observation is, of course, less straightforward than for in-depth interviews (Fleuhr-Lobban 2003), given that participant observation is a less formal method that involves observing everyday interactions and behaviours as they play out. Instead of individual informed consent, I therefore obtained permission to attend meetings and conferences for the purpose of participant observation from conference organisers and those convening meetings.

I decided to conduct all interviews in confidence (rather than offering confidentiality as and when requested) because I anticipated that doing so would encourage individuals to feel at ease about participating in interviews. Although maintaining informants' confidentiality necessarily compromises the historical value of the interviews, I felt that doing so was important to minimise the risk of exacerbating tensions or factions between individuals or sub-groups, and to

encourage the participation of informants whose individual position may be discrepant with that of their affiliated institution. When offering their consent, informants were given the option of specifying the additional condition that not be quoted directly and that no personal data about them be presented in the analysis.

In presenting the findings I have protected informants' confidentiality and anonymity by citing interviewees by position rather than by name or, if necessary, by generalising perspectives, especially perspectives expressed during participant observation where individual consent was not documented to the same extent as in in-depth interviews. I have also taken care to generalise about organisations if identifying a specific organisation is likely to jeopardise individual informants' anonymity. Because the worlds of research and policy are tightly interconnected it may still be possible to identify individuals in the presentation of the findings. The risk associated with this is partly compensated for by the fact that the research focuses on aspects of people's lives that are already in the public domain.

2.4. Methods

The study's empirical findings derive from the combination of three main ethnographic methods: participant observation, in-depth interviews and document review. These methods were first elaborated in the context of the ESRC-funded ethnographic project on evidence-based policy-making mentioned in the introductory chapter conducted from 2004-2007; in subsequent years, from 2005 onwards, I expanded upon them specifically for the purposes of my doctoral research.

2.4.1. Participant observation

Participant observation carried out within the broad 'field' of safe motherhood was an essential component of my methodology and took place throughout the duration of my research. Although day-to-day participation within the safe motherhood field and within the global health field more generally inevitably formed a backdrop for my observations, I conducted more 'formal' participant observation at specific focusing events for safe motherhood research, advocacy and policy. I identified such focusing events through informal contact with individuals in the field, and by searching the online events calendars on various organisations' websites. My research coincided with a particularly active period for safe motherhood advocacy, including the marking of the twentieth anniversary of the launch of the Safe Motherhood Initiative, as well as the thirtieth anniversary of the Alma-Ata Conference on Primary

Health Care, an event that was formative in informing the original policy vision for safe motherhood (see Chapter 3).

I attended around twenty separate such focusing events, some as an active participant and others primarily as an observer. These included a high-level meeting to define the strategic objectives for a new Partnership for Maternal, Newborn and Child Health (PMNCH); a major dissemination symposium for the Immpact project; events relating to the launch of a 'Global Business Plan' to accelerate progress towards MDGs 4 and 5 (on child survival and maternal health respectively); the launch meeting for a *Lancet* special series on maternal survival; a major conference entitled Women Deliver (convened to mark the twentieth anniversary of the Safe Motherhood Initiative); the first global conference on unsafe abortion; and the first international conference of the Countdown to 2015 Initiative, an initiative that monitors progress towards MDGs 4 and 5. My research also coincided with a period of intense political activity relating to global health more generally, as reflected in the buzz around the MDGs and political initiatives such as the International Health Partnership, formed by UK Prime Minister Gordon Brown in 2007, as well as global-level debates about the appropriate role of health research in broader global health efforts. Towards the end of my research, public debates about the benefits and drawbacks of the dominant role that global health initiatives have assumed within global health governance intensified, creating an important backdrop for my analysis and my decision to engage directly with this debate in the concluding chapter of the thesis.

Many of the relevant events for participant observation took place in London, where I was based for most of the study, providing easy access. However, I also undertook several overseas trips to attend focusing events and to conduct in-depth interviews. This included trips lasting from several days to several weeks to New York, Washington D.C., Geneva, Aberdeen, Mexico City, New Delhi and Oslo. During these trips I visited the headquarters of organisations including the WHO, UNFPA (The United Nations Population Fund), UNICEF (the United Nations Children's Fund), USAID, Norad (the Norwegian Directorate for Development Assistance) and a range of NGOs. I also conducted opportunistic fieldwork with international players that happened to be in countries that I was visiting for other research projects (especially Burkina Faso).

I kept detailed field notes of my observations from these events. Some sessions at conferences and meetings were also recorded (always with the permission of the organisers) and transcribed. All but one organiser granted me access to use an event as a venue for fieldwork; my request to record sessions and interview participants at one high-level meeting I attended was also denied to avoid overburdening participants during the meeting.

2.4.2. Document review

Alongside participant observation, I undertook a comprehensive review of academic and international policy literature. It is worth noting that the use of documents in ethnographic analysis differs from the way they tend to be used in some social scientific disciplines, including in policy analysis. While policy analysts often rely heavily on written documents, including public witness testimonies and legal documents, unlike anthropologists they tend to treat these as straightforward sources that reveal the inner workings of the policy process (e.g. Sabatier and Jenkins-Smith 1993). By contrast, anthropologists have argued that policy documents can be treated as cultural texts or classificatory devices, as “narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some and silence others” (Shore and Wright 1997:15). The way I have opted to use documents in my analysis sits somewhere in between these two extremes, since I use documents both to provide ethnographic depth, for instance of how key debates have been represented in editorials and letters, and to provide historical data on key events and developments. My document review also helped to devise a time-line of key focusing events, policy shifts and important actors within the field.

I searched literature spanning the past thirty years to build up a picture of how maternal health and mortality have been dealt with in the international sphere and to discern trends in research and policy recommendations. I identified literature by searching for key works relating to international safe motherhood policy and maternal health in developing countries in electronic databases (PubMed, Web of Science, Popline, id21). I also conducted physical searches of the libraries of international organisations and electronic searches of the web pages and online document resource lists of a wide range of organisations. I conducted some archival research at the WHO to provide background context, but access to material from the previous 20 years was restricted and the archive was thus of limited use for

discerning the more recent history of the safe motherhood field. Therefore, I collected additional materials during field visits to organisations in the various countries listed above. Two colleagues, both of them key players in the field, also gave me access to their private document collections spanning three decades.

The range of sources I consulted ensured that this review was comprehensive. It included many kinds of documents: policy documents; peer-reviewed articles; a range of grey literature including unpublished research reports; proceedings from conferences and meetings; newsletters (such as the WHO-published newsletter on safe motherhood); policy briefs; online resources; and editorials; and letters to the editor of scientific journals. The scope of this review was kept manageable by focusing on prominent policy documents and frequently cited sources. In addition to documents on maternal health, the review also included some documents pertaining to broader public health issues, such as more general WHO policy statements and reports, commentaries and editorials and advocacy materials.

2.4.3. In-depth interviews

I conducted in-depth interviews with an opportunistic sample of informants specialising in international-level work related to maternal health and safe motherhood, including from all the main agencies and organisations involved in the Safe Motherhood Initiative (these are described in below, in subsection 2.5). The selection of informants was purposive (rather than systematic), an appropriate method when studying socially complex phenomena such as the Safe Motherhood Initiative and the sensitive views of specific types of informants.

I used a number of methods to identify individual informants. An initial list of names and contact details of actors within the safe motherhood field was compiled for the purpose of the ESRC-funded study on evidence-based policy-making. This list was built up through informal discussions with various stakeholders active within the safe motherhood community, especially colleagues at the LSHTM, as well as through web-based searches of organisations' websites to identify recurrent names. In order to supplement this initial list and to ensure a broad range of participants, I adopted an approach described by Lee and Goodman (2002) to identify key players in policy networks within the international health field. This involved mapping current and past initiatives and inquiring about individuals who had been active at different times, consulting databases to identify frequently cited authors of scientific papers and main policy documents. I also reviewed participant

lists from the main safe motherhood focusing events. Finally, some additional informants were identified through 'snow-balling' when interviews generated recommendations for others to approach.

I contacted potential interviewees by e-mail or in person at meetings or conferences and asked them to participate in a fully confidential interview. 72 interviewees agreed to participate (see Table 1 below). Five potential informants declined to participate, citing time constraints or limited knowledge of the field, while around 10 of the potential informants I contacted did not respond to the interview request. The aim of having a relatively large sample size for qualitative research was to include the perspectives of a range of different kinds of actors within the field, to achieve a comprehensive coverage of the members of the field and to achieve a certain range of different perspectives from informants of diverse institutional types.

All the interviewees provided written informed consent. Almost all of the interviews were face-to face (the remainder by phone), either during my visits to informants' home institutions, during conferences or during informants' visits to London. A proportion of these interviews included topics that had been specifically developed for the ESRC-funded study described in Chapter 1, and as such contributed data to both studies. Most informants were interviewed once in interviews lasting one to three hours, but three were interviewed twice or more. Many others participated in informal follow-up discussions. I conducted the majority of these interviews, while Dominique Béhague conducted 17 of the interviews that included topics specifically pertaining to evidence-based policy-making. Three of the interviews were conducted jointly. The interviews were recorded with informants' consent and all the recorded interviews were fully transcribed, about half of them by two research assistants. Only one informant did not consent to the interview being recorded. In that case, a summary of the main points and detailed notes of the discussion substituted for a verbatim transcript. In addition to recording the interviews, I kept notes of impressions that emerged during the interviews.

The interviews followed an interview guide intended to loosely structure its content. This guide was revised during the fieldwork period to take into account and probe into unexpected findings, as is customary in ethnographic research (Bernard 1994). While the original interview guide was developed within the ESRC-funded study and therefore focused on understandings of and use of evidence for policy-making and implementation within the maternal health field, the revised interview

guide was much broader, and sought to elicit informants' accounts of their histories and experiences within the field, including the various advocacy, research and policy initiatives that they had been involved in over the years. This included questions on views regarding the appropriate strategic focus for the Safe Motherhood Initiative, and informants' perceptions of the Safe Motherhood Initiative's position within the global health field and changes to this position over time, among other topics. I adapted this guide for individual participants to tap into their specific experiences and areas of expertise. Open-ended interviews aimed to elicit insights not only into informants' opinions, but also details of their actual practices and experiences.

2.5. Description of sample and informants

The Safe Motherhood Initiative is a loosely configured community with boundaries that have changed and expanded over time, but that links actors and organisations from across a number of institutional domains into a recognisable and relatively coherent whole. Today, what can be thought of as the safe motherhood community comprises actors based in inter-governmental agencies and multilateral donor organisations; bilateral development agencies; academic and other research institutions; non-governmental organisations, including advocacy groups, and private philanthropic foundations; and professional organisations. Interviewees came from all the main international agencies and organisations involved in the Safe Motherhood Initiative and the international safe motherhood community as a whole was well covered in the in-depth interviews.

The safe motherhood network is international in nature. While it is predominantly located in international organisations based in high-income countries, it increasingly also extends to corresponding institutional venues in low- and middle-income countries. However, because I was primarily interested in conducting ethnographic research into global-level dynamics I prioritised recruiting informants working in international organisations and institutions. Nevertheless, the sample also included nine informants based in low-income countries, including policy advisors, researchers and programme managers. Moreover, some of the international-level actors were originally from low-income countries and many others had extensive field-based and clinical experience from such countries.

Both institutions and individuals can be thought of as safe motherhood 'actors.' It is not always straightforward to separate the perspectives and practices of

institutions and individuals, and individuals vary in the extent to which they reflect the institutional culture and position of their affiliated institutions. Within the institutions identified, I aimed to recruit a broad range of informants with different kinds of experience. Although the Initiative has expanded considerably over the past twenty years, I quickly became aware that many of those who played prominent roles in its formation continue to be active within the field. Given my interest in tracing developments over time, I decided to focus on individuals with long-lasting experience and internationally recognised expertise in maternal health. However, I also included many newer entrants to capture the expanded nature of the international safe motherhood network. Over half (48 out of 72, or 66%) of my informants were female.

Table 1 summarises the type and number of institutions and the number of informants drawn from each institutional group. Although I have designated each informant to a specific category for the purpose of clear presentation, in reality there is some degree of overlap between the different groups and individuals have shifted between the categories over time. While the great majority of the informants can be considered 'full' members of the safe motherhood community, a minority (around 10) can be considered 'partial' members, having significant affiliations and interests also in other public health subfields, including child health, neonatal health, HIV/AIDS and health systems. About ten of the informants self-identified as reproductive health activists rather than safe motherhood specialists, although their interests included pregnancy-related health and survival or 'safe motherhood.' Four informants self-identified primarily as child health specialists, but were collaborators within maternal health projects. Informants were recruited from each of the main categories of institution, although there was a heavier concentration of informants from the academic sphere than from other institutional settings, reflecting my specific interest in research practices. Below I provide brief contextual descriptions to introduce the different institutions from which informants were drawn.

	Total number of institutions	Total number of informants
UN agencies	3	13
Bilateral agencies	3	11
Academic institutions	12	29
NGOs or foundations	9	19
Total	27	72

Table 1: Categories of informants

2.5.1. Multilateral agencies

The multilateral agencies I focused on (WHO, UNFPA and UNICEF) were founding members of the original Safe Motherhood Inter-Agency Group (IAG) that in 1987 was charged with overseeing implementation of the initiative and remain important actors in the global health policy sphere. They are all members of a Partnership for Maternal, Newborn and Child Health (PMNCH) that in 2005 subsumed the original IAG. The WHO in 2005 established the Department for Making Pregnancy Safer, while the other agencies are also involved in a range of specific activities or fund programmes that can be designated as safe motherhood-related. Historically, these agencies have played a prominent role in setting standards and policy recommendations within the field and in providing technical advice and financial assistance to governments and NGOs working on safe motherhood issues in low-income countries. Informants from these agencies were drawn primarily from the international headquarter level (rather than regional offices) and included high-level officials specialising in maternal and reproductive health issues, as well as several high-level policy advisers working on more general issues like health systems and evaluation.

2.5.2. Bilateral agencies

A range of bilateral development agencies has played important roles within the safe motherhood field, funding activities at the country level, as well as the activities of international NGO and research groups. Bilateral donors can be seen as advocates for greater financial and technical attention to safe motherhood, and as targets for such advocacy. Although the IAG originally excluded bilateral donors as official

members, donors played an important role in shaping safe motherhood policy and research in the Initiative's early years and have gained an increasingly prominent position in recent years, including as full members of the PMNCH. I focused on three bilateral institutions that have played significant roles in the field, both by virtue of the volume of their contributions and for other reasons, as specified below.

USAID is the dominant government donor in the international health field. While being an important actor within safe motherhood globally, compared with other development agencies it has often been seen to pursue a unilateral and conservative agenda. This has especially been the case in the area of reproductive and maternal health, where its work has been subject to the restrictions associated with the 'Mexico City policy' first introduced by Ronald Reagan in 1982 prohibiting the use of federal funds to support organisations that provide abortions or support abortion-related work. This policy was later rescinded by Bill Clinton but reinstated by George W. Bush in his first day in office as US President, after which it became known colloquially as the 'global gag rule' (Office of the Press Secretary 2001).¹²

DfID has also been a leading donor to international health, both through contributions to the multilateral system and through bilateral aid. During the period of my fieldwork it was the only bilateral donor to have formulated a dedicated maternal health strategy. DfID characterises itself as unusual among development agencies for its focus on strengthening government systems and ownership in countries and for taking innovative approaches to funding programmes via government bodies (Carlson 2007). It sees itself as championing "underdog causes" such as abortion and leading for change in development practice (*ibid.*).

A third important bilateral agency, Norad (a directorate of the Norwegian Ministry of Foreign Affairs), has in recent years become an important player within the international safe motherhood field. Norad is, on some levels, taking forth a Norwegian ambition to be a leader in international gender and reproductive health and rights debates (Austveg and Sundby 2005). I included this agency primarily because, though a special initiative by Prime Minister Jens Stoltenberg, it has been a main supporter of a recent global advocacy campaign for maternal health. This reflects the Prime Minister's desire to involve Norway in international efforts to achieve progress in global health, focusing initially on expanding vaccination coverage to reduce child deaths and subsequently expanding to include action on

¹² This policy was reversed by President Barack Obama on 23 January 2009 (Nasaw 2009).

maternal survival (PMNCH 2009c). In addition to Norad interviewees, I also interviewed informants from the Norwegian Ministry of Foreign Affairs who specialise in global health issues more generally.

2.5.3. Non-governmental organisations

Non-governmental organisations (NGOs) or civil society organisations have come to play an important role within global health initiatives in recent years in terms of advocacy, research and service provision and programme implementation (Doyle and Patel 2008). Given my interest in global-level debates, I focused on recruiting representatives from NGOs involved in advocacy and, to a lesser extent, research. Specific organisations have not been identified by name to protect the confidentiality of informants. However, they included those NGOs that were founding members of the IAG in 1987 and some more newly established NGOs who specialise in maternal and reproductive health, based primarily in the US and in the UK. Some of these groups are private philanthropic foundations and fund their own maternal health programmes in Africa, Asia and Latin America. There is also some overlap in the remit of such groups and academics, with a number of NGOs conducting research and specialising in the dissemination of scientific evidence.

2.5.4. Academic institutions

Within the academic research sphere I recruited informants primarily from prominent European and North American universities with a reputation for expertise in international maternal health research, with a minority of informants being from African and Asian research institutes and universities that collaborated with Western institutions (six informants). These academic institutions have not been identified by name in order to protect the confidentiality of informants.

I focused on interviewing prominent researchers with extensive experience in the field, on the basis of an assumption that they would have knowledge of changing research trends and experience of the interface between research and policy. The sample also included less experienced researchers who were able to comment on their first impressions of the politics and social relations driving the academic network of which they were part. Among the researchers were three researchers specialising in child health, while some researchers specialised in both maternal health and another area, such as neonatal health. The majority of my academic informants had public health training, including in disciplines such as epidemiology and

demography, and many also had previous clinical training and field experience from healthcare settings in low-income countries. Epidemiology was the most frequent disciplinary background among this group, reflecting its dominance within academic public health during the past fifty to sixty years (Berridge 2001). In order to reflect the increasingly multi-disciplinary nature of international public health research, I also interviewed a smaller number of social scientists, including sociologists, policy analysts, health economists and health system analysts.

2.5.5. Professional organisations

Finally, I included informants from those professional organisations for midwives and obstetricians that are the most prominent organisations at the international level: the International Confederation of Gynaecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM.) Although professional organisations are commonly said to have been late entrants into the field, they have come to play an important role within international debates on safe motherhood, especially as they pertain to clinical standards and guidelines and the notorious human resource crisis affecting health systems in many low- and middle-income countries (see e.g. WHO/ICM/FIGO 2004; Phumaphi 2006). Members of these organisations overlapped with the categories discussed above, and as such do not appear in a separate category in Table 1.

2.6. Limitations

Although I interviewed a broad selection of informants and believe that I achieved a comprehensive coverage of the safe motherhood community, a number of important limitations must be noted with regard to my sample. A natural, but unfortunate, consequence of my focus on the international level is that I collected limited data on the perspectives of actors based in low-income countries. Although my fieldwork provided opportunities for observing interactions between practitioners from different settings, it would no doubt have been instructive to elicit the perspectives of a larger number of country-based actors on the international-level dynamics I was studying, as well as to trace their effects on national-level policy debates. Doing so, however, would have compromised my commitment to understanding, in an in-depth manner, the broad cross-section of international-level actors that constitute the safe motherhood field and the networks that they form at the global level.

A second limitation is that I did not obtain substantive data on the perspectives of actors working within other global health initiatives. Although the study included interviews with several informants specialising in child and newborn health, this was not sufficient to enable analysis of alternative perspectives on the competition between global health initiatives in which the Safe Motherhood Initiative participates. This posed a particular limitation in my analysis of responses to recent efforts to integrate the advocacy coalitions for maternal, newborn and child health into a single partnership (discussed in Chapter 6). Given my effort to develop a full picture of the international safe motherhood field, however, it would have been unmanageable to include also a wide range of informants specialising in other subfields.

Third, I did not conduct formal interviews with some of the major global health donors, including the Gates Foundation and the World Bank. Both of these organisations are highly influential actors within global health governance, funding and policy, towards which many of my informants' advocacy efforts were directed. In part, their omission from my interview sample results from my initial decision to focus on those actors who self-identified as being involved in advocating for priority to be given to safe motherhood, rather than the target of advocacy. Moreover, the initial search for key actors within the field did not elicit the names of respondents based in these donor organisations. However, as my research progressed I became aware of a number of individuals within these organisations who can be considered at least partial members of the safe motherhood community. Interviewing such individuals would have likely added nuance and depth to the ethnographic data. Interviewing representatives of donor agencies and foundations would also have allowed a critical comparison of representatives' own perspectives on their institutional culture, practices and priorities and my other informants' perspectives on their behaviour. Despite several attempts in 2007, however, I was unable to obtain interviews with current World Bank employees and did not receive a reply from one past employee that I contacted. I was unable to access representatives of the Gates Foundation, reflecting well-known challenges in accessing these high-level actors. However, the lack of formal in-depth interviews was partly offset by extensive participant observation at events, including global health conferences and research meetings, in which these donors had a strong presence, as well as by analysis of documents pertaining to their activities and positions.

Given the increasingly prominent position assumed by Gates Foundation since I started my doctoral research it is clear that future studies would benefit from eliciting key informant perspectives from within this organisation, as well as from other private and public funding bodies. In addition, future studies could also usefully advance a comparative perspective on the work of different global health initiatives and the interactions between them, and trace in more detail the effects of their global-level debates on local processes. This would help to elucidate the interplay between local experience and global-level proscriptions.

2.7. Analysis

With reference to anthropological methods, Bernard (1994:452) defines “analysis” as “the search for patterns in data and for ideas that help to explain why those patterns are there in the first place.” Beyond this general definition, qualitative data, which tend to be the basis of anthropological or ethnographic analysis, can be analysed in a variety of ways, some more structured than others.

The policy studies subfield, which also relies predominantly on qualitative data, has tended to use more structured analytical frameworks than has been customary in anthropology. Many policy analysts have applied the “stages heuristic” model, which divides the policy process into discrete stages such as “agenda-setting,” “formulation,” “implementation” and “evaluation” (Laswell 1956; Buse et al. 2005). Much of the work within this tradition has focused on one or other of these stages, often applying the “streams” theory of agenda-setting (see Chapter 1) (Kingdon 1984). However, in reality such analysis comes up against the challenge that it is difficult and indeed rare to be able to identify a clear-cut group of decision-makers, or an event which can be pinpointed as the moment when a particular decision was made (Weiss 1986:223). I am therefore reluctant to systematise policy in terms of ideal types, because doing so can obscure the social negotiations and contradictions that go into policy-making. Indeed, the focus on cohesion and shared notions of validity in many of the theoretical formulations that have been influential in policy analysis run counter to the tensions, contestations and competing interests that often exist within apparently cohesive networks. For such reasons, I have drawn on analytical approaches from anthropology, which, on the whole, tend to be less structured and more iterative or inductive (although it is worth noting that

anthropologists also vary in the formality and schematic nature of the analytical methods they use).

The method of analysis I have used can best be described as thematic. Thematic analysis is a largely inductive approach to data analysis that aims to be attentive to emerging themes, contradictions and discrepancies in the data (Pelto and Pelto 1978; Bernard 1994). The 'data' here consists of interview transcripts, field notes and the various documents described above. From a practical perspective, a thematic analysis entails familiarising oneself thoroughly with such data before searching for a pattern both in the data and, by implication, in how the informants presented, ordered and systematised their perceptions, experiences and practices, before then 'extracting' themes for analysis. Within my study, this quite mechanical process involved reading, re-reading, and underlining, noting, coding and extracting text.

In order to facilitate the management of a large dataset, I imported transcripts into NVivo, a software package for organising and analysing qualitative data. I also used NVivo for my initial coding of the transcripts for broad themes, which I later extracted from the individual documents and grouped together so that I could study specific sub-themes in more depth. NVivo was also useful for conducting key-word searches across all the transcripts, as well as for identifying specific passages for further analysis. I supplemented my initial computer-aided coding with manual coding of transcript printouts for specific themes and sub-themes.

The initial stage of analysis was concurrent with data collection inductive and aimed to identify emerging themes. Initial themes then fed into revised versions of the interview guide. This was a process that was also informed by feedback and discussions following presentation of preliminary findings at a number of meetings and conferences. A period of consolidated analysis followed after the end of the main period of data collection, starting in mid-2008. By contrast to the early inductive stages of the data analysis, this later stage was more deductive. I aimed to confirm emerging themes, identify uniformity and inconsistencies across groups of informants, conduct sub-analysis of different informant groups and juxtapose informants' accounts against more 'objective' evidence, for instance documentary evidence, to build up an accurate picture of the trajectory of key events.

Following Spradley (1979), I looked for evidence of social conflict, contradictions, things that people did in managing social relationships, methods by

which they acquired and maintained status and prestige and insights into how they solved conflict. I also tried to be particularly attentive to how my informants depicted their own professional histories and the history of the safe motherhood community. My research covered a period of over twenty years and informants reported on a range of activities and shifting policy, research and advocacy priorities during this period. In part to compensate for written historical sources, but also to gain specific individual insights, I used interview data as 'oral history' in conjunction with documentary sources to build up the historical timeline and account of the safe motherhood movement.

The later, and more deductive, stage of the analysis involved combining different analytical perspectives and uses of data, depending on the aims and specific objective that I was addressing. In a general sense, in order to analyse how safe motherhood practitioners have come to understand the field's problems and position within the global health field and their own 'diagnostic' of this situation, I relied heavily on the findings from in-depth interviews, supplementing these with accounts relayed in written documents. More specifically, studying the enduring debate between comprehensive and selective approaches to health and its impact on international safe motherhood policy and practice (the first specific objective) entailed examining both its historical origins and contemporary manifestations. In order to discern the origins of the debate, I relied on secondary historical analysis from the emerging literature on the history of international health collaboration, as well as on primary materials, including reports and policy documents and debates held in scientific journals between the proponents of each of these approaches. To delineate how this debate has impacted on safe motherhood policy I analysed specific policy documents and statements from the Initiative's start and onwards, comparing them with more general international health policy statements. I also relied on the testimonies of participants in these debates, treating these as 'oral history' accounts to corroborate and expand on available written documentation.

I used a slightly different approach in order to examine how research and advocacy practices have responded to the debate about comprehensive and selective approaches and the broader tensions within the international health context this debate reflects (my second specific objective). Here I relied more heavily on findings from participant observation and in-depth interviews. In order to address my third specific objective – to assess whether the field's various self-management practices

are likely to further its survival and be conducive to health improvement – I also drew on secondary literature, including several recent reviews evaluating the existing evidence on the impact of global health initiatives, notably of initiatives focusing on HIV/AIDS, on country health systems and on governance for global health.

Maternal health experts' preoccupation with writing their own history provided an important backdrop for the analysis. While professional historians have in recent years studied the history of global health since the formation of the WHO after the Second World War (e.g. Brown et al. 2006; Fee et al. 2008), they have yet to write about the Safe Motherhood Initiative. Indeed, when I visited the WHO archives the archivist revealed that I was the first researcher during her tenure to request materials on WHO's maternal health policies, with tuberculosis and malaria being more popular topics. The dearth of professional historical studies on international maternal health policy, however, is in contrast to collection of historical overviews of the field's development written by maternal health specialists themselves (e.g. Rosenfield 1997; AbouZahr 2001; AbouZahr 2003; Starrs 2006). Written by public health practitioners without training in historical theory or methods, these accounts have been disseminated in the public health and scientific literature, as well as in presentations at international meetings. Over time, elements of these accounts have become reiterated, repeated and taken up as semi-official history within the public health field, as my own findings show. Interpreting these narratives is complex. In the analysis, these narratives both serve as short-hand accounts of the field's history, and as ethnographic data that inform my analysis of how safe motherhood actors have come to understand and depict their own history.

Part I

3. THE HISTORICAL ORIGINS OF SAFE MOTHERHOOD POLICY

If one speaks to safe motherhood practitioners, the dominant understanding of safe motherhood today is one of a field that has failed to deliver on its original promise. Various explanations for this lack of success are put forward, but the problem is often understood to be that the Safe Motherhood Initiative's original policy recommendations were simplistic and misguided, based on a widespread and erroneous belief that improving women's status and education and putting in place preventive health approaches would reduce maternal mortality (see Horton 2006; Starrs 2006). Today, we are told, strategies are more "appropriately focused" on averting maternal deaths through treatment of obstetric complications (Rosenfield et al. 2007:1396). These interpretations form a working history of the safe motherhood field, one that most practitioners are familiar with, but also one which is partial and which obscures as much as it reveals. The primary problem with such accounts is that they situate safe motherhood policy-making processes outside of the political-economic and policy context in which they occurred. Reincorporating the elements of this history that are left out is an essential starting point for a full and proper evaluation of this history's significance today.

In this chapter I analyse the emergence of the Safe Motherhood Initiative and the first set of international policy recommendations for achieving this Initiative's goals. I examine these in relation to a broader, enduring policy debate that continues to mark global health politics even today. In short (and as mentioned briefly in Chapter 1), this policy debate concerns the relative merits of comprehensive versus selective approaches to public health. While a *comprehensive* approach implies action on both social and medical determinants of health *selective* approaches have a more explicit focus on targeted, medical approaches to addressing specific, priority diseases (Mills 2005). Comprehensive approaches involve action at all levels of the health system through 'horizontal' programmes, selective approaches imply programmes with a 'vertical' design, usually targeted

at one level of the health system. Discussions about the relative merits of these approaches are polarised, and, as I show below, reflect different framings of health, as well as power struggles between institutions that often have very different ideological starting points. Revisiting this enduring debate in relation to safe motherhood policy is essential because it provides an important backdrop against which the Initiative formulated its goals and policy proposals. In fact, I would argue that tensions between comprehensive and selective approaches to public health created the main impetus for the creation of the Safe Motherhood Initiative.

Disease-targeted, vertical programmes are often thought of as one of the core characteristics of today's global health initiatives. In this chapter, however, I want to show that the Safe Motherhood Initiative in its early years – and, as later chapters show, on many levels still today – deviated from what we might associate with or expect from a policy community advocating for a specific health issue. By analysing the original safe motherhood policy vision in some detail, I aim to show that the Safe Motherhood Initiative presents a rather interesting case of a policy community that, although focusing on the 'disease-specific' goal of reducing maternal mortality, promoted a comprehensive (rather than a disease-specific) approach to health.

The Initiative's history thus serves to highlight that it is neither self-evident nor inevitable that a health initiative promoting attention to a specific health issue or disease should adhere to a narrow, disease-specific approach to public health, as is often assumed today. Instead, at the pivotal moment of its formation, the Safe Motherhood Initiative was at the forefront of promoting a social-based vision of public health, resisting the reduction of public health solutions to 'magic bullet' disease-targeted technologies of the kind associated with so many of today's global health initiatives.

3.1. An overview of competing framings of health

While my main aim here is to analyse the emergence of the Safe Motherhood Initiative and its particular policy vision, doing so first requires a broader discussion of what I characterise above as a debate between comprehensive and selective approaches. While coming to a head around the time of the Safe Motherhood Initiative's launch, in many ways, the debate about the relative

merits of these approaches was not new. Historians insist that there have always been tensions between social and disease-based visions of public health (Brown et al. 2006). They are not necessarily incompatible, but they have often been at odds (*ibid.*). Indeed, the tensions between these approaches are discernable in the early history of international health collaboration. As I show in the subsections below, such tensions shaped in formative ways the early decades of the World Health Organisation (WHO), always intersecting with broader institutional power dynamics.

3.1.1. Social versus technological agendas in international health collaboration

Historians of public health have shown that disease-based and technological approaches to health improvement were at the core of much early international health collaboration (Weindling 1995; Birn 2006). For instance, the primary purpose of early international health organisations (such as the International Office of Public Health in Paris, established in 1909, and the Health Organisation of the League of Nations, set up in 1923) was the control of epidemic disease across national borders (*ibid.*). According to Weindling (1995), the work of international health organisations was also driven by a desire on the part of the colonial powers these organisations represented to transfer the benefits of medical progress to their colonies.

Like today, philanthropic organisations played an important role in this process, especially in the international health work of the United States. In a study of international health organisations' work in Mexico, Birn (2006) argues that international health cooperation in the 1920s and 1930s was characterised by a reliance on a "technobiological" paradigm. This entailed technical and biomedical solutions to health problems, driven in turn by the primacy of donor needs, emphasis on budgetary incentives, and a dependence on transnational professionals, often trained in the donor countries. For instance, the Rockefeller Foundation's (a major American philanthropic foundation) activities in Mexico clearly demonstrated a continuing struggle between global and local needs, the tensions between funders and community agencies and the power struggles ensuing from differing concepts of 'public health' (*ibid.*).

While much early international health work may have focused on technological and biological solutions to health, the growth of international health collaboration itself also coincided with the emergence of welfare states and bilateral welfare schemes in European colonies, leading to an emerging *social* agenda in health. This included a concern for maternal and child welfare, which contrasted with the initial goals of infectious disease control (Manderson 1992; Balinska 1995; Weindling 1995). This social agenda became manifest in the early work of the World Health Organisation (WHO), the UN's specialised health agency formed on April 7, 1948 (Fee et al. 2008).

The founders of the WHO shared a social vision of health. Indeed, the WHO's constitution officially defined health as "a state of complete, physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO 1948:100). This broad definition reflected the view that the WHO and its member states must take responsibility for tackling the social and environmental determinants of illness as part of the UN's broader commitment to protect human rights (Irwin and Scali 2007). As such, the WHO's mission was not only to advise on the provision of health services and disease control, but also to work with national governments and other UN agencies to improve nutrition, housing, sanitation, recreation, economic and working environments, as well as other aspects required to achieve health progress (Cueto 2004).

Despite this broad remit, the political context of the post-World War II period, marked by *Cold War* power struggles and decolonisation, impeded implementation of a social approach to health (Mills 2005). Instead, it favoured one focusing more on health technologies delivered through targeted campaigns (*ibid.*). The Soviet Union's temporary withdrawal from the UN and its agencies in 1949 granted the US great influence over the international development and health agendas. Irwin and Scali (2007) argue that despite the key role of the US in shaping the WHO constitution, in practice, American officials were reluctant to pursue a social model of health improvement because of the perceived ideological (communist) implications of doing so during the *Cold War* era.

Subsequently, international health became characterised by a series of programmes targeting diseases such as malaria, smallpox, tuberculosis and yaws that were delivered in a vertical manner as disease-eradication campaigns, mostly separate from overarching public health provision (Werner and Sanders 1997).

Historians have since interpreted the emergence of such vertical programmes as the application of American-style development theory to health, characterised by the promotion of technologies brought in from outside to eradicate disease, generate economic growth and create markets for US expansion to help in the battle against communism (Brown et al. 2006). These were short-term interventions designed to bring about results rapidly.

While disease eradication campaigns had some notable successes – especially the eradication of smallpox in 1980 – they also exposed some of the limitations of relying on targeted approaches. For instance, it is widely claimed that the disease-specific focus of these campaigns exacerbated problems in many developing countries relating to the concentration of health services in urban areas and poor access to services for people living in rural communities (e.g. Brown et al. 2006). A WHO campaign to eradicate malaria, initiated in 1959, also illustrates the limits of vertical disease-eradication programmes. The campaign had been developed amid enthusiasm about the prospects of insecticides to kill mosquitoes, the vectors of malaria. But problems emerged from the mid-1960s, resulting in part from greater than expected resistance to insecticides and realisation of the environmental damage caused by toxic insecticides (Brown et al. 2006; Fee et al. 2008). It soon appeared that malaria eradication programmes were failing (Carson 1962; cited in Fee et al. 2008). According to Fee and colleagues (2008) such setbacks resulted in growing understanding in the late 1960s and 1970s of the need for an underlying infrastructure of health services and health education to support malaria control efforts and other vertical programmes in disease prevention and health promotion. A sign of such recognition is that in 1969, the World Health Assembly (the WHO's governing body) concluded that malaria could not be eliminated in the absence of a comprehensive rural health service (*ibid.*). By the mid-1960s, the evident failure of disease-eradication programmes to meet the needs of poor and rural populations thus fed into a renewed concern for the social, economic and political dimensions of health, which intensified throughout the 1970s, underpinned by a shift in development theory overall (Newell 1988).

3.1.2. 'Health for all' and comprehensive primary healthcare

The emergence of decolonised nations and the spread of nationalist and socialist movements during this period led to new development theories that emphasised

long-term economic growth instead of short-term technological intervention (Brown et al. 2006). At the national level, health-based movements came to play an important role in political change, including in anti-colonial struggles (Werner and Sanders 1997). Cueto (2004) describes the expansion of community-based programmes built on grassroots participation in many countries, especially across Central and South America and Asia. In Africa too, there was growing momentum around developing functioning health systems in countries that, after gaining independence from colonisers, had been left with a hospital-based system benefiting only the urban minority (*ibid.*).

In line with this vision, the WHO was involved in efforts to expand healthcare at the primary level during the 1950s and 1960s, alongside the disease-eradication programmes described above. For instance, the WHO had supported many governments in low-income countries in setting up maternal and child health (MCH) divisions as part of a broader effort to expand healthcare to the community level (Campbell 2001). Although there is scant documentation of specific international work in maternal health during this period, one WHO official who worked in several developing countries during the 1950s and 1960s recalls in her professional memoirs that the WHO established MCH services in the countries where she worked, as part of the agency's more general work in primary healthcare (Barton 1998). This included programmes for training of midwives and traditional birth attendants, and establishment of antenatal care services and referral mechanisms to hospitals. This was in addition to more general efforts to improve health and nutrition levels and to overcome massive challenges posed by weak health systems and healthcare provider shortages (*ibid.*).

National level movements and activities fed into growing international momentum to promote the health of poor and rural populations in low-income countries. By the early 1970s, an international social movement formed around the promotion of health as a social good, a human right and an issue of social justice. This ideological vision was debated within the WHO, where it was most vociferously championed by Halfdan Mahler, a Danish public health physician appointed as the WHO's Director-General in 1973. Mahler promoted the slogan "health for all by the year 2000," and insisted that *comprehensive primary healthcare* was the best strategy for achieving health for all (Cueto 2004).

In 1978, the WHO collaborated with UNICEF to convene the Alma-Ata Conference on Primary Health Care, held between 6 and 12 September 1978 in Alma-Ata in the Soviet Union (now Almaty, Kazakhstan). At the conference, participants affirmed the right to health as a state of complete, physical and mental well-being (WHO and UNICEF 1978). The Alma-Ata Declaration on Primary Health Care was adopted by WHO member states and called for urgent national and international action – supported by UN agencies, multilateral and bilateral donors, NGOs and health workers – to develop and implement comprehensive primary healthcare, particularly in developing countries (WHO and UNICEF 1978).

Comprehensive primary healthcare entailed both a philosophy of health as part of socio-economic development, *and* attention to the most peripheral level of the health system at which the basic health needs of the majority of people would be met (Cueto 2004; Irwin and Scali 2007). Its focus was thus on equity as well as on effectiveness and efficiency, to be achieved through the implementation of preventive, rural, peripheral and “appropriate” services and inter-sectoral collaboration, as well as participation of local communities. A main premise of this approach was the idea that specific disease control efforts should not be delivered as isolated vertical programmes, but should, instead, be integrated into a broad range of health and social services (Fee et al. 2008). As such, the realisation of the highest possible level of health required action not only in the health sector, but also in other social and economic sectors, such as agriculture and food, industry, education and housing (WHO and UNICEF 1978). Action in such social sectors was considered necessary to address causes of ill health such as malnutrition, unsafe drinking water, sanitation and lack of knowledge about health (*ibid.*). While the Declaration emphasised community participation in planning and implementing healthcare, it was also explicit that the state held ultimate responsibility for providing adequate social and health sector services (*ibid.*).

The Alma-Ata Declaration recommended a series of measures for improving people’s access to healthcare. These included, first, shifting the concentration of resources from hospitals in cities to services delivered at the primary level of the health system, in rural areas where the majority of the population in many low- and middle-income countries lived (WHO and

UNICEF 1978). Achieving 'health for all' would thus involve establishing a new infrastructure consisting of a system of health posts and centres to replace the 'disease palaces' of the post-colonial era (Fee et al. 2008). A second set of recommendations was related to human resources and called for the deployment of 'mid-level' healthcare providers as well as community-based health workers in order to overcome shortages of qualified doctors, a recommendation that was inspired by the success of the 'barefoot doctors' of communist China (*ibid.*).

Perhaps because the Alma-Ata Declaration was innovative in drawing attention to the need for community-based services to improve access, it has often with hindsight been erroneously assumed that the approach called for action *only* at this basic level of healthcare. In fact, the designation 'primary healthcare' is somewhat of a misnomer. While Alma-Ata became famous for calling attention to the need for primary level or community-based healthcare, the Declaration also insisted that countries must develop a network of hospitals and a referral system to supplement activities at the most peripheral 'community' or 'primary' level of the health system (Van Lerberghe et al. 1997; Turshen 1999:24). Indeed, in 1981 Halfdan Mahler, then WHO's Director-General, made an often-cited statement that, "a health system based on primary care cannot, and I repeat, cannot be realised, cannot be developed, cannot function, and simply cannot exist without a network of hospitals" (cited in Van Lerberghe et al. 1997:801). The prevalent misunderstanding that the primary healthcare philosophy referred only to the community-based level has carried over into a common misunderstanding about the role of primary healthcare in safe motherhood policy too, namely that it implied only low-tech, preventive community-based solutions such as training of traditional birth attendants.

In sum, the Alma-Ata vision of comprehensive primary healthcare represented a radical and new approach to development and health. It epitomised a conceptual shift in the emphasis of public health from curative to holistic care, from specialised hospital care to improve access to health posts in rural areas, and from biological determinants of disease to the socioeconomic determinants of health (Walt 2008). However, as the next subsection highlights, despite the initial philosophical and ideological momentum this shift gained at the international level and the support it drew from many WHO member states, the Alma-Ata Declaration almost immediately met with considerable resistance.

3.1.3. Selective primary healthcare

Almost no sooner than the Declaration had been signed did the idealistic vision it had articulated begin to get scaled back. In 1979, the year after the Alma-Ata Conference, a paper published in the *New England Journal of Medicine* argued that the Declaration's comprehensive vision was unrealistic for poor countries and proposed that an interim strategy was needed to begin the process of implementing primary healthcare in such countries (Walsh and Warren 1979). As a more pragmatic and feasible alternative to the Declaration's insistence on strengthening all aspects of the health system simultaneously, the authors Walsh and Warren, both representatives of the Rockefeller Foundation, recommended that donors and governments should start by targeting major sources of mortality and morbidity through a small number of cost-effective interventions whose effects could be easily monitored and measured. As the authors put it, "aiming services at the most important diseases is the only rational approach to absolute poverty and unsanitary conditions" (Walsh and Warren 1979:967). The 'interim' strategy they promoted was labelled '*selective* primary healthcare,' a concept that was further elaborated at a conference the World Bank and the Rockefeller Foundation convened in Bellagio, Italy that same year (Cueto 2004).

Selective primary healthcare heralded the establishment of a technocratic and technical approach to setting health priorities. Proponents of the approach suggested that specific diseases or conditions would be selected on the basis of their prevalence, morbidity and mortality and the feasibility of their control, which would in turn be established through assessment of the effectiveness and cost of available interventions (Walsh and Warren 1979). As Table 2 shows, whereas the comprehensive interpretation of primary healthcare incorporated preventive and therapeutic care delivered across the different levels of the health system, the selective interpretation implied a focus on simple, relatively low-tech interventions. The presumed advantage was that such interventions could be delivered directly to households and communities rather than in health facilities, thereby effectively sidestepping the need to wait for the development of a functioning health system (Freedman, 2003, citing Claeson and Waldman 2000). A greater role for private providers and heavy reliance on community health workers who would require minimal training and remuneration would, proponents argued, improve efficiency (Turshen 1999). Above all, selective

primary healthcare implied a 'vertical' design of health services, targeting specific diseases at one level – usually the community level – of the health system, rather than a 'horizontal' approach linking all the different levels of healthcare.

Death and illness among children in low-income countries was quickly singled out as a priority health problem for selective intervention, in large part on account of the high number of child deaths (Werner and Sanders 1997). UNICEF's Child Survival and Development Revolution, launched in 1982, became the flagship selective primary healthcare programme, introducing a series of selective interventions that aimed to improve survival of children up to the age of five, summarised under the acronym GOBI: growth monitoring, oral rehydration therapy, breastfeeding, and immunisation (UNICEF 1986; Cash et al. 1987; Black 1996).¹³ As I will show below, public health specialists were prompted to form the Safe Motherhood Initiative in part in reaction against this approach.

	Comprehensive	Selective
Overall goal	Long-term, sustainable health improvement and social and economic development	Disease eradication and measurable progress on mortality and morbidity indicators
Healthcare provider	Primarily state	State and non-state, including private and NGO
Sector	Health and other social sectors	Health sector primarily
Determinants of health addressed	Medical, social, economic, political	Medical
Organisation of health services	All levels of the health system (horizontal), primary-level to tertiary level	One level of the health system (vertical), usually primary/community level
Human resource strategy	Flexible; community health workers, mid-level providers and specialist providers, collaborative approach	Heavy reliance on community health workers

Table 2: Main elements of comprehensive and selective approaches to health (Sources: WHO and UNICEF 1978; Walsh & Warren 1979)

¹³ Family planning, female education, and food supplementation (FFF) were added later, targeting women of childbearing age (15-45) (UNICEF 2006).

3.1.4. A politically palatable approach?

Selective primary healthcare rapidly surpassed comprehensive primary healthcare as the dominant international public health paradigm, in part for practical reasons. First, economic downturn, precipitated by the oil crisis of 1979, raised prescient concerns about the financing and feasibility of a comprehensive approach (financing being an issue that had received insufficient attention at the Alma-Ata Conference) (Cueto 2004). The new economic circumstances meant drastic reductions in funds for healthcare in developing countries and translated into lack of political commitment or ability in many debt-ridden countries to implement comprehensive primary healthcare, despite the widespread nominal support that had been given to the Alma-Ata Declaration (Claesson and Waldman 2000; Cueto 2004).

The situation in low- and middle-income countries was exacerbated by the fact that there were no significant resources in the WHIO or other agencies devoted to training auxiliary personnel, improving nutrition and drinking water or creating new health centres (Rifkin et al. 1988). This was in contrast to other international campaigns, such as the global malaria eradication program of the 1950s, where UNICEF and US bilateral assistance provided dedicated funding (*ibid.*). Moreover, the economic crisis also severely restricted the finances of UN agencies themselves, including the WHO, making it even more difficult to finance comprehensive approaches (Brown et al. 2006; Fee et al. 2008). The economic downturn left WHO member states – who had financed the WHIO's activities through contributions to its regular budget – unable to maintain their contributions (*ibid.*). The damage this caused to the WHO's budget was exacerbated when the US, the biggest contributor, withheld its contribution to the budget due to a dispute over the WHO's essential drugs programme, which US officials perceived to contradict US commercial interests and that was opposed by leading US-based pharmaceutical companies (Brown et al. 2006).

At the same time, the scaling back of comprehensive primary healthcare in favour of a selective interpretation must be seen in relation to broader ideological shifts. Some increasingly powerful international health actors, including the World Bank and the US government, were opposed to the 'radical' undertones of the Alma-Ata Declaration and championed a selective approach (Irwin and Scali 2007). On an ideological level, selective primary healthcare was

politically acceptable to the US and the World Bank (which was heavily influenced by US interests) because, unlike the Alma-Ata Declaration, it did not imply that health improvement was an adjunct to social revolution (*ibid.*). Indeed, the growing dominance of selective primary healthcare as a policy paradigm in the 1980s relates directly to the rise of the World Bank as a major player in public health during this period. Although the WHO had been the unquestioned authority in international health since its creation in 1948 – enjoying considerable authority within the UN and among its member states – in the years immediately following the Alma-Ata Conference its legitimacy as an international agency began to be challenged by the World Bank (Lee and Walt 1992; Walt 1993).

Originally formed to finance reconstruction of Europe after World War II, from the 1970s onwards the World Bank began investing in population control, health and education in low- and middle-income countries, driven by the view that social sector investment to improve these areas would accelerate economic growth (Benerji 1999; Ruger 2005). It soon overran the WHO as a financier of international health activities, gradually becoming a global health leader in its own right but bringing with it its own particular approach to health (Walt et al. 1999). While the WHO had largely operated according to a model of state-led development of the health sector and conceived of health as a matter of social justice and human rights, under the influence of the World Bank health sector development became subject to market-oriented influence, reflecting the Bank's ideological affiliation with the economic and political model that became known as 'neoliberalism'. According to Sparke (2006), neoliberalism has become an umbrella term for the diverse ideologies, policies and practices associated with liberalising global markets and expanding entrepreneurial practices and capitalist power relations into new areas of life. Also referred to as the "Washington consensus" since its main proponents (the World Bank, the International Monetary Fund and the US government) are based in Washington, D.C. (Navarro 1998), the core of the neoliberal vision is the idea that markets freed from government interference can allocate resources in the best and most efficient way and thereby promote common goods, including health (Coburn 2000). Key assumptions include that the role of the state should be reduced to curb inefficiencies and that policies for stimulating growth should be a priority, since economic growth is understood to be essential for development, even if the

effort to accelerate economic development may involve short-term negative consequences (*ibid.*). Selective primary healthcare was articulated within this political ideology, which became increasingly dominant during the early 1980s.

That UNICEF with its Child Survival Revolution should join the World Bank and USAID (the US Development Agency) in promoting selective primary healthcare may seem curious given its role, only a few years earlier, in formulating the Alma-Ata approach jointly with the WHO. However, this development reflected, among other things, a leadership change within UNICEF in 1979, the year after the Alma-Ata Declaration had been signed. UNICEF's new Director, Jim Grant – often described as a charismatic leader who masterminded the GOBI approach – believed international agencies had to work within existing political constraints to do their best to achieve short-term success by focusing on narrow but feasible interventions (Black 1996; Irwin and Scali 2007).

3.1.5. A counter-revolution?

The seemingly successful implementation in the early 1980s of the Child Survival Revolution as the flagship selective primary healthcare programme did much to bolster support for the approach. Major donor resources were mobilised, and the Child Survival and Development Revolution (or the Child Survival Initiative) formed what can perhaps be seen as the first global health initiative. Within a few years of UNICEF launching the Child Survival Initiative, many in the international health community were celebrating the apparent success of GOBI at reducing child mortality. According to Cueto, GOBI was in particular attractive to donors because it enabled them to tie their inputs to specific interventions and outcomes (Cueto 2004:9). The popularity of vaccines – one of the key interventions in the GOBI strategy – had already been secured by the announcement in 1980 of the eradication of smallpox, the first disease ever to be eliminated through human action (Fenner et al. 1988; Fee et al. 2008).

At the same time, supporters of a comprehensive interpretation of primary healthcare vehemently opposed the selective approach, resulting in a polemical debate that intensified during the early 1980s. Some commentators declared that comprehensive and selective primary healthcare were “irreconcilable” and “diametrically opposed” (Rifkin and Walt 1986). Others mounted practical, philosophical and political objections to selective primary

healthcare. While conceding that selective primary healthcare could effectively address the immediate causes of death and ill health from specific diseases, they argued that public health involves more than selecting death-reducing technology (Newell 1988; Wisner 1988; Walt and Gilson 1994; Werner and Sanders 1997). They also derided primary healthcare for failing to address the development of a functioning health system and the underlying social and economic determinants of health. As one such critic argued, health planning cannot be reduced to an abstract task of allocating resources “to maximise a weighted combination of effectiveness, equity and efficiency” (Berman 1982:1054).

Not surprisingly, many proponents of a comprehensive approach also saw selective primary healthcare as an unwelcome extension of neoliberalism, which they opposed on the grounds that it challenged the political vision for social justice, equity and state-led development espoused in the Alma-Ata Declaration (Turshen 1999; Magnussen et al. 2004:44). One critic was particularly scathing, arguing that UNICEF was “dangerously mistaken” in thinking that its so-called “revolution” is “a precursor or 'leading edge' of comprehensive primary healthcare” (Wisner 1988:963).

Although immunisation campaigns accelerated in developing countries after the mid-1980s and dramatically increased immunisation coverage, such apparent success did not lessen the debate (Cueto 2004). Wisner (1988) argued that UNICEF’s approach – the diffusion of a package of technologies by campaigns organised from the top down – was likely to undermine the social basis for comprehensive care. The supporters of comprehensive primary healthcare cited above saw oral rehydration solutions championed under the GOBI strategy as a ‘Band-Aid’ in places where safe water and sanitation systems did not exist (Cueto 2004). These objections rose to a clamour in the pages of *Social Science & Medicine* around the time the Safe Motherhood Initiative was being launched, with one author labelling selective primary healthcare a “counter-revolution” (Newell 1988).

Cueto (2004), one of the few historians to have written about the history of primary healthcare, offers an analysis of this debate, suggesting that it illustrates two diverse assumptions in international health in the 20th century. Supporters of comprehensive primary healthcare assumed that diseases in less-developed nations were socially and economically sustained. The social and

economic basis of ill health implied that a political, and not simply technological, response was needed. Conversely, supporters of selective primary healthcare worked from the assumption that the main diseases in poor countries primarily needed technological solutions. In the second half of the chapter I show how the work of early safe motherhood advocates was premised very much on the former of these assumptions, something that would shape the future development of the movement in important ways.

3.2. 'Where is the M in MCH?'

The Safe Motherhood Initiative was created in the midst of the debates reviewed above. In fact, I would argue that a core impetus for the creation of an initiative dedicated to maternal ill health and mortality was intense dissatisfaction within parts of the international public health community with the growing dominance of selective primary healthcare as the main paradigm for international health. Indeed, the formation of the Safe Motherhood Initiative can be seen as part of a broader effort to revive political commitment to the comprehensive primary healthcare or 'health for all' agenda as against the broader trend of selective approaches. This can be seen both in the framing of the issue of 'safe motherhood', as well as in the specific international policy recommendations that safe motherhood practitioners promoted for achieving it.

By the mid-1980s, commentators noted that "despite international commitment to primary healthcare and 'health for all by the year 2000,' in many countries relatively little attention has gone to maternal health" (Herz and Measham 1987:5). This statement is indicative of the fact that some public health specialists came to equate the scaling back of Alma-Ata with the neglect of women's health in international health efforts (relative to the focus placed on saving children's lives). Public health specialists identified an important gap between policy rhetoric and realities, pointing out that although "stated health policies stressed maternal and child health and family planning (often noting that all three are linked and that neglect of one jeopardises the others)," most health budgets for low-income countries allocated less than 20 percent to these issues (Herz and Measham 1987:5). Moreover, the bulk of this funding was said to go to child health. Such observations reflect growing dissatisfaction in the 1980s that women's health was receiving little attention in international debates, despite

the fact that healthcare for mothers and children – so-called MCH services – had been seen as the heart of the primary healthcare system model (WHIO and UNICEF 1978). While MCH services had clearly been intended to benefit mothers and children alike as the basis for improved population health, once selective primary healthcare became implemented through child survival initiatives in the early 1980s, many believed that the maternal component of MCH was being sidelined in favour of the interventions targeted at children (Rosenfield and Maine 1985).

This point was made cogently in a highly influential article entitled 'Where is the M in MCH.' This article was written by Allan Rosenfield and Deborah Maine (*ibid.*), both public health specialists then based at Columbia University in New York who would later become key figures within the safe motherhood movement, and published in the medical journal the *Lancet* in 1985. The 'Where is the M in MCH' article is often credited with almost single-handedly launching safe motherhood as an international health movement, because of the scale of the response it galvanised within the international public health community. The crux of Rosenfield and Maine's argument was that selective primary healthcare – exemplified by GOBI – was an inadequate model for responding to the full range of public health problems of low-income countries. While lauding GOBI for expanding access to services in rural areas and moving away from the hospital-based model of healthcare characteristic of the immediate post-colonial era, they argued that for certain important public health problems, selective approaches of the kind promoted by the GOBI approach would simply not suffice.

The case of maternal mortality illustrated particularly clearly the limitations of selective primary healthcare as a single paradigm for addressing the health problems of poor countries. As Rosenfield and Maine (1985) argued, maternal mortality is a health problem that cannot be tackled through a selective approach comprised of preventive, low-tech and community-based interventions. They claimed that such approaches are inappropriate for tackling maternal mortality because most pregnancy-related deaths occur following obstetric emergencies (including haemorrhage, infection, toxæmia, obstructed labour and unsafe abortion) that, on the whole, can be neither prevented nor predicted through community-based programmes (Rosenfield and Maine

1985:84). Instead, to avert deaths from such complications, relatively sophisticated treatment is required, such as caesarean section for obstructed labour and blood transfusion for massive post-partum haemorrhage (*ibid.*). Such interventions, routinely used in maternity care in Western countries since at least the 1930s, had helped to virtually eliminate maternal mortality as a public health problem in those countries (Högberg et al. 1986; Loudon 1986). In order to ensure women's access to such life-saving treatment in low- and middle-income settings, it would be necessary to build comprehensive systems of maternity care, spanning from the primary or community level to referral hospitals, mirroring the model of comprehensive primary healthcare described in the Alma-Ata Declaration (*ibid.*).

3.2.1. A social movement for women's health

Public health specialists opposed to exclusive reliance on selective primary healthcare buttressed the call for comprehensive maternity care systems. Such support was further enhanced by the rise of an international feminist social movement in the 1980s that was supportive of the need to draw special attention to women's health. As I show below, by the mid-1980s, momentum around the need to revive the principles of Alma-Ata and demand for action on women's health converged to create support for the establishment of an international initiative dedicated to maternal health.

For feminists, advocating for women's health was part of a broader agenda to improve women's social status and ensure their rights to work and control over their own bodies, including through access to contraception and abortion (Turshen 2007). Feminist health activists, primarily from the US, were motivated by grave dismay that many women in low-income countries were restricted by male family members from seeking healthcare, in part due to a general devaluing of women's lives. As one informant explained, they were alarmed by the truth behind the saying from countries such as Bangladesh that "it is better to lose your wife than your cow." For feminists, the aim of ensuring women's autonomy and access to healthcare was, in turn, closely linked to demands to abolish population control measures through vertical family planning programmes, which sometimes included coercive sterilisation. Since the 1950s, such programmes had become commonplace in a number of countries pursuing donor-supported population-control policies (Lane 1994; Pearson and Sweetman

1994; Gruskin et al. 2008). According to Gruskin and colleagues (2008), global feminist activism for health impacted on the UN Decade for Women (1976-1985), and created a policy context that was receptive to the demand for attention to women's pregnancy-related health.

By the mid-1980s, a group of international experts driven by the convergence of feminist and public health concerns, galvanised by the 'Where is the M in MCH' article, thus began to promote a new agenda on women's health, driven at least in part by the aim of challenging the growing dominance of the popular Child Survival Revolution. During in-depth interviews, informants who had been involved in this development described how a network of people interested in maternal health and mortality started to form, promoted by the links between technical staff at various international agencies and research- and advocacy-oriented international NGOs. Following several WHO-hosted meetings in 1985, the first international Safe Motherhood Conference convened in Nairobi, Kenya in February 1987, drawing more than a hundred participants.

At the conference, UN member states committed to pursuing the goals of improving women's health and reducing maternal mortality (see Starrs 1987 for the conference report, including the Call to Action). The conference officially launched the 'Safe Motherhood Initiative' as a multi-agency effort to formulate strategies to deal with the problems of maternal mortality and ill health, as well as the underlying issue of women's low social status. An Inter-Agency Group (IAG) was appointed to oversee implementation of the Initiative's programme of action. The IAG consisted of representatives from the WHO, UNICEF, UNFPA and UNDP (the United Nations Development Programme), as well as the World Bank and NGOs (the Population Council, the International Planned Parenthood Federation (IPPF) and a newly formed NGO called Family Care International (FCI), which was to serve as the group's secretariat). The fact that such a wide range of actors converged reflected growing commitment to women's health, but also the fragmentation of the international health field marked by the emergence of the World Bank as a key actor, as noted above.

A result of the complex composition of the IAG was that the Initiative was torn between the different institutional agendas and priorities of its members. Nevertheless, the fact that its individual members managed to promote a relatively coherent agenda despite their diverse institutional affiliations

serves to highlight that there was a variety of different positions even within the various agencies represented in the IAG. For instance, despite the World Bank's overall espousal of the *selective* primary healthcare paradigm, it was representatives of the World Bank who were the main authors of the Initiative's avowedly *comprehensive* policy agenda, which I review in detail below (see Herz and Measham 1987).

3.2.2. The imperative for action on maternal mortality

The 'Where's the M in MCH' article drew attention to the technical limitations of selective primary healthcare as a response to the public health problem of maternal mortality. In the years that followed, public health specialists and women's health advocates went about framing the issue of pregnancy-related morbidity and mortality in a way that explicitly rejected not only the selective primary healthcare paradigm's focus on 'magic bullet' community-based approaches, but also its priority-setting approach. While the selective primary healthcare paradigm had formalised the notion that health priorities should be selected according to the magnitude of deaths and infirmity attributed to them and the cost-effectiveness of the interventions available, the case for 'safe motherhood' was made rather differently, and was more in keeping with the ideological basis of Alma-Ata. The way 'safe motherhood' came to be framed clearly supports the notion that the Initiative sought to reaffirm the core principles encapsulated in the 'health for all' agenda discussed above.

A principal argument put forth to justify the call for action on safe motherhood was that the high level of maternal mortality in low-income countries was not inevitable or natural, but instead represented *avoidable* loss of life. As such, it was a preventable tragedy that governments and the international community had an ethical obligation to address. As my informants explained, the fact that effective treatment existed to avert maternal mortality was perhaps the most compelling argument for action.

Second, advocates posited action on maternal mortality as an essential task for international development efforts more broadly. They interpreted the fact that women in poor countries continued to die of medical complications that had been almost eradicated as causes of death in industrialised countries over 50 years ago as a clear indication of the failure of international development efforts overall, suggesting the need for a revised response. Indeed, many early

advocates seem to have perceived pregnancy-related mortality to be so interwoven with broad-based development that one Safe Motherhood Conference delegate claimed that, “there is no greater indictment of development efforts than the high rates of maternal deaths that prevail in much of the world” (cited in Starrs 1987:42). To support this view, participants in the conference pointed to the discrepancy between maternal mortality rates of poor countries and rich ones, where maternal mortality is no longer a major public health problem. New statistics provided clear evidence of the inequity underpinning maternal mortality. The first global estimates of maternal mortality published in 1986 revealed that nearly all – 99 percent – of half a million pregnancy-related deaths annually, occurred in low-income countries (WHO 1986). Rates in low-income countries were 200 times higher than those in Europe and North America, “the widest disparity of all statistics in public health” (Mahler 1987b:668).

At the same time, advocates pointed to the success of Western countries in drastically reducing maternal mortality through dedicated health and social policies as inspiration for countries still beset by high maternal mortality rates. As Mahler (1987b:670) put it to the participants at the first Safe Motherhood Conference in Nairobi in 1987, “we need to remember that the industrialised countries faced this challenge in the past. For some the change has taken place in our lifetime, through dedication and the reallocation of priorities.” According to informants, the fact that in certain countries, such as Sweden, maternal mortality declines had preceded large-scale socio-economic developments lent further support to their call for action.

Further, framing maternal mortality as a social injustice implied an obligation on the part of governments and international community to respond to this public health problem (Cook and Dickens 2002). Mahler, for instance, was adamant that maternal mortality had been neglected first and foremost precisely because “its victims are those with the least power and influence in society – they are poor, rural peasants and female” (Mahler 1987b:668). Interviews with informants who participated in the conference suggest that there was broad consensus that, while specific medical complications are the direct cause of maternal deaths, such deaths result ultimately from poor women’s limited access to healthcare, especially to emergency care, sustained by underlying

discrimination in areas such as education, employment, property and decision-making authority.

Although an underlying goal for the Initiative was to improve women's status and autonomy over their bodies and reproductive lives, it is important to note that certain of the most controversial aspects of this agenda – namely abortion rights – were toned down in the Initiative's public rhetoric, so as not to alienate decision-makers with conservative attitudes towards women's rights from supporting the broader call to action. Instead, advocates promoted the idea of ensuring safe 'motherhood,' which, with its implied focus on childbirth and maternal nurturing, they considered to be largely uncontroversial. Indeed, informants who were active in the Initiative's early days explained that they deliberately avoided incendiary demands for the expansion of abortion rights. This was a useful tactic at a time of great religious and political opposition to abortion, as manifest in the Mexico City policy introduced in 1984 by US President Ronald Reagan, which prohibited allocation of federal funds to organisations that provide abortions or support abortion-related work (Finkle and Crane 1985). Rather than make demands for expanded abortion rights *per se*, maternal health advocates chose to approach the abortion issue primarily from a public health angle. They framed unsafe abortion as a cause of maternal death and issued demands for post-abortion care to treat consequences of unsafe abortion (including perforated uterus, haemorrhage, infections and secondary infertility) as one component of the medical interventions needed to reduce maternal mortality.

The very choice of the term 'safe motherhood' to describe the Initiative's work and goals was motivated by its largely uncontroversial connotations, as well as its potentially wide scope. According to one informant who had participated in preparatory meetings for the 1978 Safe Motherhood Conference, it was in fact the husband of one of the chief authors of the Initiative's main policy documents who "came up with the term one night over dinner." Although many quibbled at first, finding it quite a "strange term," she explained that consensus rapidly emerged around its political value as a catch-all term that was not immediately contentious:

One of the things that was so useful about the term 'safe motherhood' from the very beginning was that it's something no one could say they were against. The most hardnosed

unsentimental decision-maker or economist has a mother, or has a sister or has a wife, or has a daughter. Nobody can say they are opposed to reducing maternal mortality. So it's very useful in that sense. And if you take the broad approach to maternal health you do bring in issues not just of training of midwives and supplying health facilities but also the issues of education for girls, for women's status and women's rights in society and how women are viewed. But you can do so in a way which is not so threatening to men and decision-makers who might otherwise... I'm all for women's rights obviously, but you do find it's very threatening to some decision-makers. Safe Motherhood, at least overtly, is not.

As this quote suggests, although early safe motherhood advocates were ideologically committed to feminist ideals, they were also clearly attentive to the political sensitivities surrounding their objectives, shaping the language of their demands to the political realities of their time. Meanwhile, although they were careful about the way they publicly portrayed the abortion issue, their framing of safe motherhood as an ethical, social justice and development imperative provided a clear challenge to the emerging disease-specific, neoliberal bias in international health policy. In sum, it seems clear that early safe motherhood advocates worked from the premise that high levels of maternal mortality in poor countries were caused by underlying social and economic factors and, as such, would require a political as well as a medical response. Indeed, at the Nairobi Conference Mahler (1987*a*) advised the public health community to resist the urge to search for "a single magic bullet that could slay this dragon," suggesting that such a search would be futile. Failure to address the underlying social and economic causes of maternal mortality would mean that the problem would only increase in magnitude with population growth (*ibid.*).

3.2.3. Saving women's lives through comprehensive primary healthcare

The social vision of public health discussed above is clearly reflected in the international policy recommendations on safe motherhood that the IAG issued at and around the time of the Nairobi Conference, as I show below. On the whole, these policy recommendations echoed the core principles of the Alma-Ata agenda. Several important elements stand out.

First, in their call to action, the IAG recommended a combined and simultaneous focus on social, economic and medical determinants of health,

including social sector policy interventions to address the underlying determinants of women's pregnancy-related ill health and death. They urged governments and donors to address the full range of causes of high levels of maternal mortality within a population: "the chain of poor nutrition, illiteracy, lack of income and employment opportunities, poor environmental conditions, inadequate health and family planning services, and low social status" (Starrs 1987:4-5).

Second, the IAG's health sector recommendations called for a combined therapeutic and preventive approach, stretching from the primary to the tertiary level of the health system, linking communities with health facilities (Starrs 1987). The aim was not only to avert deaths, but also to improve health through a range of distinct, but complementary interventions. The IAG identified the district as the appropriate level of the health system for administering this model of primary healthcare, with separate specific recommended actions for the primary (or community) and first-referral levels. In the model that was recommended, the primary level included outreach programmes and health dispensaries, posts or centres, while the first-referral level comprised "usually a district or cottage hospital with 20 beds or more, with capability for blood transfusion and caesarean section" (Herz and Measham 1987:19).¹⁴ Table 3 summarises the main aspects of the proposed health sector strategy.

As Table 3 indicates, according to the IAG's model interventions designed to maintain health and treat minor morbidity should be implemented at the primary level. Such interventions included preventive measures and relatively simple medical care, such as family planning, prenatal care and supervised delivery without complications. Additionally, it was recommended that screening for high risk of pregnancy complications should be carried out at this level of the health system, if necessary followed by referral of the patient to a higher level of care.

The IAG further recommended that interventions designed to treat severe morbidity and avert deaths from obstetric complications be delivered at the first-referral level. These interventions included relatively sophisticated

¹⁴ This model built on Rosenfield and Maine's 1985 suggestion for a specific model of a comprehensive system that would comprise small maternity centres in rural areas and, for every 100,000 people, 20-bed rural MCH centres that would be referral centres for high-risk women and women with serious complications. The system they proposed was modelled on Taylor and Berelson (1968) had outlined in the late 1960s.

procedures such as caesarean section and blood transfusion. A good referral mechanism between the primary and the referral level was seen as essential for ensuring women's timely access to such life-saving care. In addition to this recommendation that pregnancy and delivery complications should primarily be treated at the first-referral level, a series of community-level experimental therapeutic approaches was also proposed, such as antibiotics to treat complications of abortions and certain cases of sepsis (Herz and Measham 1987).

	Primary/community level	First-referral (district) level
Type of health issue addressed	Uncomplicated delivery Family planning Antenatal care Antenatal screening for high-risk pregnancies General healthcare	Complications and emergencies related to pregnancy, abortion and delivery
Type of intervention	Supervised delivery Detection of complications Referral in case of complications Contraceptive care	Emergency care (c-section, blood transfusion etc.) Treatment of incomplete abortion (Abortion where legal)
Type of healthcare provider	Community health workers, including traditional birth attendants (supported by professional staff)	Mid-level providers (specially-trained nurses and midwives) (later called skilled birth attendants) Physicians Specialists (obstetricians)

Table 3: The IAG's 1987 health sector recommendations for maternal health (Sources: Starrs 1987; Hertz & Measham 1987)

While safe motherhood advocates clearly called for system-level change, they anticipated arguments about prohibitive costs by arguing that this did not imply large-scale investment in new medical technologies or hospitals. As informants explained, they argued that a comprehensive maternity care system could be implemented with relatively minor investments to improve the organisation and management of the health system. What was needed was a change in prioritisation away from vertical programmes towards strengthening core elements of the health system, for instance by upgrading existing facilities, instituting managerial changes and strengthening referral systems. In a similar vein, advocates, such as Rosenfield and Maine, also tried to appeal to the broader

benefits of such investments for existing selective programmes, such as the potential to expand family planning services through maternity care, an effort to appeal to the World Bank's and others' interest in population control (Rosenfield and Maine 1985).

A third important element of the safe motherhood policy agenda related to how comprehensive health systems would be staffed. This posed an obvious challenge, given the short supply of specialists (obstetricians) and physicians in most low-income countries. The Alma-Ata Declaration had recommended a pragmatic solution to such staff shortages, relying on 'task shifting' from more specialised to lesser specialised cadres and mobilising a large number of community-based health workers without formal medical qualifications – who would require minimal training, supervision and remuneration – to deliver the bulk of healthcare at the primary level (WHO and UNICEF 1978). Mirroring the Alma-Ata Declaration, the Safe Motherhood Initiative recommended a similar pragmatic response. More specifically, the IAG recommended that primary-level services be delivered principally by community-based health workers, including traditional birth attendants (TBAs), given that professional midwives and obstetricians were reaching very few women (Campbell 2001).¹⁵

According to informants, TBAs were seen as the 'default' birth assistants in rural communities. Involving them in formal healthcare delivery was therefore understood as a strategy for facilitating women's access to basic medical care and improving referral links between communities and formal, higher-level health facilities. The expectation was that improving such links would improve the likelihood of women using life-saving biomedical healthcare in the event of a pregnancy or delivery complication (Sibley and Sipe 2004). However, it is important to note that the recommendation to involve TBAs in the delivery of formal maternal healthcare was premised on the assumption that TBAs would be supported by formally accredited biomedical healthcare providers at higher levels of care (Herz and Measham 1987). It was never assumed, as has often been

¹⁵ Use of community-based and indigenous providers was a point of convergence between comprehensive and selective interpretations of primary healthcare. The Child Survival Revolution, for instance, relied heavily on community-based health workers to implement GOBI. However, a major difference was that while selective programmes like GOBI focused almost exclusively on such providers to implement 'vertical' programmes, within the comprehensive primary healthcare model the intention was that community-based workers should be integrated within a horizontal health system and supported by more highly qualified staff.

claimed with hindsight, that training TBAs alone would reduce maternal mortality.

Another important rationale behind the recommendation to involve TBAs was the assumption that they could contribute to the goal of inter-sectoral development, while also being respectful of local childbirth cultures. TBAs' close community ties and frequent contact with women were thought to put them in a good position to teach better health practices to communities and to help change attitudes towards women, thereby helping to improve women's status (see Starrs 1987). As the Safe Motherhood call to action stated, "improving the skills of community health workers and TBAs, providing them with equipment, and enlisting their assistance and support in disseminating information to the community are critical steps to improving healthcare for pregnant women at the community level" (Starrs 1987:30).

While community-based workers were defined as the backbone of the primary level of the health system, policy documents were also explicit the need for "adequately staffed and equipped health facilities" at the first-referral level, to complement community-based care (Herz and Measham 1987:33). In terms of human resources to staff higher levels of the health system, the priority was on training and deploying formally accredited and biomedically-trained staff competent to deliver relatively sophisticated medical care, including surgery such as caesarean sections. Given that most low-income countries were known to be beset with shortages of both general and specialist physicians, the recommendation was that 'mid-level providers' (specially trained nurses and midwives) rather than doctors should provide such life-saving care (*ibid.*).

Certain medical professional organisations initially resisted the proposal to train mid-level providers. According to my informants, such resistance stemmed from physicians' reluctance to devolve their specialist medical tasks to lesser-accredited staff, for fear that doing so would undermine their own medical authority and threaten their professional turf and status (see also Newell 1988). In the end, however, pragmatism appears to have prevailed to create support for the proposal on mid-level providers. As Dr. Beverly Winikoff – a physician representing the NGO Population Council – starkly put it to the Nairobi Conference participants, "given the lack of resources and personnel, it isn't a

question of nurse C-section versus a doctor C-section. It's a question of a nurse C-section or no C-section at all, and probably death" (cited in Starrs 1987:34).

With its emphasis on combined social and medical, preventive and therapeutic care and its call for pragmatic responses to women's constrained access to care, the Safe Motherhood Initiative thus in effect called for comprehensive primary healthcare as the best model for achieving the Initiative's goals. This was quite explicitly stated in a commentary Mahler (1987b:668) published in the *Lancet*, which summarised the core elements of the strategy described above:

The commitment by all the governments of the world to the Health for All Strategy gives a ray of hope. The only solution [to maternal mortality] must involve a certain basic equity not merely from an ethical point of view, but because these deaths strike disproportionately on the poor in remote rural areas. We can succeed in making a major impact only by ensuring for all women access to the essential elements of preventive and promotive maternal health and family planning care – and, particularly, essential obstetric care in life-threatening emergencies of pregnancy and childbirth. To take this combination of preventive and therapeutic care to the most peripheral level possible, the only approach which can succeed is that of primary healthcare. A well-planned combination of the community's and the families' own efforts with the inputs of governments and agencies offers the best hope of success. Local healthcare, however, cannot exist in a vacuum. It needs technical and management support.

Although Mahler insisted that primary healthcare is the only approach that could succeed, this should not be mistaken as his endorsement of blueprint solutions to health problems. Instead of offering universal prescriptions, the original set of policy recommendations offered a set of guiding principles for the organisation of healthcare delivery, emphasising the fundamental importance of simultaneous action in social and health sectors to address maternal mortality as a social justice, development and rights issue. While stressing the importance of adapting the comprehensive set of recommendations to each country context, the bottom line in the policy documents reviewed above was that *any* safe motherhood strategy seeking to bring about major reductions in maternal mortality would have to tackle the pregnancy and birth complications and emergencies that are the direct cause of the majority of maternal deaths (Herz and Measham 1987). Doing so, in turn, would require not the kind of 'magic

bullet' approach espoused by the Child Survival Revolution, but would depend on building up functional health systems. As stated in the policy proposals, "the system will be no stronger than its weakest element. No maternal health programme can work effectively through action at one level only" (Herz & Measham 1987, cited in Starrs, 1987:40).

3.3. Conclusion

The Safe Motherhood Initiative was launched at a decisive moment in the history of international health collaboration, and was indeed in many ways a product of this moment. Its emergence as an inter-agency coalition incorporating UN agencies, including the World Bank, and several NGOs is emblematic of the rapidly changing nature of global health governance at the time. Launched to temper the dominance of UNICEF's Child Survival Revolution and its perceived sidelining of women's specific healthcare needs, the formation of the Safe Motherhood Initiative provides an early example of the impact of growing competition for attention and resources in the global health arena. In later years, similar processes would contribute to a proliferation of disease-specific (selective) global health initiatives.

In this chapter I have shown that the set of international policy recommendations for achieving 'safe motherhood' that was formulated in 1987 can best be understood in relation to an enduring ideological struggle between competing visions of health. This was expressed in broader policy debates about the best overall strategy – comprehensive or disease-specific – for improving health in low-income countries. Although the debate about comprehensive and selective approaches is today often reduced to a technical debate about the relative effectiveness and efficiency of alternative strategies for achieving health outcomes, I have sought to draw attention to the ideological and political origins of these debates. Highlighting these broader origins is important because misunderstanding and misrepresentations about the early competing policy visions prevail, muddling efforts to assess their value. For instance, current discussions rarely distinguish between comprehensive and selective interpretations of primary healthcare. With reference to safe motherhood policy, this has sometimes led commentators to describe primary healthcare in terms of a set of preventive, community-based interventions – TBA-training and antenatal

screening – rather than in terms of the combined social, economic, preventive and therapeutic approach described. On the basis of such incomplete depictions, contemporary commentators often denounce primary healthcare as an appropriate strategy for improving maternal health. Such misrepresentations, though often unintended, feed into rejection of primary healthcare as an appropriate response to the challenges of securing safe motherhood on erroneous grounds. This, however, is a major simplification and misrepresentation of the original primary healthcare vision for safe motherhood, which was in fact inherently comprehensive rather than selective.

In the common narrative that circulates of early safe motherhood policy, it is often implied that in its early days the field was driven by, in the words of one of my informants, “people on a mission,” who recommended misguided strategies driven by idealism rather than technical understanding. However, while early safe motherhood advocates were certainly idealistic – in that they hoped to improve women’s social status and health – such idealism co-existed with sophisticated appreciation of the need also for specialised curative and emergency care to tackle obstetric complications that, without treatment, lead to women’s death. More significantly, these advocates should be credited with delineating the specific medical requirements for averting maternal deaths, as well as for insisting that ensuring access to these interventions would depend on functioning health systems. Indeed, this is a message that the Safe Motherhood Initiative is still struggling to garner support for today.

The Safe Motherhood Initiative clearly went against the orthodoxy that was becoming established in global health, which favours disease-specific, low-tech solutions delivered through vertical programmes, calling instead for revival of political commitment to the Alma-Ata Declaration and comprehensive primary healthcare. As I explore in the next chapter, this was a call that came up against significant obstacles. While ‘safe motherhood’ was taken up as an international health issue after the first Safe Motherhood Conference in 1987, its comprehensive vision was gradually reduced to a set of vertical programmes of the kind that the Safe Motherhood Initiative had originally denounced.

4. IMPLEMENTING SAFE MOTHERHOOD POLICY: THE PATH OF LEAST RESISTANCE

A decade into the Safe Motherhood Initiative the verdict on its performance was dismal at best. One analysis of available health statistics concluded that whereas there may be certain “grounds for optimism” regarding trends in maternal mortality in parts of North Africa, Latin America, Asia and the Middle East, the situation in sub-Saharan Africa “remains disquieting” (AbouZahr and Wardlaw 2001:561). Although there was clearly much greater international awareness of maternal mortality in low-income countries, one commentary queried whether the Safe Motherhood Initiative was an “orphan initiative,” struggling to achieve support and funding (Weil and Fernandez 1999). In summarising the history of the movement to the International Federation of Gynaecology and Obstetrics in 1997, Rosenfield (1997:8), by now a leader in the field, lamented that “little has changed in terms of specific national initiatives in this area.” Certainly it was the case that by the end of the first decade, there was a perception that the Initiative had fallen well short of expectations, and even that it had “stalled” (Maine and Rosenfield 1999). Indeed, as I show in this chapter, in terms of implementation, safe motherhood came to be equated primarily with vertical, community-based programmes for training traditional birth attendants (TBAs), far from the original comprehensive agenda outlined in Chapter 3.

Such lack of progress may seem surprising given the initial widespread international commitment to the Initiative’s goals, and the fact that these goals were later endorsed at a series of regional and national meetings sponsored by the World Bank, UN agencies and others during the first years after the Nairobi Conference, including by the representatives of over 90 countries (Rosenfield 1997; AbouZahr 2003). Moreover, the UN-sponsored Conference on Population and Development (ICPD) in Cairo, Egypt in 1994 declared safe motherhood a core component of reproductive health and rights and reaffirmed global goals for maternal mortality reductions (DeJong 2000). By 1997, ten years after the Nairobi Conference, Rosenfield (1997:8) was thus able to note that “virtually all

discussions of women's health now contain at least a general reference to maternal deaths and most governments of developing countries have pledged to fight this long-neglected problem." Given such attention, one is therefore forced to ask: Why so little action?

I aim to answer this question by analysing what I term the 'implementation gap,' or the discrepancy that emerged between stated commitment and action on safe motherhood. In doing so, I seek to address the question of how it was that the same international agencies that formulated and promoted the comprehensive policy agenda discussed in the previous chapter came to support a dramatically scaled back set of programmes. How and why did international action on safe motherhood come to resemble the selective, vertical programmes that the Safe Motherhood Initiative had vehemently rejected as an inadequate response to maternal mortality and ill health in poor countries?

In answering this question, I do not provide in-depth analysis of policy implementation at the country level, but focus instead on delineating some of the more important trends in the work of international organisations in countries depending heavily on external financial and technical assistance to the health sector, notably in sub-Saharan Africa. In the first section of this chapter I briefly describe the safe motherhood programmes that I argue came to represent a scaled back version of the Safe Motherhood Initiative's original policy vision. This is followed by an analysis of safe motherhood practitioners' own explanations of this 'implementation gap.' The practitioners commonly posit that the Initiative's lack of 'strategic focus' and confusion over its priorities translated into limited support for its full agenda. In the third section, I juxtapose this set of explanations with a broader perspective on the political-economic and policy context into which the Initiative was launched. Taking this broader context into account, I argue, helps to better understand why, despite its good intentions, the Safe Motherhood Initiative struggled so hard to realise itself.

4.1. Comprehensive vision and selective programmes

In the decade from 1987 to 1997 the Safe Motherhood Initiative's recommendation that the international community should support the expansion of comprehensive systems of maternity care in low-income countries, backed up by social and economic policies to ensure access to healthcare, did not correlate

with actual practice (AbouZahr 2001; Campbell 2001; AbouZahr 2003; Starrs 2006). This was especially the case in the donor-dependent countries of sub-Saharan Africa, where health systems were the weakest and maternal mortality the highest. Although a number of countries developed extensive plans for safe motherhood, in large part on the basis of international recommendations, few of these plans were actually funded (Starrs 2006).

Donors and international agencies may have committed in principle to policy change to achieve the Initiative's goals, but there was a striking gap between their stated commitments and their actual practices in low-income countries. According to informants who were active in the field during this period, there was, for instance, limited international support for building up referral health systems or for the training, recruitment or retention of accredited healthcare providers, including the recommended enhancement of mid-level providers' clinical skills in emergency obstetric care. Nor was there any systematic effort to take forward inter-sectoral collaboration to address women's status, education and physical and financial access to healthcare. In fact, international action on safe motherhood was largely restricted to a limited set of activities that came to resemble the kind of selective programmes that the Initiative had denounced as an inadequate solution to the challenge of improving pregnancy-related survival. More specifically, during the Initiative's first decade the international community principally supported 'vertical' safe motherhood programmes focused on low-tech, largely preventive actions at the community-level, most notably antenatal screening for high-risk pregnancies and training programmes for traditional birth attendants (TBAs) in biomedical approaches to delivery care (Dujardin et al. 1995; Campbell 2001). Such programmes rapidly became ubiquitous: by 1994 85% of developing countries had some form of TBA-training, up from only a handful of countries in the early 1970s (Fleming 1994). It was thus TBA-training programmes, supported by international agencies, bilateral donors, the World Bank, many NGOs and some low-income country governments, that most clearly came to be associated with 'doing safe motherhood.'

However, it is important to note that these programmes bore little similarity with the recommended role of TBA-training in the original safe motherhood strategy. As discussed in the previous chapter, the IAG had

recommended that TBAs be involved in safe motherhood, but only as one component among many within comprehensive policy change. TBAs, the IAG had argued, could help ensure culturally appropriate care, build links between communities and formal health services and overcome health worker shortages while countries built up professionalised delivery care (Herz and Measham 1987). TBAs were to be integrated into existing health systems, so that they could be supported by more highly trained workers based in formal health facilities, including at the referral level. In practice, however, within donor-supported safe motherhood programmes in low-income countries, TBAs generally worked without coordinated support from professional healthcare workers, their activities developing separately from any overarching health plan (Bergström and Goodburn 2001; Campbell 2001). For this and other reasons, safe motherhood specialists most often describe these early safe motherhood programmes as 'piecemeal'. According to Sibley and Sipe (2004), who have conducted perhaps the most thorough review of TBA-programmes, one indication of their piecemeal nature is that while international agencies often supported TBAs' training through various public sector initiatives, a range of other actors, including individuals, NGOs and missions, trained them through the private sector, with different training programmes and with focus on different competencies.

Another indication of the training programmes' piecemeal nature was their varied content. Sibley and Sipe (2004; 2006) report that most programmes sought to upgrade clinical skills to ensure safe deliveries and many also included training in expanded functions of prevention, screening of high-risk pregnancies (the antenatal screening programmes mentioned above) and referral. Very few programmes, however, included content on how TBAs should respond to obstetric complications, not even on detection and management of sepsis to reduce infection-related mortality and morbidity, a function that could arguably have been carried out at the community level (Sibley and Sipe 2004). Moreover, only some programmes included clinical practice at a health facility, follow-up supervision, and continuing education (*ibid.*). Informants who were active in the field in the Initiative's early years recalled that within the donor-driven or NGO-operated programmes, the content and quality of training was also inconsistent and the techniques and training materials used were often inappropriate.

Later evaluations of TBA programmes have delineated some further problems. Anthropologists, for instance, have argued that efforts to involve TBAs in safe motherhood failed to foster the intended links between communities and indigenous medical and birthing traditions on the one hand, and the formal biomedical health sector on the other (Jenkins 2001; Jenkins 2003; Berry 2006). Others have also shown that indigenous healers' knowledge and skills were often devalued within the training programmes in favour of uncritical expansion of a medicalised model of childbirth (Jordan 1983; Davis-Floyd and Sargent 1996). Drawing on ethnographic research in Nepal, Pigg (1997:238) claims that international agencies' and health planners' interest in local healers, including TBAs, had little to do with these practitioners' expertise or practice *per se*, but rather lay "in the potential that exists to channel their practice towards health development aims." Such alleged lack of interest in local healers' knowledge systems is, according to some anthropologists, revealed by the way in which international actors used the term 'TBA' to designate a whole range of people who attend deliveries, without sensitivity to the varied expertise of different healthcare providers and to local understandings of what kind of knowledge counts as authoritative (Davis-Floyd and Sargent 1996). Perhaps not surprisingly, such training programmes for TBAs have been found to have had little, if any, impact on maternal health outcomes (Bergström and Goodburn 2001; Ray and Salihu 2004; Sibley and Sipe 2004).

The situation described above pertains primarily to donor-dependent countries and it is important to note that there were, of course, heterogeneities between and even within countries. Furthermore, a number of countries, principally those that were less dependent on external financial and technical assistance, including Malaysia and Sri Lanka, implemented much more comprehensive policies than the TBA-training programmes described above. These countries were able to incrementally strengthen health systems, train and deploy staff, improve access to services at all levels of the system and quality of care – policy successes that were rewarded with improved health statistics (Koblinsky and Campbell 2003; Pathmanathan et al. 2003). Even so, the summary above serves to highlight the magnitude of the gap that developed between the stated ambitions and commitments of the international public health community and the programmes implemented by international actors operating

in countries with high maternal mortality. TBA-training, which the IAG had recommended as one component of an overarching strategy, in effect became a single intervention programme for safe motherhood. This gap occurred despite international organisations' endorsement of the view that pursuing single interventions without addressing underlying systemic issues would not achieve sustained improvements in maternal health (Mahler 1987*b*). The question remains, therefore: why did such an 'implementation gap' occur?

4.2. Explaining implementation gaps

Ethnographic and historical data point to multiple possible interpretations of the reasons for the implementation gap described above. Within the safe motherhood initiative, many have attributed the limited uptake of the initiative's comprehensive policy vision to confusion and lack of understanding within the wider public health community about the requirements for improving maternal health. The subsections below explore different aspects of this general explanation that were put forth in written accounts, as well as in informants' narratives.

4.2.1. Confusion and a lack of strategic focus

Reflecting in 1997 on the limited implementation of the safe motherhood agenda, Allan Rosenfield (1997:8) argued that an important reason for the Initiative's apparent problems was "the widespread confusion regarding the nature and focus of the Initiative." In doing so, he identified a perception that pervaded many of my informants' accounts of their field, namely that the wide scope of the term 'safe motherhood' had created confusion about the priority actions for achieving safe motherhood. Within the WHIO, for instance, the term encompassed a range of actions related to women's health, including family planning, antenatal care, clean/safe delivery, essential obstetric care, basic maternity care, primary healthcare, and equity for women (Maine and Rosenfield 1999). Although safe motherhood advocates felt that all of these issues were important, there was a clear sense that the broad scope of the agenda had in effect back-fired. As Maine and Rosenfield (1999:481) observed at the time: "some policy-makers and programme managers believe that they are already conducting Safe Motherhood programmes because, as they understand it, the activities comprise their usual activities – antenatal care, family planning,

nutrition.” Others, they said, had been discouraged, because they perceived safe motherhood programmes to require “dauntingly vast efforts” (*ibid.*). Rosenfield and Maine claimed that where the Child Survival Initiative had succeeded by promoting a small and discrete set of interventions, the Safe Motherhood Initiative had failed because it had managed neither to specify nor to promote a clear ‘strategic focus.’

By the end of the first decade of the Safe Motherhood Initiative, many within the field had come to question whether the original framing of safe motherhood as part of a broader development and social justice agenda had, in fact, been a mistake. A particular worry was that including women’s status within the Initiative’s remit had diverted focus from the IAG’s specific recommendations for the health sector, and especially the emphasis on general strengthening of the health system’s capacity to delivery maternal healthcare. As one informant recalled,

When this started in 1985, 1987, a lot of really great people thought, ‘at last – a woman’s initiative.’ And they loaded everything that you would want a woman’s initiative to be, onto this. A lot of it didn’t fit...I mean, there’s certain ways and certain contexts in which maternal mortality is an indicator of women’s status and there are other ways in which it’s not. Saudi Arabia has very low maternal mortality [but] women aren’t allowed to drive a car. You know, it doesn’t always work that way. But people want it to be...about nutrition, about women’s status in society, about all those things – and it is, but only secondarily. It’s like the elephant in the living room is the *medical system*.

This informant’s concern that attention to health system development had been sidelined by the simultaneous effort to advance women’s status was common among safe motherhood advocates I interviewed.

Informants also explained that confusion about what safe motherhood actually entailed in programmatic terms resulted not just from the broad range of actions encompassed under the term ‘safe motherhood,’ but also from the fact that not all the IAG members backed the full agenda. As one early safe motherhood advocate put it at a conference I attended in 2007, “the Safe Motherhood Initiative had many adoptive parents among the international agencies. We were very happy about that at the beginning, but these agencies had different approaches, had different dogmas and had different political sensitivities.” Several informants made similar comments, singling out UNICEF

as being particularly difficult to accommodate within the IAG because, as one informant put it, “reproductive health wasn’t its thing, and so every time we got into discussions that involved adolescence or abortion it was really hard and we spent an enormous amount of time negotiating language that everybody could agree.” Informants explained that these tensions had been difficult to contain within the IAG and had been damaging to the Initiative’s ability to promote a coherent vision. Moreover, one informant claimed that UNICEF had co-opted TBA-training programmes to further the goals of the Child Survival Initiative, rather than those of the Safe Motherhood Initiative.

4.2.2. Conflating safe motherhood and reproductive health

Findings from in-depth interviews suggest that the rise of the ‘reproductive health’ movement in the 1990s exacerbated the perceived problems noted above relating to the broad scope of the original safe motherhood agenda. The reproductive health movement sought to shift policy debates away from the existing focus on selective programmes of family planning and safe pregnancy dominated by activity-specific programmes that were heavily supported by donors such as UNFPA, USAID and UNICEF and NGOs (Mayhew 1996; Mayhew et al. 2005). Instead, at the International Conference on Population and Development (ICPD) in Cairo, Egypt in 1994, women’s health activists called for governments to realise the right to reproductive and sexual health.¹⁶

Reproductive health was a concept that had broader scope, both conceptually and programmatically, than safe motherhood, and safe motherhood practitioners came to worry that this new term created further confusion about the distinct meaning of ‘safe motherhood.’

The ICDP resulted in stated international commitment to implement “comprehensive, integrated reproductive health” (Cohen and Richards 1994; Faundes 1996). The Cairo Programme of Action included maternal healthcare as just one among a range of services aimed at improving reproductive health in a

¹⁶ Whereas the Safe Motherhood Initiative had focused on demands to address women’s pregnancy-related health and survival, the reproductive health movement focused more explicitly on enabling women to make autonomous decisions about their bodies and reproductive rights, and made expansion of access to contraception and abortion one of its principal programmatic objectives (Germain 2004). The concept of reproductive health emerged from feminist concerns about the coercive nature and narrow demographic targets of population and family planning programmes (Cohen and Richards 1994; Petchesky 1995; Hempel 1996; DeJong 2000).

broad sense, including family planning, sexual health and access to abortion. According to informants who were active within the field at the time, many safe motherhood specialists worried that this broad agenda was further detracting policy attention from health system development and safe delivery care for maternal mortality reduction. Such concern stemmed from the fact that although the Cairo agenda did include recommendations on safe delivery care, it was more explicit in its demand for expanded access to family planning services and abortion than it was in securing adequate healthcare for pregnant women (Lush and Campbell 2001). One informant even claimed that reproductive health advocates lacked interest in the details of obstetric care because of their reluctance to focus on ‘motherhood,’ given that their primary objective was to promote women’s rights *irrespective* of their role as mothers.

Moreover, many safe motherhood practitioners I spoke with perceived that the conflation of reproductive health and safe motherhood had been damaging to the Safe Motherhood Initiative by implicating it – through its association with the broader reproductive health movement – in the vociferous debate over abortion rights that erupted in the lead-up to and during the ICPD. The controversy over abortion rights was fought out between reproductive health activists on the one hand and the Vatican and leaders of many Catholic countries and certain conservative governments on the other hand (Finkle and McIntosh 1996). Informants explained that the way in which the Safe Motherhood Initiative became associated with the abortion debate was unwelcome, especially given the IAG’s earlier efforts to avoid direct confrontation on the abortion issue (see Chapter 3). Indeed, by one account, after the ICPD, safe motherhood came to be seen as “the Trojan horse for the introduction of legal abortion” with the consequence that some donors and governments who had initially been supportive of safe motherhood became wary and withdrew their support (AbouZahr 2003:18).

4.2.3. Nostalgia and romanticism

In addition to confusion about programmatic requirements resulting from inappropriate framing and conflation with reproductive health, another set of explanations that informants put forth for the limited uptake of the comprehensive agenda centred on direct resistance within the broader international health field to the Initiative’s emphasis on health system

development, and especially facility-based obstetric care. According to informants, such resistance was itself a reflection of the widespread enthusiasm for community-based health solutions that, throughout the 1980s and 1990s, became increasingly pervasive within the broader international health field. Enthusiasm for community-based solutions, in turn, resulted in part from the apparent success of UNICEF's community-based GOBI strategy. According to a senior WHO official, GOBI's apparent success in saving children's lives led many of those working on the ground to think that "you could do everything with a community health worker and that you really didn't need access to sophisticated medical care." This, in turn, he claimed, translated into an unrealistic belief among some public health practitioners that TBAs alone had the capacity to reduce maternal mortality and to a concomitant "over-discounting" of what was needed for maternity care. Such over-discounting translated into poor recognition of the need for ancillary services related to good supplies, a professional health workforce and clean and functioning facilities.

According to informants, it was not only proponents of selective primary healthcare but also some of those who were ideologically committed to the 'health for all' agenda that contributed to such "over-discounting." According to one informant, many within the broader public health field, especially those working on the ground, uncritically equated community-based care with culturally relevant, accessible and appropriate healthcare and consequently rejected the need for facility-based services, reinforcing support for community-based TBA-programmes and resistance to calls for strengthening of hospitals. As she recalled: "When I first went to Bangladesh in 1992 and said antenatal care won't reduce maternal mortality, training TBAs won't reduce maternal mortality, it was as if though I had said there's no God...People were *furious*."

Informants also drew attention to the way in which the expansion of the home birth movement in certain Western countries encouraged an attitude among some women's health activists that birthing in 'traditional' cultures must be protected from the sort of excessive medicalisation that had come to characterise birthing in the West, particularly in the US. According to one interviewee, such activists promoted home birth in low-income countries without adequate appreciation for the challenges that TBAs would face in responding to obstetric emergencies in the absence of a functioning health

system. She referred to a misplaced “nostalgia” among women in rich countries and even upper class women in poor countries for traditional birthing and a “a past that never existed,” adding, “to me, [the past is] a 24-year old woman dying in agony after three or four days in labour. You know, that’s not something I get nostalgic about.” Conceding that ensuring culturally appropriate and accessible birthing care is important, my informant nevertheless insisted that it should not take precedence over attention to ensuring women’s access to a health facility with the right supplies and technical competencies in the event of an emergency. As she put it, “if I’m dying, I would like a doctor please.” For this and other informants, such romantic attitudes reinforced the effect of inadequately articulated messages to feed into the neglect of core components of the original safe motherhood agenda, particularly its emphasis on health system strengthening and strengthening of facility-based care to save women’s lives from pregnancy complications.

4.3. An unfavourable context for a comprehensive vision

While the factors discussed above may help to explain why community-based programmes for training TBAs received considerable support on the ground, I want to argue, however, that they offer an *inadequate* explanation as to why the international organisations that were members of the IAG came to support such programmes to the neglect of the more comprehensive agenda they had previously espoused. The IAG was not unaware of what was needed. Indeed, an IAG statement on traditional birth attendants published in 1992 was explicit that although UN agencies were supporting TBA-training programmes, substantial improvement in healthcare would not occur “without implementation of appropriate technologies and strengthening of referral and support systems” (WHO 1992). In the statement, the IAG was firm that trained TBAs cannot be expected to reduce overall mortality and morbidity rates “when poverty, illiteracy, and discrimination – the underlying causes of these problems – are not addressed” (*ibid.*). The agency statement further explained that, given inadequate funding and support for comprehensive approaches in the broader international health and development field, TBA-training would be pursued as an “interim” measure until comprehensive primary healthcare could be implemented (*ibid.*). I now turn to look at the broader set of political-economic and policy factors that

helps to explain why the IAG member organisations may have come to find it difficult to commit to more than such interim responses.

4.3.1. Weakened international governance

When trying to understand the behaviour of international actors, organisations and donors it is useful, first of all, to place their responses within a broader context. Specifically, it is important to take into account that in the early years of the Safe Motherhood Initiative, the WHO, perhaps the strongest advocate of a comprehensive primary healthcare approach to safe motherhood, was itself beset by financial difficulties and weakened authority, compromising its ability to support and coordinate comprehensive policy responses in countries (Vaughan et al. 1995). Its dwindling regular budget, discussed in Chapter 3, was offset by a growing reliance on “extrabudgetary” funding from multilateral agencies, including the World Bank, donor nations and private donors (*ibid.*). In theory, the World Health Assembly, the WHO’s representative governing body, continued to set the international health agenda, but in reality it was the donors – more or less independently of the WHO’s decision-making structures – who were now in control of priority-setting (Lee and Walt 1992; Walt 1993; Lee et al. 1996; Walt 2005).

Health policy analysts have noted that during the early 1990s, lack of coordination and poor predictability of financing became major issues, creating pressure on the WHO to appeal to external donors by focusing on short-term, technical and vertical programmes with clearly defined, dedicated budgets, rather than broadly defined health programmes (Rifkin et al. 1988; Godlee 1994). The TBA-training programmes that international agencies supported can be seen as one of these cheaper, vertical responses.

4.3.2. Economic and health sector crisis in low-income countries

In trying to understand why the comprehensive safe motherhood agenda was not fully implemented it is also important to acknowledge that the Safe Motherhood Initiative was launched during a time marked by economic crisis and health system decline in low-income countries. These circumstances, I would argue, severely curtailed the prospects for implementation of the kind of comprehensive policy vision outlined at the Nairobi Safe Motherhood Conference in 1987. Economic crisis in the 1980s had left many low-income

country governments effectively bankrupt and critically dependent on external assistance, including to fund health and social services. Authors describe how already weak health facilities fell into further disrepair during this period, with repercussions for service quality and staffing, and flight of patients and staff to largely unregulated private sector healthcare services (Turshen 1999; Standing 2002). More generally, donor-driven projects, private providers and non-governmental organisations came to challenge the state's position as the main provider of healthcare (Turshen 1999).

Others have noted a mismatch between government and donor responses in poor countries during this period, which especially affected the sort of services needed to save women's lives. For instance, at the same time that many donors focused their resources on community-based programmes such as TBA-training schemes, domestic budgets in many low-income countries remained skewed towards tertiary care facilities in cities, as they had been since colonial times (Gillam 2008). Hospitals retained their disproportionate share of government health expenditure, and domestic professional medical resistance to the expansion of community health workers with less training widened the gulf between donor-driven community-based projects and national health plans (*ibid.*). There was no organised effort to reorient medical education towards primary healthcare in many countries (Cueto 2004). A major consequence of the gap between donors' emphasis on community-based care and governments' continued bias in favour of hospitals was that the levels in between the primary and tertiary level were neglected. Specifically, the first-referral level, which in 1987 had been identified as essential for delivering life-saving obstetric care, was 'squeezed out' of health budgets and neglected in both national and international health plans (Task Force on Child Health and Maternal Health 2005; Johnson 2006).

4.3.3. Structural adjustment and health sector reforms

A related set of factors was the impact of 'structural adjustment programmes,' or SAPs, implemented during the first decade of the Safe Motherhood Initiative, reinforced by internationally-recommended health sector reforms carried out in many low-income countries between the 1980s and the mid-1990s (Breman and Shelton 2006). Together, these policy reforms contributed to a climate hostile to

the implementation of the comprehensive set of policy changes the IAG had called for in 1987.

By the 1990s, the World Bank – along with the International Monetary Fund (IMF) and supported by the US government – started to look for alternative financing mechanisms to overstretched public sector budgets, emphasising markets as the basis of public sector reform (McPake 2008). The resulting structural adjustment programmes were imposed on many countries as a condition for debt restructuring and access to external financial and technical assistance. These advocated a diminished role for governments and greater role for free markets. This implied a range of fiscal and policy measures, such as drastic cuts in consumption and public spending to reduce inflation and public debt – including cuts in health sector spending – a greater involvement for private industry in all sectors, decentralisation and a lower profile for central governments (McPake 1993; Navarro 1998; Segall 2003; Di et al. 2007).

Alongside structural adjustment programmes, the World Bank (along with the WHO and some bilateral donors) promoted health sector reforms in low-income countries during the 1980s to mid-1990s (Standing 2002). Critics have seen such reforms as an extension of the privatisation agenda of the structural adjustment programmes mentioned above (Sahn and Bernier 1995; Turshen 1999; Standing 2002). More generally, health sector reforms were a policy response to the weakened public healthcare delivery systems of poor countries, which many had come to see as wasteful, inefficient and ineffective (Cassels and Janovsky 1998; Brown et al. 2006; Cooper et al. 2007; Irwin and Scali 2007). Health sector reforms aimed to address structural problems in the health systems of poor countries, including inefficiencies, poor management, and inadequate access to services, as well as the poor quality of existing services. Specifically, they aimed to improve the performance of Ministries of Health in low-income countries through more efficient financial management and human resource management (Cassels 1995, cited in Standing 2002). Donor-driven reforms mirrored the neoliberal basis of structural adjustment policies. The World Bank's first health strategy paper 'An agenda for reform' promoted fee payment for health services, privatisation of large parts of health services and introduction of private insurance programmes, as well as decentralisation of the management of health care (World Bank 1987).

One effect of such reforms was to reinforce selective approaches to healthcare. The World Bank's (1993) highly influential World Development Report 'Investing in health' (World Bank 1993) encouraged governments that could not afford comprehensive public health services to provide only a minimum package of low-cost, selective or "basic" public health services, supplemented by a package of "essential clinical services," leaving "non-essential services" to the private sector. Preference for such a selective approach to healthcare planning was in many ways institutionalised through the World Bank's new priority-setting framework. The World Bank recommended that low-cost interventions to be included in a basic package of publicly provided healthcare should be selected through 'burden of disease' and cost-effectiveness analysis that would ascertain the best value for money (World Bank 1993).

The World Bank proposed that burden of disease and cost-effectiveness analyses should incorporate the DALY – or the disability adjusted life year – a new summary measure of population health that combined the effect of single diseases not only on premature death, but also on morbidity and disability (Murray and Chen 1994; Fox-Rushby 2002). The DALY methodology was used to establish a ranking of diseases according to their impact on the total 'global burden of disease' (Murray and Chen 1994). As such, the new priority-setting framework reaffirmed core principles of selective primary healthcare. Critics exposed the way in which the measures internalised a bias against women's health conditions, including pregnancy-related health problems, in part because the disease rankings used were not disaggregated for gender (Sundby 1999; Allotey and Reidpath 2002; Hanson 2002). Nevertheless the 'burden of disease' framework quickly became influential at the international level and was put to use for determining priorities in a number of countries.

The growing dominance of such priority-setting tools was on several levels unfavourable to the promotion of women's health issues or to the comprehensive approach consisting of the inter-linked interventions that the Safe Motherhood Initiative had promoted in 1987. According to one informant who was active within the WHO in the early 1990s, the focus on cost-effectiveness and efficiency in health sector reforms and its associated analytical tools fed into the more general resistance among some within the international health community to the expansion of facility-based maternity services noted

above. He claimed that many public health practitioners believed that such services lacked cost-effectiveness and could not impact the global burden of disease in a significant way, since the number of maternal deaths is relatively small relative to other major public health problems in low-income countries. However, this was not a conclusion that was supported by actual analyses; the World Bank's own analyses identified maternity services, including pre-natal, delivery and post-natal care in health facilities as among the most cost-effective interventions in low-income countries in its recommended package of "essential clinical services" (World Bank 1993). Nevertheless, according to one of my informants, the general attention that was paid in policy debates to reduced public spending and concentration of "essential" public health services engendered a widespread "anti-high-tech predilection" among many health policy-makers and planners in which investments were "implicitly deemed – to be a luxury and too expensive." As another of my informants put it: "The idea that you would address this big public health issue by strengthening health systems would have been so anathema, so contrary to the prevailing economic and political trends in the international community's dealing with the social sectors in poor countries." The perception that facility-based maternity care was an unaffordable luxury made sense within this context. As the WHO informant cited above put it: "It's hard to recommend highly skilled, relatively highly skilled people working in rural areas when you are spending, you know, \$2 per capita on health." Therefore, implementation of both the social agenda and the call for comprehensive healthcare embodied in the Safe Motherhood Call to Action became increasingly untenable within the broader context of international health.

4.3.4. The path of least resistance

The effects of the reforms discussed above likely contributed to the difficulty of implementing comprehensive agendas, such as that of the Safe Motherhood Initiative. It is difficult to evaluate the impact of broad-based policy reform on health outcomes and health systems, in part because of the complexity of the reforms and in part because of the time-bound nature of the effects. Some of the unintended consequences of various forms of structural adjustment have only recently been documented, the effects, such as the migration of health workers and the now well-established human resource crisis in health, taking time to materialise (Breman and Shelton 2006). Nevertheless, although the 'selective'

health sector reforms promoted by the World Bank and others were intended to improve management of health systems, later evaluations suggest that these reforms failed to correct inefficiencies and, in some cases, inadvertently contributed to further weakening of health systems (Sparr 1994; Simms et al. 2001; Breman and Shelton 2006; Haddad et al. 2008; Mohindra 2008).

There is a prevailing consensus that donor-imposed health sector reforms were matched by further privatisation of health services, expansion of deregulated markets for healthcare and pharmaceuticals and crumbling public structures, as well as a burgeoning human resource crisis (Wakhweya 1995; Bloom and Standing 2001; Magnussen et al. 2004). This meant that it became progressively more difficult to mobilise a professional workforce to support community-based services (*ibid.*). The way in which privatisation and fragmented health systems, as well as user fees imposed on services to make up for spending shortfalls, restricted people's ability to access healthcare has also been documented, including the effects of user fees on restricting women's ability to access life-saving obstetric care (Borghini et al. 2003; Janes and Chuluundorj 2004; Storeng et al. 2008). Freedman's (2003:104) description of health systems in low-income countries at the end of the 20th century captures some of these circumstances:

In vast parts of the world, health centres stand empty and deteriorating. In others, they are overwhelmed and unable to cope. User fees and exemption schemes have routinely failed to protect the poor, with 'informal' or illicit payments sometimes being the only way health providers can earn a living wage, while drug shortages force patients into the streets to find life-saving supplies or to forgo needed care altogether. In many countries, the public health system is plagued by personnel posting and transfer policies that put patients' interests last, and by absenteeism as public employees (sometimes driven by necessity) engage in private practice and steer patients accordingly. At the same time, massive 'brain drain' draws trained professionals out of countries while IFI (international financial institutions) policies pressure for bans on government hiring. Those who remain are often poorly trained and supervised, leaving even the best-intentioned providers without confidence or skills. Over-worked and demoralised, they can barely cope with their workloads, much less follow protocols for improved inter-personal relationships with clients. And, all the while, patterns of social and gender discrimination that shape society as a whole often end up reflected in health systems

where shocking maltreatment of patients and their families is almost routine.

The sort of conditions evoked in this quote are not specific to maternal health services, but their impact is captured particularly well through maternal health indicators, with continuing high levels of maternal mortality being a manifestation of poorly functioning health systems. The heavy reliance on TBAs in the Initiative's first decade should be seen in conjunction with the human resource crisis in healthcare delivery that intensified during this period. As one informant put it: "it makes sense – if you don't have people [qualified healthcare providers], women die."

In sum, by the end of the 1990s, the toll of economic downturn, weakened international governance for health, and the consequences of structural adjustment policies and health sector reforms converged, making it virtually impossible to implement comprehensive programmes in impoverished countries whose already weak health systems had been further weakened and fragmented. As others have noted, the fragmented nature of health systems – perhaps not surprisingly – reinforced a preference among donors and those responsible for programmes that could go around the constraints posed by weak health systems and that could be more easily overseen and monitored (e.g. McCoy et al. 2007a).

From this perspective, and contrary to safe motherhood practitioners' expressed anxiety, there is in fact nothing unique about the lack of uptake of the comprehensive safe motherhood agenda. The scaling back of the original comprehensive vision to a limited set of activities was mirrored in neglect of more general calls to strengthen the healthcare delivery systems of poor countries. The way in which UN agencies, donors and NGOs dedicated to safe motherhood often pursued their own objectives in an uncoordinated manner instead of working within national health plans was not specific to their efforts within maternal health, but was typical of international health action at this time. It can be seen as the result of pressure to respond to the exigencies of budgets, bureaucracies and existing health system constraints by doing *something* to address public health problems, rather than the result of deliberate design or naïve expectations that such a limited set of actions would be sufficient to bring about health improvement. Within this context, there was also a clear incentive, as one informant pointed out, for both planners and programme managers to opt for

the simplest strategies, as exemplified by the popularity of TBA-training: “it’s ideal. You spend rapidly, you make people happy, you redistribute the money to the poorest, it’s quick and easy to manage.”

4.4. Conclusion

In this chapter I have identified and described what I term the ‘implementation gap’ that characterised internationally-supported safe motherhood efforts in the first decade of the Initiative. As shown above, policy recommendations for systemic change and health system strengthening were reduced to limited and largely preventive, community-based programmes, paralleling the more general scaling back of comprehensive primary healthcare in favour of selective primary healthcare in the 1980s and 1990s. Although I have not examined country examples in detail, my discussion of international trends helps to discern an emerging transformation in the very meaning of ‘safe motherhood,’ from the term’s initial association with plans for comprehensive, inter-sectoral policies that would improve women’s health and pregnancy-related survival to its association with community-based, vertical programmes, principally focusing on the training of TBAs.

Implementation gaps of the sort discussed here are not untypical in international health. Many authors have noted that mismatches frequently occur between international policy recommendations and national- and sub-national level implementation, as well as lack of correlation between international organisations’ and donors’ rhetoric and their actual practices (e.g. Mayhew and Watts 2002; Mayhew et al. 2005). The more pertinent question, of course, is how should such gaps be understood? Safe motherhood practitioners’ own accounts attribute the limited uptake of the Initiative’s original agenda to technical deficiencies in that agenda and in the Initiative’s advocacy approach, including a lack of strategic focus that allegedly bred confusion about the Initiative’s priorities. These accounts also emphasise that widespread misconceptions and erroneous beliefs about the effectiveness of community-based actions, including TBA-training, translated into support for such programmes, and, conversely, resistance to the Initiative’s emphasis on facility-based services. With hindsight, the original decision to recommend the involvement of TBAs has been rejected as erroneous, described as one of “a few strategic missteps” that the Initiative

initially took and that compromised its success (Rosenfield et al. 2007:1396). Similarly, in 2006, an editorial reflecting on the Initiative's first twenty years published in the *Lancet* commented that the prospects for safe motherhood seemed promising after the Nairobi Conference, until strategic mistakes, such as pursuing TBA-training programmes, dashed those hopes (Horton 2006). Such accounts not only over-emphasise the faith that early safe motherhood actors placed in such programmes, but also unduly places the burden for the implementation gap within the Safe Motherhood Initiative alone.

I have sought to nuance this sort of account, however, by considering the political-economic and policy context within which the implementation of the Initiative took place. I have shown that those charged with implementing the comprehensive safe motherhood agenda faced distinctly unfavourable odds for success. Through a brief overview of the broader political-economic and policy context of international health in the late 1980s and 1990s, I have illustrated how selective approaches to health improvement, as well as resistance to broad-based and systemic change, became gradually entrenched within global level priority-setting for public health, reflecting economic challenges and changing governance structures within international health as a whole. International policies for economic recovery and health sector reform contributed to fragmenting international health approaches in a way that made it increasingly difficult to advocate for and implement a comprehensive approach. On many levels, the vertical training programmes for TBAs that I described at the beginning of the chapter are thus illustrative of a more general trend.

This chapter highlights the danger, when making historical evaluations of international policy initiatives such as that for safe motherhood, of overlooking the broader policy and indeed political-economic circumstances into which specific policies are implemented. Only a small subset of my informants situated the safe motherhood field's experiences within the broader policy environment outlined above. Most informants simply left this broader context largely unexamined. Policies are not implemented in isolation, however, but within pre-existing and dynamic political contexts that can variably facilitate or constrain successful implementation. When seen within its broader context, the history of the Safe Motherhood Initiative's first decade illustrates how difficult it became to pursue public health strategies emphasising systemic social and health sector

changes. The policy context increasingly favoured selective, piecemeal approaches. While some actors were clearly opposed to the Initiative's ideological and programmatic aims or were ignorant of its priorities, on another level, the neglect of comprehensive health systems in favour of scaled-down, vertical interim solutions can be seen as more broadly indicative of international health actors seeking the "path of least resistance" within an international health field that has become excessively fragmented, weak and difficult to coordinate (McCoy 2007*b*). In the next chapter I reflect on the implications of these developments for international policy and advocacy at the end of the 1990s.

5. DEFINING THE SAFE MOTHERHOOD INITIATIVE'S STRATEGIC FOCUS

A decade into the Safe Motherhood Initiative, the scientific press was replete with analyses of a faltering initiative that had lost its momentum and that had failed to achieve global-level reduction in maternal mortality (see Rosenfield 1997; Maine and Rosenfield 1999; 2001:30-31). Reinforcing such assessments were dismal statistics suggesting that maternal mortality had not decreased on a global level since the launch of the Initiative. In 1996, for instance, UN agencies published revised estimates of country-level maternal mortality, which showed that the number of maternal deaths was in fact higher than previously assumed (WHO and UNICEF 1996). Although there was some indirect evidence of maternal mortality reduction in North Africa, Latin America, Asia and the Middle East, the situation in sub-Saharan Africa was said to remain “disquieting” (AbouZahr and Wardlaw 2001:567). Indeed, despite a few isolated instances of success in a limited number of countries the Initiative’s goal of halving maternal mortality within a decade had not been met (*ibid.*).

Within this context, the IAG in 1997 convened a Technical Consultation in Colombo, Sri Lanka as part of an effort to revitalise the initiative (AbouZahr 2003). The consultation was the first element in a comprehensive two-year effort to acquire additional funds and to expand activities aimed at reducing maternal mortality. More than 300 representatives from UN agencies, academia and NGOs gathered in Colombo to discuss an agenda structured around ten key ‘Action Points’ that had been defined by the IAG in consultation with experts in the field (see Starrs 1997 for the conference report). After three days’ deliberation, these Action Points were revised and put forth as new global ‘best practice’ guidelines for achieving maternal mortality reduction. The IAG’s proposals would bring about a major shift in international policy recommendations for how countries should go about achieving safe motherhood. Earlier calls for a multifaceted strategy linking health, social and educational sectors and combining preventive and therapeutic care now gave way

to the recommendation that safe motherhood programmes should be targeted at averting deaths from obstetric complications through professional, obstetric care, including emergency care. So major was this shift in policy advice that the Colombo meeting is often cited as a turning point in the history of the safe motherhood movement. But how did it come about? And how should it be interpreted?

In the public health literature, the new focus on professional obstetric care is often attributed to new technical knowledge that fed into revised policy guidelines and proposals (e.g. Rosenfield 1997; Weil and Fernandez 1999; Horton 2006; Starrs 2006). Indeed, some commentators have lauded it as a sign of a new era of evidence-based decision-making for the Safe Motherhood Initiative, in which new research-based knowledge finally forged a technical consensus about how best to reduce maternal mortality (Weil and Fernandez 1999). Contrary to this common depiction, my aim here is to demonstrate that the role of international actors in formulating international recommendations is in no way a straightforward process of appraising and adapting policy in light of new technical knowledge or evidence. Instead, I consider the policy shift that took place in the late 1990s as part of a broader 'top-down', marketing-driven process that was initiated by international agencies and other maternal health experts in response to the limited success of the previous decade (cf. Walt et al. 2004). The aim for these experts was to define a strategic focus for the Initiative: one that would assure a place for safe motherhood in international policy debates and encourage uptake of the Initiative's long-neglected recommendations on professional obstetric care and health system strengthening.

In the first part of the chapter I show how the IAG from 1997 onwards reformulated the international safe motherhood policy agenda to focus on a much more targeted set of recommendations than those the group had proposed at the Initiative's launch. I then critically evaluate the reasons behind this shift. Doing so entails attention to a crucial sub-story of this policy shift, namely the proposal from a subgroup of safe motherhood practitioners to define a very narrow strategic focus on 'emergency obstetric care' or EmOC. This proposal exemplifies many of the broader developments at play, not least because the efforts to introduce EmOC as the Initiative's main strategic focus represented, on the surface at least, the strongest possible challenge to the comprehensive

approach espoused in the early years of the Safe Motherhood Initiative. At the onset of this shift, the field was beset with considerable internal conflict. However, as I show in the last section, through internal negotiation and conceptual modifications, a narrow focus in policy recommendations on EmOC came to be reconceptualised not as a rejection of the Initiative's original comprehensive vision, but as a pragmatic starting point for achieving it.

5.1. A new policy agenda: targeting obstetric causes of death

The policy recommendations that the IAG first introduced in 1997 and elaborated on in the years that followed diverged significantly from the Initiative's original agenda, as summarised in Table 4 below. The table reveals that the new recommendations were much more targeted, in two main senses: first, they focused on health sector policy exclusively, rather than inter-sectoral policy change. Second, they focused on reducing maternal mortality from obstetric complications, rather than improving women's health and survival through coordinated attention to social, economic and medical determinants. Because this vision was so dramatically different from the original one, it is important to understand in some detail what it entailed.¹⁷

Perhaps most dramatically, by restricting its remit to primarily issuing recommendations for health sector policy targeted at the direct causes of maternal deaths, the Safe Motherhood Initiative clearly distanced itself from its identity as 'the women's initiative' concerned with promoting women's status and health. Saving women's lives, rather than improving women's health and survival more broadly, were redefined as the Initiative's ultimate goalpost for success. Significantly, the original emphasis on multiple and interlinked strategies to achieve the Initiative's goals gave way to an emphasis on 'priority' interventions for averting deaths. Although ten Action Points were specified, the primary message to come out of the revised agenda was that countries must target safe motherhood programmes at saving women's lives by treating obstetric

¹⁷ This section's analysis of the policy shift (including Table 4) is based principally on the conference report from the 1997 Technical Consultation in London (Starrs 1997) and a policy document on technical interventions issued by the IAG member agencies (UNICEF/WHO/UNFPA 1997). These are compared with the conference report from the first Safe Motherhood Conference in 1987 (Starrs 1987) and original strategy for reducing maternal mortality and morbidity (Herz & Measham).

complications. This was justified by the fact that such complications are the most important, direct cause of women's death during pregnancy and childbirth. This focus on essentially therapeutic solutions to prevent deaths once complications occurred meant that previous recommendations on preventive public health approaches – such as antenatal screening to detect high-risk pregnancies – were rejected in favour of the recommendation that all pregnancies should be treated as potentially at risk of developing complications. Two, inter-linked 'interventions' were identified as priorities for safe motherhood programmes: 'emergency obstetric care' to treat pregnancy and delivery complications and 'skilled birth attendants' to assist deliveries and ensure access to and provision of emergency obstetric care. It was implicit in the recommendations that the first-referral level of a district health system would be the main site for delivering emergency obstetric care.

'Emergency obstetric care' summarised a set of therapeutic responses targeted at those women who develop complications during pregnancy, childbirth or the post-partum period, including haemorrhage, obstructed labour, infection and eclampsia and complications from unsafe abortion. The rationale for emphasising emergency obstetric care was that in the absence of such care, the obstetric complications listed above would likely lead to a woman's death. The concept of emergency obstetric care designated the 'signal functions' or medical interventions required within the health system to treat obstetric complications (UNICEF/ WHO/ UNFPA 1997). The IAG specified two different levels of such care: basic and comprehensive. Basic emergency obstetric care included interventions such as assisted vaginal delivery and manual removal of retained products, as well as administering of antibiotics, oxytocic drugs and anti-convulsants for eclampsia, while comprehensive emergency obstetric care included all these functions as well as caesarean section for obstructed labour and blood transfusion for massive haemorrhage (*ibid*). For convenience, I refer in this discussion simply to emergency obstetric care.

The IAG also identified 'skilled birth attendance' for every woman as an essential intervention to improve safe motherhood. The designation 'skilled birth attendant' was restricted to refer "exclusively to people with midwifery skills (for example, doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage and refer

complications” (WHO/UNFPA/UNICEF/World Bank 1999:31). The definition excluded traditional birth attendants and community health workers, even if trained. It was recommended that ‘skilled birth attendants’ should assist uncomplicated deliveries, and detect, refer and treat women with pregnancy complications.

	1987 Call to Action	1997 Action Points
Primary remit of the Safe Motherhood Initiative	Improve maternal health and reduce maternal mortality Improve women’s status	Reduce maternal mortality (and serious pregnancy-related morbidity/disability)
Health determinants addressed	Social, economic and biomedical	Primarily biomedical (social and economic in as much as they directly affect access to care)
Approach	Comprehensive, multi-sectoral	Targeted, health sector
Recommended social sector interventions	Girls’ education Women’s empowerment Women’s economic and political rights	Social sector interventions recognised as important for “long-term” improvement but not immediate priorities of the Initiative
Recommended health sector interventions	Family planning Antenatal care, screening for high-risk pregnancies Delivery care General healthcare Treatment of obstetric complications	Skilled birth attendance Treatment of pregnancy-related complications Emergency obstetric care (EmOC)
Type of healthcare provider	Community health workers, including TBAs Focus on mid-level providers (nurses and professional midwives)	Skilled birth attendants No TBAs Unclear position on specialist physicians vs. mid-level providers

Table 4: The IAG’s 1987 and 1997 policy proposals for maternal health (Sources: Herz & Measham 1987; Starrs 1987; Starrs 1997; UNICEF/WHO/UNFPA 1997)

The 1997 Action Points put heavy emphasis on ‘skilled birth attendance’ for all women as the main priority for safe motherhood programmes, although the concept of skilled birth *attendance* in effect subsumed emergency obstetric care because it incorporated referral of women to emergency care when necessary. The report of the Colombo Technical Consultation stated that “having a health worker with midwifery skills present at childbirth, backed up by

transport in case emergency referral is required is perhaps the most critical intervention for making motherhood safer” (Starrs 1997:ii). Subsequently, a special session of the United Nations General Assembly in 1999 agreed targets for scaling up global coverage of skilled birth attendants, to 80%, 85% and 90% of all births by 2005, 2010 and 2015 respectively (WHO/UNFPA/UNICEF/World Bank 1999).

In sum, from 1997 onwards, the comprehensive, inter-sectoral policy vision originally associated with the Safe Motherhood Initiative was thus replaced with a more targeted set of recommendations designed primarily to avert deaths from obstetric complications through treatment of such complications. By identifying skilled birth attendants and emergency obstetric care as essential interventions for reducing maternal mortality, the IAG very clearly departed from its previous emphasis on the inter-related nature of health and social policies, as well as its emphasis on both preventive and therapeutic approaches by introducing a set of recommendations that appeared much more selective than comprehensive in nature. But how did this major shift come about?

5.2. A triumph of idealism over idealism?

At the Technical Consultation, the changes described above were presented as the result of a new research-based consensus on the priority interventions needed to reverse the disappointing record of the Initiative’s first decade (see Starrs 1997). The Consultation report itself claimed that consensus on the Action Points had been ensured on the basis of “research, community-based experience and technical expertise” and through the involvement of a broad range of expert participants, including physicians and midwives “with hands-on experience,” researchers and programme staff from governmental and non-governmental agencies, as well as policy-makers and programme planners from both donor agencies and developing countries (Starrs 1997:1). Indeed, at the meeting one or more speakers summarised key facts and findings for each Action Point on the agenda and presented case studies to illustrate how that action could be implemented at the country level, while subgroups focused more intensively on certain sub-topics to identify the most effective interventions.

Participants presented a range of evidence to justify the need for a shift in policy focus to professionalised obstetric care (see Starrs 1997 for a list of

references of these studies). This included epidemiological analyses suggesting that an estimated two-thirds of maternal deaths occur around the time of delivery, as well as evaluations of antenatal screening revealing a very low predictive value for identification of obstetric complications, indicating a need to shift focus onto therapeutic approaches, namely emergency obstetric care. Moreover, experts presented results from field-based studies showing that trained TBAs could not save women's lives, suggesting that 'skilled', biomedically-trained birth attendants were needed (see Bergström and Goodburn 2001 for a review of the evidence on TBA-training). To further buttress the call for skilled birth attendants, participants presented historical research and case studies, demonstrating that in both developed and developing countries where maternal mortality had been significantly reduced, skilled or accredited healthcare personnel rather than indigenous practitioners had attended the majority of deliveries (see Högberg et al. 1986; Loudon 1992; De Brouwere et al. 1998; Van Lerberghe and De Brouwere 2001; Pathmanathan et al. 2003 for details on the evidence presented). Indeed, one presenter at the Technical Consultation summarised research showing that the dramatic decline in maternal mortality ratios in Western countries in the early 20th century was due to "improved and expanded midwifery care, as well as improved techniques (antibiotics, caesarean sections, blood transfusions), the adoption of systems to monitor and enforce standards for quality of care, and access to care for the majority of women, whether in hospitals or at home" (cited in Starrs 1997:6). In sum, the recommendation that safe motherhood programmes should prioritise professionalised obstetric care was framed as a new 'technical consensus' on how to most effectively reduce maternal mortality in low-income countries.

Given this emphasis on research-based evidence, it is perhaps not surprising that the 1997 Technical Consultation has been heralded in the public health literature as signalling a new era of evidence-based decision-making in the history of safe motherhood (e.g. Rosenfield 1997; AbouZahr 2003; Horton 2006; Starrs 2006). By one account, it was not until the Technical Consultation that clarity was finally achieved about which interventions actually work to reduce maternal mortality (AbouZahr 2003). Writing in the scientific literature towards the end of the 1990s, authors extolled the new policy focus as the triumph of scientific rationality over previous idealistic, and misguided, beliefs that social

interventions like women's education or enhancing the links between traditional and biomedical care could bring about maternal mortality reduction (Weil and Fernandez 1999). As Weil and Fernandez (1999:940) put it,

Unknown territory barely a generation ago, the breadth and the details of maternal mortality and morbidity in less developed countries are now much better known. The most important advance, nonetheless, may be that the very concept of maternal mortality prevention has changed. We now have a better understanding of what can really improve the health of mothers, and we are beginning to see, partly because of past errors, how to implement truly effective strategies in less developed countries.

In referring to the changed "concept of maternal mortality prevention," Weil and Fernandez were implying that maternal mortality had now been appropriately reconceptualised as a public health problem and medical challenge, rather than as a social problem. As the authors saw it, research had now proved that the reduction of maternal mortality in Europe and North America that started in the 19th century was *not* due to economic growth or improvements in women's status, "but to the diffusion and professionalisation of obstetric care" (Weil and Fernandez 1999:941).

But how exactly did this "change the concept" of maternal mortality prevention occur? And how important was new knowledge in bringing about this shift? It is doubtless true that research findings played an important role in justifying the new policy agenda, and in establishing its legitimacy. The fact that a 'technical' consultation was convened to announce a shift in policy is itself indicative of the importance that was placed on giving scientific credibility to the new set of guidelines. But I would argue that it is inappropriate to see the new policy focus as the direct result of a 'bottom-up' assimilation of research-based learning from safe motherhood programmes (cf. Walt et al. 2004), not least because, in reality, research did not generate genuinely *new* insights about the technical requirements for maternal mortality reduction. In fact, as I illustrate below, the recommendations were not as dramatically different from the Initiative's original vision as commentators suggest.

It will be recalled from the discussion in Chapter 3 that the Initiative's original health system strategy emphasised the importance of skilled birth attendants (although not named as such), both as a support to community-based workers and to staff first-referral level health facilities. Similarly, it will be recalled

that the 'new' focus on strengthening emergency obstetric care capacity was contained within the original call to expand comprehensive systems of maternity care, an important component of which was ensuring treatment of obstetric complications. In fact, despite its new label, 'emergency obstetric care' comprised medical functions that were almost identical to the list of functions that had been specified in the 1987 strategy paper for reducing maternal mortality and morbidity in 1987 (Herz and Measham 1987). 'Emergency obstetric care' was thus little more than a reformulation of this original set of clinical recommendations, presented now as research-driven policy solutions with presumed universal validity, lending new credibility and emphasis to old ideas, rather than presenting genuinely new insights. As one informant put it during an interview, "from the beginning we were saying pretty much the same thing – it was just that now we had better evidence for it."

Significantly, that professional obstetric care was in 1997 put into focus should not be misinterpreted to imply – as Weil and Fernandez claim – that maternal health specialists now dismissed, on the basis of revised evidence, the significance of comprehensive, socially-informed policies in maternal mortality decline. On the contrary, there is evidence that the mainstream of maternal health advocates remained committed to the view that maternal mortality and ill health reflect underlying social disadvantage and could be improved through the promotion of norms, regulations and investments, as well as through policies designed to ensure equitable access to healthcare. Although influencing social policy was declared outside of the Initiative's remit, the 1997 Technical Consultation report was explicit that maternal mortality is "a social injustice that governments are obliged to remedy through political, legal and health systems" (Starrs 1997:ii). Indeed, the report insisted that "efforts must be made to give women more autonomy and choices through social and economic policy changes, such as increasing education for girls and women, expanding access to income-generating opportunities and giving them opportunities to learn life skills" (Starrs 1997:1).

As such, I would argue that what was presented and promoted as research-driven policy change can more appropriately be seen as a reformulation or adaptation of existing policy that repackaged policy recommendations in a new way. Through such reformulation, the IAG sought to bring into focus the

original, but neglected, aspects of safe motherhood policy recommendations, notably professional healthcare providers and emergency obstetric care. To the IAG, doing so implied reducing the emphasis on, but not rejecting, broader social and health sector changes addressing women's social status and general health. Recommendations for professional care and emergency obstetric care that had originally been presented as essential components of a multi-faceted and inter-sectoral policy strategy were now put forth as core, biomedical interventions that should be prioritised in order to achieve maternal mortality reduction.

Such repackaging can be understood as part of a sustained effort by safe motherhood advocates to define a 'strategic focus' for the Initiative. This was perceived to be necessary because of the belief discussed in the previous chapter, that an excessively broad policy agenda had detracted attention from the original core, health systems recommendations for averting maternal death. In order to achieve such a focus, other components of the original policy vision were de-emphasised. They were de-emphasised not because they were considered unimportant, but rather in order to achieve an unequivocal and unmistakable policy focus on the importance of professional obstetric care, the aspect of the original agenda that had, during the previous decade, been almost systematically neglected in favour of vertical, community-based safe motherhood programmes. The way in which the safe motherhood field reformulated its international policy recommendations thus pursued a very pragmatic goal of redirecting the focus of current international and national safe motherhood activities away from the sort of 'vertical' community-based TBA-training programmes that had become the mainstay of international safe motherhood work during the past decade. Indeed, discussions held during the Technical Consultation reveal that TBAs were excluded from the definition of a 'skilled birth attendant,' not because their contributions were considered worthless, but rather to discourage government officials from resorting to them as substitutes for professional providers (Starrs 1997).

In addition to the pragmatic goal of reorienting policy, a clearer strategic focus on technical interventions to avert maternal deaths represented an effort by the Safe Motherhood Initiative to appeal to the dominant priority-setting ethos that had become entrenched in international health during the preceding

decade. Within this ethos, different health issues – and indeed different health policies – were increasingly seen as ‘products’ to be sold to donors and governments. In light of the rising dominance of neoliberal ideas within development planning and the Initiative’s limited success in achieving uptake of its comprehensive agenda, the turn to a concise set of messages to encourage appropriate action on safe motherhood made considerable sense, even if this entailed downplaying other important aspects for the sake of clarity. Defining unambiguous messages and ‘marketing’ these became a strategy for securing support for previously neglected policies, and also served to ensuring a place for safe motherhood on the global health agenda, amidst intensified competition from existing and emerging global health issues like HIV/AIDS. But none of this had anything to do with new technical insights about what was actually needed in order to save women’s lives. Rather, it was a strategy that was practically and politically motivated. The extent to which this was the case is illustrated most clearly by examining the proposal by a subgroup of safe motherhood actors that the Initiative should make ‘emergency obstetric care’ alone the strategic focus for its advocacy and recommendations.

5.3. EmOC and the ‘branding’ of safe motherhood policy

In the aftermath of the 1997 Technical Consultation a subgroup of safe motherhood practitioners proposed that international safe motherhood recommendations should be even more narrowly targeted than the Action Points that had been endorsed at the Colombo meeting. They argued that in countries with weak health systems and few healthcare workers, maternal mortality efforts would be best directed at ensuring life-saving care for those women who develop pregnancy and delivery complications – estimated to be about 15 percent – rather than the other recommendations that had been emphasised, including providing access to a skilled birth attendant to every pregnant woman (Maine and Rosenfield 1999).¹⁸ This subgroup, consisting of key US-based public health specialists and later incorporating UN agencies too, proposed to the rest of the movement that rather than simply re-orienting advocacy around the ten Action Points specified at the Colombo meeting, it would be an advantage to make emergency obstetric care *alone* the strategic focus of the Safe Motherhood

¹⁸ See Hussein and Clapham (2005) for a discussion of the implications of this debate for managers of safe motherhood programmes.

Initiative and centre international advocacy on the message that improving “the quality of, access to, and utilisation of emergency obstetric services” should be the priority for countries (Maine and Rosenfield 1999:481). While acknowledging that other aspects, especially accredited healthcare providers, were important, proponents argued that focusing narrowly on creating support for emergency obstetric care was, from a strategic perspective, preferable to a primary focus on the *providers* of that care. The main justification for this argument was that emergency obstetric care is the most essential component of saving women’s lives, without which other actions aimed to improve safe motherhood will fail to reduce maternal mortality within a population. For instance, it was argued that ensuring access to skilled birth attendants to all women will not reduce maternal mortality in the absence of emergency obstetric care to treat the acute complications that cause most maternal deaths (Paxton et al. 2005).

While this technical justification was important, another dimension of the rationale behind a recommended strategic focus on emergency obstetric care seems very much to have been that such a focus would help to simplify, package and disseminate safe motherhood policy recommendations in a new and compelling way. Unlike the original comprehensive vision or even the 1997 Action Points, a focus on emergency obstetric care implied attention to discrete, clinical interventions that could be synthesised into an ‘essential clinical package’ for saving women’s lives. As some informants explained, such a package could be marketed as a single policy solution, thereby increasing its appeal to donors and other decision-makers. The attraction was also that it was a package that, unlike a comprehensive strategy of inter-linked policies, could, be ‘costed’ and evaluated in order to ensure good value for money for donors and governments.

‘Branding’ emergency obstetric care or EmOC as *the* solution to maternal mortality can be seen as a strategy that was in many ways modelled on UNICEF’s successful promotion of GOBI as a universally valid set of policy prescriptions. With GOBI, UNICEF had succeeded in building a recognisable ‘brand’ for this policy package, using the catchy acronym ‘GOBI’ as a reminder of the four main activities needed to reduce child mortality (growth monitoring, oral rehydration for diarrhoeal disease, breastfeeding, and immunisation). According to Maine and Rosenfield – who were strong advocates of a focus on emergency obstetric care – it was the way in which GOBI gave governments and

international agencies “a short list of actions required to prevent deaths among young children from the most common causes” that had secured UNICEF’s Child Survival Revolution’s success (Maine and Rosenfield 1999:481). By contrast, they perceived that the long list of actions subsumed under the term ‘safe motherhood’ had overwhelmed and confused decision-makers (as discussed in Chapter 4). As one informant put it, “a multiplicity of strategies acts as a disincentive for donors to act.”

Mirroring the GOBI brand, ‘emergency obstetric care’ boiled safe motherhood policy down to its essence – the discrete clinical interventions for obstetric complications, without which, experts believed, maternal mortality would not be substantially reduced. Like GOBI, emergency obstetric care could be summarised through an acronym – EmOC – that could help disseminate the policy idea globally while also clarifying its priority status for achieving maternal mortality reduction. This adoption of a marketing logic represented a particularly interesting development, because while the Safe Motherhood Initiative at the beginning was framed in opposition to and as a rejection of UNICEF’s simplified GOBI strategy, ten years later key safe motherhood advocates were now taking on board more than a few lessons from the GOBI branding success.

A further attraction was that focusing on EmOC made it possible to discuss and present safe motherhood policy within the terms of reference of the normative criteria and tools that had been introduced by the World Bank in the early 1990s and that quickly became influential within international health policy and priority-setting (Murray and Acharya 1997; Murray and Lopez 1997; Hyder et al. 1998). The strategy implied action targeted at specific diseases with clinical solutions and was therefore more amenable (certainly more so than a comprehensive policy approach) to the sort of analyses valued by burden-of-disease specialists. Specifically, the discrete, clinical interventions subsumed under the term ‘EmOC’ could be assessed for cost-effectiveness more easily than the multiple, interacting policy components implied by comprehensive approach spanning health and social sectors. Because it incorporated medical interventions with ‘known’ clinical effectiveness, it was possible to argue that EmOC, despite its higher absolute costs, was a more ‘cost-effective’ way to save lives than cheaper, but less effective strategies, such as TBA-training. As Maine and Rosenfield (1999:482) argued in an influential commentary:

It is often assumed that improving emergency obstetric care is too costly. This assumption implies that other solutions exist that are equally effective but cheaper. In the case of maternal mortality, this is not true. No matter how many resources are devoted to improving women's education and nutrition, or to prenatal care and training traditional birth attendants, no substantial reduction in maternal mortality will result without access to emergency obstetric care. Effectiveness, in turn, strongly influences cost-effectiveness. An intervention that is not effective can never be cost-effective. Therefore, seemingly less expensive interventions, such as antenatal care and traditional birth attendant training, are much less cost-effective than providing emergency obstetric care. The one exception to this rule is the provision of family planning services at the community-level, which will help to decrease numbers of unwanted and unplanned pregnancies.

As this quote suggests, by appealing to the logic of cost-effectiveness, advocating for EmOC was seen as a way to discourage the use of TBA-training programmes and preventive, community-based programmes as the foundation of safe motherhood efforts, while also challenging resistance to expansion of facility-based emergency care by appealing to the dominant decision-making logic.

When compared with more broad-based or comprehensive demands, the EmOC strategy can also be seen as a policy brand that appealed to the apparent political preference for discrete interventions with both tangible and immediate benefits. This was important for the safe motherhood field, my informants claimed, given a widespread impression that a major reason that international actors and governments had been unwilling to implement the full comprehensive agenda was that they were reluctant to commit to solutions whose benefits could take decades to materialise, including skilled birth attendance. Achieving universal coverage of skilled birth attendants – as the Action Points called for – could take decades given the weak capacity of midwifery schools in sub-Saharan Africa (AbouZahr and Wardlaw 2001). Although the process could theoretically be sped up by upgrading existing staff or alternative cadres, the skilled birth attendance message nevertheless implied a long-term commitment with few immediately visible results (Buttiëns et al. 2004). By contrast, it was argued, improvements in EmOC could be achieved relatively quickly, by making a series of managerial and fiscal changes and by upgrading existing health facilities rather than building new ones (Maine and Rosenfield 1999). On the basis of this rationale, EmOC advocates insisted that if a strategy targeted at improving the

availability and quality of medical treatment of obstetric complications was embraced, substantial reductions in maternal deaths would be possible in a relatively short period of time (*ibid.*).

Finally, a safe motherhood policy rebranded around EmOC – with its technical and medical focus – offered a convenient way to distance safe motherhood from its association with the politicised reproductive health movement, which many felt had damaged its ability to generate support (Lush and Campbell 2001). In addition to the controversy surrounding the demand for abortion rights discussed in Chapter 4, by the late 1990s the reproductive health movement had also come under criticism for being too idealistic and all-inclusive in its demands (e.g. Basu 1997). The proposal to focus advocacy on EmOC can thus be seen as an effort to extricate the Initiative from its damaging association with the broader reproductive health movement, in part by honing in on technical life-saving solutions designed to improve the credibility and appeal of the Initiative’s policy proposals.

5.3.1. “Support but an awful lot of undercurrent”

While treatment of obstetric complications had been part of the original safe motherhood policy recommendation, the narrower focus on EmOC discussed above clearly simplified that original approach. It also deviated in important ways and certainly in emphasis from the socially-grounded, comprehensive vision that early safe motherhood advocates – many of whom remained key actors within the field – had initially rallied around. It seems remarkable, therefore, that there was seemingly widespread support for the policy shift within the Initiative.

In part this might be explicable because, as one informant put it, “I think what the EmOC people did is try to get everybody [on board] and the bulk of folks in maternal health went there as we didn’t have anything else.” It was also certainly the case that strong pressure from some of the more dominant actors within the Initiative was brought to bear on others to support the revised policy focus. Informants described calls from the staunchest EmOC proponents for all practitioners to back a coherent and cohesive agenda. Many suggested that publicly challenging the narrower policy messages, and especially the recommendations on EmOC, would have been interpreted as disloyalty towards the movement as a whole and damaging to its struggle for survival. One informant even went so far as to liken the strongest EmOC advocates to

members of a “cult.” As she recalled it, “if you didn’t ‘believe’ [they] would literally cut you off ... [they] lambasted people that would even discuss the fact that you could work in [the community]...I mean, seriously, there were times when it was ridiculous.” As this last quote reveals, for some the Initiative’s members the narrowed focus was not unproblematic. One academic I interviewed, for example, lamented the tensions that had arisen with a colleague during debates about how to publicly promote the Initiative’s agenda:

She was very big on being very clear and narrow and specific. I remember her writing that maternal mortality was not ‘the woman’s initiative,’ so everything to do with maternal empowerment couldn’t come into maternal...and it wasn’t [about] morbidity and so it was a very narrow mortality focus. The same thing with EmOC. To me, I interpret her trying to be very clear and correct and I think she was, but it was at a great cost of antagonising people.

Interviews with other informants confirm that there had indeed been more disagreement and discord within the policy community than is conceded in polished and condensed policy documents and advocacy materials, especially regarding the proposal to focus advocacy narrowly on EmOC. As one informant stated: “I think the EmOC message was, what’s the word, it was a bit far from the sense that, I mean, there were a lot of people who rallied but there was also an awful lot of undercurrent and people going ‘wait a minute, we’re missing some pieces here’.” Such undercurrents reflected a series of core concerns.

Not surprisingly, at the heart of many informants’ unease had been some considerable discomfort that promoting EmOC as the strategic focus of safe motherhood policy oversimplified the process of population-level maternal mortality decline. The idea that professional care and EmOC would be essential components of any policy initiative for mortality decline was not in itself contested, but many felt uncomfortable about publicly distancing themselves (albeit for well-founded strategic reasons) from the social, political and economic agenda they still believed was important for addressing the underlying determinants of maternal mortality, and that they themselves remained personally committed to. There was a sense that the baby had been thrown out with the bathwater. These informants had worried in particular about the potential backlash for the broader reproductive health agenda of promoting a more narrow policy focus on maternal mortality reduction (rather than the

broader concept of maternal health). This included fears that reproductive and pregnancy-related morbidity would be further neglected in international health policy debates as a result of the intensified focus on reducing mortality alone, rather than improving women's health in a broader sense.

More generally, academics in particular had felt uncomfortable that promoting EmOC as the field's strategic focus oversimplified the dynamics of maternal mortality reduction. They had worried especially that research findings had been used rather selectively to support the new recommendations: The same historical analyses that had been used to justify the focus on skilled birth attendants and emergency obstetric care also pointed to the importance of favourable social policies, including promotion of norms and regulations to empower midwives and investments to ensure equitable access to healthcare. However, one of the authors of these studies complained that public presentations of these findings downplayed these latter points in favour of an emphasis on the technical aspects (see De Brouwere et al. 1998). Similarly, noted several informants, case studies from Malaysia and Sri Lanka that had been used to justify recommendations on professional obstetric care had also pointed to the role of context-specific policy implementation and the importance of health policies articulated around the idea of universal access to healthcare and the elimination of financial barriers (Koblinsky and Campbell 2003; Koblinsky 2003). In fact, the case studies had highlighted the importance of a context-specific and incremental approach, suggesting a more complex reality than what was being communicated through the universalising language of global-level advocacy.

Maternal health specialists, notably those working at the programmatic level in countries with high maternal mortality, had also worried that the Initiative was making TBAs scapegoats for the failure to improve maternal mortality rates. They queried the IAG's justification for now rejecting a role for TBAs on the basis of research showing that they could not save women's lives when, as originally envisaged, their role had not even included life-saving care. As one informant put it to me in an interview conducted ten years later, "of course the research showed that they couldn't save lives – they were never trained to do so." A number of informants claimed that pinning the blame on TBAs obscured that it was not TBAs' lack of skills that had been the real problem in countries as much as the fact that TBAs worked in isolation from any

functioning health system, without supervision, follow-up or support. Referring to a World Bank-sponsored TBA-training programme, one informant said, “we knew in 1991 why that World Bank [traditional] midwife programme wasn’t going to work – because they had no medical backup.” At a time when most countries with high maternal mortality had extreme health worker shortages and health systems with poor links between communities and health facilities, the sidelining of TBAs – who played other important roles, especially in areas underserved by formal health services – had been considered particularly worrying.

Many informants had also been reticent to transfer an oversimplified set of messages to diverse country contexts and thereby contribute to the formulation of inappropriate policies and programmes. One issue, informants explained, had been concern that the targets for skilled birth attendance would lack credibility and therefore be dismissed outright by countries experiencing severe human resource crises and established traditions of home birthing with ‘traditional’ or lay providers. Another was the implication for health system organisation of de-emphasising the Initiative’s original focus on community-based care in favour of an exclusively facility-based approach. In theory, ensuring access to emergency obstetric care did not necessarily imply that all women should deliver in a health facility, but rather that all women should have access to a facility that can provide emergency obstetric care in the event that they experience complications. However, safe motherhood specialists had worried that those implementing policy would misinterpret the focus on EmOC as a proposal for universal institutionalisation of childbirth. This, in turn, might not only lead to neglect of the primary level of care but also to higher demand for institutional deliveries that health systems in low-income countries would be unable to absorb, thereby potentially compromising quality of care and contributing to higher, rather than lower, numbers of maternal deaths in hospitals.

Finally, the exclusive advocacy for EmOC also raised fears of excessive medicalisation of childbirth, as exemplified by one WHO official’s letter to the editor of the *Lancet* in 1999, in which she warned that “identification of major obstetric interventions as the core of safe motherhood programming risks over-intervention, iatrogenicity and inappropriate use of scarce resources” (AbouZahr 1999: 2085). The author also worried about concomitant neglect of care in

normal birth, important for preventing certain kinds of complications and ensuring timely treatment or referral of obstetric complications and emergencies. She further warned that the emphasis on skilled providers and emergency obstetric care might be misinterpreted as a recommendation for the use of highly-specialised staff, a misguided policy for African countries where doctors are in short supply (*ibid.*).

5.3.2. EmOC as a strategic entry point for systemic change

Those who proposed a strategic focus on EmOC were not unaware of or unsympathetic toward such underlying concerns that existed within the safe motherhood policy community. But, these actors also seem to have recognised that their vision for rebranded safe motherhood policy would fall apart without the full support of the movement. This may explain their perceived ferocity in seeking to persuade others of their approach. Through frequent editorials, opinion pieces and articles in the scientific press and through advocacy at meetings (e.g. Maine 1997; Freedman 2003; Paxton et al. 2005), EmOC proponents sought to convince the wider safe motherhood community to back the proposal for more targeted policy advice and advocacy. In many ways, this is an effort that is still actively being made within the movement today. I would argue that the gradual process of building support within the safe motherhood community for a much narrower strategic focus has involved bringing about important shifts in the way in which the movement relates to and makes use of advocacy.

A first conceptual shift has been to see advocacy for EmOC not simply as a call for a socially unengaged biomedical solution designed to avert deaths from obstetric complications, but rather as a strategic entry point for broader health system development. Proponents have argued that advocating for EmOC can help prompt governments and donors to upgrade health facilities, infrastructure and training schemes for healthcare providers in ways that benefit not only maternal health and survival, but also the health system as a whole (Maine and Rosenfield 1999). While the same could be said for advocacy for skilled birth attendants, EmOC proponents have claimed that by focusing on the system into which health workers must be integrated (rather than the person who attends the birth) it becomes possible to force attention onto cross-cutting health system issues. As such, EmOC can be seen as an essential first step

towards expanding not only life-saving care, but also more routine care related to maternal and reproductive health and even public health services more generally. Furthermore, proponents have argued that a focus on EmOC can direct attention to questions of access to healthcare, because ensuring access to EmOC implies not only making certain that EmOC is in place (which in itself requires a health system) but also ensuring that women with complications can and do use it (Maine and Rosenfield 2001; Freedman 2003).

In order to dissipate residual fears that focusing on EmOC means reverting to an urban hospital model, advocates have also described how it instead involves upgrading services that people can reach, including district hospitals and health centres, as well as updating hospitals to perform obstetric surgery (such as caesarean delivery for obstructed labour) (Maine and Rosenfield 1999). Of equal importance, implementing EmOC implies strengthening links with other levels of the health system, such as health centres or first aid posts, where a number of the life-saving procedures encompassed by EmOC can be delivered. As Maine and Rosenfield (1999:481-482) put it, implementing EmOC implies recognising that for “postpartum haemorrhage, which can kill in a matter of hours, treatment and first aid (e.g. manual removal of the placenta and injection of ergometrine) need to be available at the most peripheral level of the health care system.”

A second conceptual shift has been to understand a focus on EmOC not only as a way of potentiating health system development, as outlined above, but also as a way of galvanising social and political changes and thereby addressing underlying social and economic determinants of health. In order to help generate such a reconceptualisation, EmOC advocates have claimed that health systems should be understood not simply as “delivery mechanisms for technical interventions” but rather as “core social institutions” that are fundamental parts of social and civil life (Freedman et al. 2005:997). In doing so they have turned to the work of Maureen Mackintosh (2001), who has argued that poorly functioning health systems are core to the experience of poverty and discrimination and thus can also be conceptualised as sites for enacting citizen entitlements and holding governments and others to account for the provision of adequate services and for non-discriminatory access to such services.

On the basis of this expanded conceptualisation of health systems, EmOC advocates have argued that organising claims for safe motherhood around a demand for EmOC provides an opportunity to link activism on maternal mortality reduction to other important aspects of women's health and social justice and human rights (Freedman 2003:102). For instance, Freedman, a human rights lawyer and prominent advocate for emergency obstetric care, has insisted that debates about EmOC can be used to remind those responsible for the provision of care that 'access' involves not simply implementing services in health facilities, but also ensuring "physical and financial access to non-discriminatory, culturally sensitive, high-quality, facility-based services" (Freedman 2003:102). By forcing engagement with health systems issues, a strategic focus on EmOC can thus come to be seen as an entry point for improving social inclusion and justice, with the health system being "a vehicle for fulfilling rights, for active citizenship, and for true democratic development – poverty reduction in its fullest sense" (Freedman et al. 2005:997).

It is, I would argue, on the basis of such reconceptualisations of what is entailed by a strategic focus on EmOC that many within the safe motherhood community have become reassured that embracing a more targeted set of messages will not necessarily sideline the more comprehensive agenda to which they remain committed. Although there were certainly factions within the safe motherhood community who resisted the new agenda regardless of these reconceptualisations, with time and despite their initial reservations the mainstream of the movement seems to have come to appreciate that a targeted advocacy focus may not be counterproductive to the Initiative's original ideological aims. Many had come to accept that, despite their somewhat bombastic attitudes, EmOC advocates had, in the words of one informant, "articulated things that were very important to articulate."

A considerable number of my informants had thus eventually come to appreciate a strategic focus on EmOC as a way of promoting a concrete "do-able" agenda for structural change. This agenda was judged to have a greater chance of winning concessions in the global health policy arena than the original all-encompassing and, apparently, overwhelming demands for social, economic and health-sector reform that had been ignored in the initiative's first decade (Freedman 2003). As the informant quoted above saw it, "it's an exciting part of

history because I think that was what brought maternal health to the forefront and made it visible.” As I have also tried to show, however, maternal health actors’ engagements with the new realities and the need to adopt a more targeted approach *have* on some levels impacted upon their original comprehensive vision. By the turn of the century, safe motherhood became equated much more directly with maternal mortality reduction through technical-medical intervention, even as its advocates claimed to have retained their original commitments to broader social and economic change. From the late 1990s, safe motherhood thus came to embody something of a paradox: safe motherhood actors’ practical uptake of the new approach required the ideological commitment to the old, at the same time as the nature of that original ideological vision was gradually being reshaped in light of the challenges of the present.

5.4. Conclusion

International actors’ role in the transfer of policies from the international to the national level is not just about promoting and marketing policy packages to donors and governments, but also about negotiating political, ideological and conceptual, as much as technical, consensus within their own policy communities. The policy shift that appeared a decade into the Safe Motherhood Initiative was presented as the result of technical or scientific re-evaluation of the errors of the past, but can be better understood as the product of a reformulation of the movement’s policy vision as part of a new advocacy strategy. By shifting the emphasis of the safe motherhood policy agenda onto medical interventions designed to avert deaths from pregnancy and delivery complications – skilled birth attendance and emergency obstetric care – the Safe Motherhood Inter-Agency Group aimed to direct policy attention onto those aspects of the original safe motherhood agenda that had been neglected during the late 1980s and 1990s, namely the need for health systems capable of ensuring women’s access to life-saving care. In the interest of defining a clear strategic focus, the social and political agenda that had been a core component of the original Safe Motherhood Call to Action in 1987 was de-emphasised.

In safe motherhood, the policy shift that was instituted in 1997 thus came about as international actors – primarily the IAG – adapted and reformulated the complex, original international recommendations on safe

motherhood in order to define a strategic focus for the Initiative. In doing so, they sought to present a cohesive and coherent policy agenda for global dissemination that appealed to market-oriented donors and to the preference for disease-specific, targeted interventions that had become entrenched in international health during the preceding decade. This is illustrated particularly well by the branding of core safe motherhood policy recommendations as 'EmOC.'

In many ways such repackaging was successful in achieving wide-spread, global and national-level appreciation for the importance of emergency obstetric care delivered by accredited health professionals – rather than trained TBAs – as the core of public health strategies for reducing maternal mortality. However, the uptake of the messages has perhaps not been as focused on EmOC as some safe motherhood advocates might have preferred. Despite targeted advocacy for EmOC, both EmOC and skilled birth attendants are now routinely seen as global 'solutions' for maternal mortality. This has sometimes resulted in confusion about which of these interventions should be prioritised, despite most safe motherhood advocates conceding that they are complementary (Buttiens et al. 2004; Hussein and Clapham 2005). Yet, on the whole, there is little doubt that the 1997 Technical Consultation's Action Points and subsequent strategic advocacy targeted at EmOC have helped to achieve greater recognition of the importance of professional obstetric care – and to some extent health systems – among actors involved in international health efforts. Signs of this include that indicators of both skilled birth attendance and emergency obstetric care are now often used to measure and monitor progress on maternal health. 'Skilled birth attendance' was defined as a Millennium Development Goal (MDG) subtarget when the UN in 2000 declared improving maternal health one of eight MDGs, a move that has been cited as a clear demonstration of "the trust [the skilled attendance strategy] inspires at the level of international policy-making" (Buttiens et al. 2004:653). Moreover, donors have pledged to support efforts to expand coverage of these interventions. A good example is the Gates-funded Averting Maternal Death and Disability (AMDD) project that was established at Columbia University in 1999 to improve availability, quality and utilisation of emergency obstetric care (Maine and Rosenfield 2001). At the same time, the reformulated policy messages helped to discourage reliance on TBA programmes alone. In

many places, TBA-training programmes have been discontinued, sometimes, but not always, replaced by programmes designed to enhance institutional deliveries (Rosenfield 1997; Starrs 2006). Most often, however, such efforts have fallen well short of the sort of health system strengthening advocates envisaged when promoting EmOC.

As I demonstrate in the next chapter, for all the advocacy and branding that has gone into the formulation of a new strategic focus for the Safe Motherhood Initiative, advocates did not deal head-on with the broader reasons for the neglect of safe motherhood, including the bias that exists in international health practice against complex health system interventions. Branding of policy cannot get around the problem that emergency obstetric care is not a discrete intervention that can be implemented in the way that GOBI was. Instead, implementing EmOC implies systemic reform. As my informant highlighted, in the maternal health field, “we don’t have magic bullets in maternal health...we don’t have a vaccine, a vitamin A or something fantastic that we can promote and say, ‘this is it’. We have EmOC. But what is EmOC? It is the health system. So it is diluted into reform of the health system.” Despite all the careful work to gain internal and external acceptance for a more targeted set of recommendations, the problem of safe motherhood remained.

6. THE UNFULFILLED PROMISE OF INTEGRATION

In the years following the Safe Motherhood Technical Consultation described in the previous chapter, the broader global health policy context underwent important changes, which would shape the safe motherhood agenda in significant ways. On the one hand, rapid escalation of new public health problems such as HIV/AIDS and the growth of many strong and dedicated initiatives to address these issues created a competitive environment in which safe motherhood practitioners felt that they were losing out. This was despite nominal political commitment towards the focused policy agenda they had begun to adopt since the 1997 Technical Consultation. Although improving maternal health was defined as Millennium Development Goal 5 in 2000, there was, by 2005, a growing sense that safe motherhood risked being eclipsed by the stronger, more prominent global health initiatives. Meanwhile, growing international pressure to rationalise aid grew out of dissatisfaction with neoliberal approaches and concerns that international aid had become excessively fragmented, and led to a search for new financing mechanisms and efforts to harmonise the aid architecture (Mosse and Lewis 2005). For the Safe Motherhood Initiative, while this development was in many ways welcome, as I show in this chapter, it also signalled intensified threats to its survival as a distinct policy community.

Within this context, the formation of a partnership between the Safe Motherhood Initiative and other advocacy coalitions dedicated to promoting newborn and child health emerged as one course of action that could help to ensure the survival of safe motherhood as a policy issue. Announced at the UN General Assembly in September 2005, the Partnership for Maternal, Newborn and Child Health (PMNCH) is by its own description a global health partnership bringing together “the world’s three leading maternal, newborn and child health alliances” around a common mission “to support the global health community to work successfully towards achieving MDG 4 and 5” (the Millennium

Development Goals on child mortality and maternal health respectively) (PMNCH 2009*b*:12). The formation of a Partnership amalgamating the child, newborn and maternal health fields can be seen as an ironic development given that the Safe Motherhood Initiative was initially created as a reaction against the growing dominance of UNICEF's Child Survival Revolution (see Chapter 3). Such coalition-building may also seem surprising in light of the strategic efforts described in the previous chapter to revive safe motherhood as a global health priority by advocating a focus on specific technical solutions to maternal mortality. Nevertheless, by 2005 many maternal health specialists had come to see the establishment of the Partnership as an inevitable and necessary development to ensure the survival of international policy attention to safe motherhood. "We've been waiting for this for a long time," one UN agency official said in an interview shortly after the Partnership's launch. "It needs to happen...because as a single topic we can't fight this alone, we can't survive."

In this chapter I take this process of partnership formation as my analytical focus. I examine, from the perspective of safe motherhood advocates, the factors that created the impetus for the launch of the Partnership for Maternal, Newborn and Child Health (PMNCH), as well as safe motherhood practitioners' reactions to the Partnership in the first two to three years of its operation. After first describing the broader policy context against which the Partnership was launched, the rationale for its creation and its distinct policy vision, I turn to reflect on how and why many safe motherhood practitioners quickly revised their initial welcoming attitudes towards the Partnership. As I show, within just two years of the Initiative's launch, this initial enthusiasm was ceding to scepticism and frustration. Such scepticism stemmed from a burgeoning perception that maternal health was being subordinated to other policy aims and that the 'M' in 'MNCH' was in fact in need of renewed protection.

6.1. The impetus for partnership

Before describing the specific developments that culminated in the launch of the Partnership, I must first review some of the main developments in the broader global health field that converged to create the impetus for its establishment.

6.1.1. Competition versus integration

In the years following the 1997 Technical Consultation discussed in the previous chapter, the international – or by now perhaps ‘global’ – health field became increasingly complex, fragmented and, not least, competitive. As discussed in Chapter 1, during these first five years of the new century a large number of public-private partnerships or global health initiatives emerged, competing for resources in order to pursue predominantly disease-specific goals (Richter 2004; Walt 2005). The rapid expansion of global health initiatives like the Global Fund to Fight HIV/AIDS, TB and Malaria came to highlight the vulnerability of the Safe Motherhood Initiative (Graham 2002). Hence, if the Safe Motherhood Initiative had struggled to compete for attention against the Child Survival Revolution in its early years (see Chapter 3), the prominence of these new global initiatives now threatened it even further.

Perceptions that the Initiative faced serious perils were, however, somewhat in tension with external indications that the Safe Motherhood Initiative had in fact achieved a certain, renewed prominence and that the strategic advocacy that had been initiated around 1997 had, at least on some levels, paid off. Most significantly, perhaps, in 2000, improving maternal health was declared one of eight Millennium Development Goals (MDGs), and one of three health-related MDGs, the other two being to improve child survival (MDG 4) and to combat HIV/AIDS and other major diseases (MDG 6) (United Nations 2009). However, while attention and funding to MDGs 4 and 6 grew rapidly, many perceived that actual commitment to MDG 5 on maternal health lagged behind. Commentaries in the public health literature reveal a perception that, despite their stated commitment, donors and governments remained reluctant to make necessary investments to strengthen national health systems to enable the ‘scaling-up’ of emergency obstetric care and skilled birth attendance (Travis et al. 2004; Powell-Jackson et al. 2006; Rosenfield et al. 2006). The creation of GAVI (the Global Alliance for Vaccines and Immunisation) in 2000 and, in particular, the Global Fund in 2002, put into sharp relief the Safe Motherhood Initiative’s relative failure to attract investment and international political will (see AbouZahr 2003). Many also perceived that donor prioritisation of HIV/AIDS in particular actually *displaced* funding away from other global

health issues, including reproductive and maternal health (Berer 2004; Crossette 2005; Shiffman 2007 *b*).

In parallel with, and in many ways driven by, the changes to the global health architecture described above, debates about the need to improve the 'effectiveness' of external assistance and aid intensified, due to growing recognition that external assistance to low-income countries, including to the health sector, had become too fragmented and top-down, unpredictable and lacking in transparency (OECD DAC 2005). The debate about aid effectiveness had intensified due to concerns that heavy emphasis on project-based and donor-driven funding was distorting national planning and priority-setting, but also with concern that efforts in the 1990s to address such problems through new aid modalities had not come to fruition (Mosse 2005). Such new aid modalities included sector wide approaches (SWAPs) and direct budget support to low-income country governments, designed in part to improve governments' autonomy over planning and spending (Cassels 1995; Standing 2002). While many donors embraced these new modalities, others, including the major donor USAID, rejected them. As a result, as Standing (2002) has observed, international initiatives such as safe motherhood programmes and Integrated Management of Childhood Illnesses (IMCI) continued to operate in parallel, with separate budgets and management structures. With the proliferation in the early 2000s of new global health initiatives and the establishment of the "new philanthropy," exemplified by the Gates Foundation, vertical approaches to health became reinforced, in a way that fitted poorly with system-driven approaches to sectoral reform (such as SWAPs) and longer-term planning and financing of health sectors (Standing 2002). Indeed, authors note that the unprecedented number of donors pursuing often-separate agendas was having detrimental effects on public health systems and on the ability of countries to implement coherent health plans (Buse and Walt 2000*a*; Buse and Walt 2000*b*). Worries about such problems fed into more general international disquiet about the poor effectiveness of international development assistance overall (Mosse and Lewis 2005).

In reaction, by the mid-2000s the principles of 'ownership,' 'alignment,' 'harmonisation,' 'managing results' and 'mutual accountability' gained prominence as core ideals that should underpin international aid practices (OECD DAC 2005). These principles, contained within the Paris Declaration on

Aid Effectiveness, were endorsed by more than 100 signatories from donor and low-income country governments, multilateral donor agencies, regional development banks and international organisations at a high-level international forum convened in Paris, France in February 2005 (*ibid*). Aid effectiveness in this context implied not only efficiency of expenditure, but also a range of development-related goals, including improved country 'ownership' over development spending, signalling a (rhetorical) departure from the now discredited structural adjustment programmes and donor conditionalities of the 1980s and 1990s (*ibid*). The Paris Declaration can thus be seen as the product of a development rhetoric that, according to Mosse (2005), speaks simultaneously of neoliberal reform, democratisation, poverty reduction and global governance, despite the potential contradictions between these different goals.

The Paris Declaration's aims for aid effectiveness was, at least in theory, widely supported within the global health field, including within safe motherhood, since the effect of fragmented governance and disease-specific donor-driven projects with separate budgets often translated into neglect of cross-cutting health system issues deemed necessary for reducing maternal mortality (Task Force on Child Health and Maternal Health 2005). All the main agencies involved in the Safe Motherhood Initiative endorsed the Declaration.

At the same time, in speaking to informants it became clear that the Declaration also signalled to actors within the Initiative that it would become increasingly unsustainable for many different groups to coexist as parallel initiatives and raised fears that weaker ones, like the Safe Motherhood Initiative, would risk being swallowed up by more powerful initiatives as part of efforts to make aid more efficient. This perception was grounded in explicit messages from donors that they wished to rationalise and fund fewer global health initiatives.

Together, these somewhat contradictory tendencies – greater competition to survive as a single initiative combined with pressure to harmonise and integrate development efforts – converged to create an impetus for the Safe Motherhood Initiative to find strategies to protect the status that maternal health had achieved through being assigned as one of the MDGs. Partnership formation was part of such a strategy. In an interview conducted shortly after the Partnership had been announced, one member of its interim steering committee explained that safe motherhood actors' decision to seek merger with other global

health initiatives had been driven by both implicit and explicit pressure from donors who “really wanted to see this field co-ordinated and connected and they didn’t want several sets of transaction costs for the funding that they *did* want to put into the work.” Given such views, by 2005 many maternal health specialists had come to see the establishment of the Partnership as an inevitable and necessary development to ensure the survival of safe motherhood as a global health issue.

6.1.2. Defusing competition through partnership

Within the general context described above, it was the emergence in 2003-2004 of a new transnational advocacy coalition for *newborn* survival that perhaps provided the most direct stimulus for the Safe Motherhood Initiative to pursue partnership formation as a strategy to ensure its own survival. Many safe motherhood practitioners perceived the newborn lobby to be a direct competitor for donor resources and attention, not least because they thought that donors and politicians were more likely to support initiatives to save the lives of ‘innocent’ newborns than efforts to avert maternal deaths.

Members of this new movement – primarily academics and international NGOs such as Save the Children – argued that newborn survival had been neglected in global health efforts, since neither child survival nor safe motherhood programmes had focused on preventing newborn deaths. In a ‘call to action’ published in the *Lancet*, advocates argued that addressing neonatal deaths is necessary given that each year an estimated four million babies die in the first four weeks of life (the neonatal period) (Lawn et al. 2004). Proponents of a distinct focus on newborn survival argued that the proportion of child deaths that occur in the neonatal period is increasing, such that by implication “the Millennium Development Goal for child survival cannot be met without substantial reductions in neonatal mortality” (Lawn et al. 2005:891).

Already dismayed that MDG 4 on child survival seemed to be attracting greater commitment and resources than MDG 5 on maternal health, many of those I spoke with had feared that the promotion of newborn survival as a subsidiary goal of child survival would further skew such prioritisation. In order to preempt this situation, the IAG proposed to individuals affiliated with the newborn survival movement (in particular the newly established Healthy Newborn Partnership) to join forces with the Safe Motherhood Initiative. The

main rationale they presented for such a partnership was the mutual benefits that each health subfield could accrue from joined-up advocacy. In meetings, safe motherhood advocates argued that newborn survival is so closely related with women's survival and safe delivery that any efforts to improve the safety of pregnancy and delivery will also benefit newborn survival. Safe motherhood advocates also hoped that the benefits of maternal health interventions for newborn survival would help to improve political commitment to skilled healthcare providers and emergency obstetric care.

The resulting Partnership for Maternal and Newborn Health was formed in January 2004, effectively disbanding the original Safe Motherhood Inter-Agency Group. A new Partnership secretariat was established in Geneva, replacing the New York-based NGO Family Care International (FCI), the NGO that had been created specifically to help with the organisation of the first international Safe Motherhood Conference in 1987 and that had served as the IAG's secretariat ever since (although FCI retained an important role as an advocacy group).

With newborn survival as the link between MDGs 4 and 5, discussions soon got underway within the UN agencies and the broader advocacy communities about whether it would "make sense" to incorporate the existing child survival community into the partnership, so as to jointly advocate for resources to achieve MDGs 4 and 5. Meanwhile, there were also ongoing talks within the child health community about the need to revive the Child Survival Revolution to drive progress on MDG4, a discussion that was, according to one informant, driven in large part by USAID. It soon became clear that certain of those donors who were particularly strongly committed to the Paris Declaration, including DFID in particular, would refuse to handle requests from three different partnerships that all claim to be *the* Partnership, creating an impetus for the child health lobby to merge with the new maternal and newborn health coalition. As my informant put it, "they said, 'either you merge or die, you are not funded,' so we decided to merge." Although my informant went on to add that "the pressure came from the donors," there is perhaps also scope for arguing that the donors merely executed, in a perhaps more literal fashion, the process begun by the safe motherhood movement itself.

6.1.3. The Partnership for Maternal, Newborn and Child Health

Subsequent to the initial discussions mentioned above, a high-level meeting attended by maternal, newborn and child health representatives from across the UN specialised agencies, academia, donor bodies and country-level health authorities was convened in New Delhi, India in April 2005. The aim of this meeting was to discuss the institutional structure and strategic objectives for a new partnership. The Partnership for Maternal, Newborn and Child Health (PMNCH) was then officially launched a few months later during the UN General Assembly in New York City in September 2005, joining together the Partnership for Safe Motherhood and Newborn Health (hosted by the WHO in Geneva); the Healthy Newborn Partnership (based at Save the Children USA); and the Child Survival Partnership (hosted by UNICEF in New York). An interim steering committee operated until a Director was appointed in February 2006. At the same time, a small staff was recruited for the secretariat, housed in an annex to the WHO Headquarters in Geneva – although the PMNCH was purportedly independent from the WHO. The Board became the PMNCH's governing body and advisory committees were assembled, drawing representatives from across six constituencies: donors and foundations, health care professionals, multi-lateral agencies, NGOs, partner countries and researchers and academics.¹⁹ In short, a new institutional structure was created, modelled in many ways on the Global Fund and other initiatives like it, especially in as far as the Partnership incorporated donors within its governance structure.

The Partnership was framed within the discourse of the Paris Declaration on Aid Effectiveness, no doubt reflecting that it was launched just six months after the Declaration had been signed. Like the Paris Declaration, the PMNCH's strategic objectives promised to usher in a new era of more appropriate financial and technical assistance to low-income countries, entailing the elimination of overt conditions on aid and greater country 'ownership' of national policy processes (PMNCH 2009a). In the spirit of promoting country ownership, the PMNCH pledged to advocate for maternal, newborn and child health within national development plans and investment plans, rather than to pursue separate donor-driven projects (*ibid.*). Related to this was the pledge to ensure that

¹⁹ For a full description of these different constituencies see <http://www.who.int/pmnch/about/constituencies/en/index.html>, accessed 23.09.09.

interventions to improve health would be 'scaled up' to cover entire populations, rather than restricted to small donor-driven and NGO projects reaching only the few. As the PMNCH (2009*a*) itself put it, its aim was "to catalyse implementation at scale of national MNCH plans and essential packages of interventions," while also improving equity in the coverage of "essential MNCH services" and raising demand for healthcare among underserved populations.

The Partnership also reiterated the Paris Declaration's commitment to the values of "transparency," "good governance" and "accountability" in development work, espousing the imperative of attaining development "results" or "targets" (OECD DAC 2005). It promised to achieve measurable results and to "monitor and evaluate progress towards Partnership and country level results and promote stakeholder accountability" (PMNCH 2009*a*). Today, these strategic objectives have been crystallised, such that the Partnership's stated mission is to help achieve MDGs 4 and 5 by "enhancing partners' interactions and using their comparative advantages" in order to build consensus on and promote "evidence-based high-impact interventions and means to deliver them through harmonisation," raise funding through advocacy (with a target of US\$ 30 billion for 2009-2015) and "track partners' commitments and measurement of progress for accountability" (PMNCH 2009*b:12*). In sum, the Partnership's strategic objectives illustrate how the dictates of aid effectiveness and the heightened emphasis on accountability through monitoring of objective outcomes have come to provide an increasingly influential code of practice for international development in general, and global health in particular.

6.2. Safe motherhood practitioners' perspectives on the Partnership

The irony that the Inter-Agency Group sought to align itself with precisely the child health field that it had been created to compete against was not lost on safe motherhood practitioners. Yet many expressed hope that the PMNCH could help bridge the damaging, and ultimately false, dichotomies between maternal and child health that had become established in the 1980s. Some even felt that the 'case' for maternal health had now been made, such that joining forces with child health no longer posed the same threat. As one informant assessed,

I think there was a need in maternal and child health, the mother was always forgotten. So I think in 1987, people perceived the distinct need to focus on the mother and think of interventions specifically to save the mother. So I think it was important to make a strong case that mothers...that childbirth was different. I think we've made that case now and I think to integrate the neonates made complete sense.

Although not all my informants agreed that the threat of maternal health objectives being subordinated to child health goals had been defused, most safe motherhood specialists did not resist the Partnership, and indeed many welcomed it. This was perhaps especially because the previously competing subfields now faced a common threat from other prominent global health initiatives. Indeed, a main justification for an expanded collaboration was to create a “multiplier effect” to enable the Partnership to become a counterweight to the HIV/AIDS field that was rapidly assuming a dominant position within the broader global health policy domain. The combined annual death toll of maternal and child deaths (including newborn deaths) far exceeded that attributed to HIV/AIDS, which could help, my informants claimed, to create priority for these issues relative to HIV/AIDS. Combining maternal mortality with child and neonatal mortality figures also masked that the number of maternal deaths is relatively small, which many considered a benefit given the perception that the “small” number of maternal deaths had underpinned the international neglect of the issue. As one informant put it, “it makes sense to bung in the babies for the numbers game.” Moreover, when maternal, newborn and child health were addressed alongside each other, the potential to save lives appeared correspondingly greater. To this end, the Partnership promoted the slogan “lives in the balance” for the PMNCH, drawing attention to the potential that scaling up cost-effective interventions would have to save seven million lives that are lost annually to pregnant women, newborns and children.

6.2.1. The prospect of institutional strengthening

In addition to the anticipated benefits of joined-up advocacy, another reason for initial support for the new Partnership was an expectation that it would help strengthen the safe motherhood policy community's institutional identity. This expectation reflected a pervasive view among safe motherhood practitioners that part of the Initiative's enduring struggle to achieve real commitment to improving maternal health had to do with the institutional weakness of the

Initiative itself. A lack of focused institutional representation at the highest level was something many felt had hampered the movement's success. Unlike AIDS, which had its own UN agency (the Joint United Nations Programme on HIV/AIDS or UNAIDS), or child health, which was clearly associated with UNICEF, safe motherhood had no directly corresponding institutional platform at the international level. Instead, it was dealt with by different UN agencies and NGOs coming together in the IAG. Many felt that the 'inter-agency' status of the initiative had been a serious impediment to achieving progress. Even after almost twenty years of advocacy, the predominant view among my informants was that the Initiative had a weak public profile resulting from such institutional fragmentation. Complaining of poor public awareness and media interest, one UNFPA informant said, "you ask people who can cite two or three people who are shouting for maternal health in the media, in the public and they will not say one... You go to the street and you ask people 'which agency in your opinion does maternal health?' They won't say anything, but for child health they will immediately say UNICEF."

The Initiative's lack of public profile was widely attributed to weak leadership within the field. "We never had a Jim Grant," one of my informants remarked, referring to UNICEF's charismatic leader in the 1980s, who championed the Child Survival Revolution and the GOBI approach. The PMNCH offered a way to enhance international leadership for the issue. In an interview conducted just after the Partnership had been formed, one informant who was a member of the PMNCH interim steering committee admitted that she hoped that the recruitment drive for a Director would enlist someone who could act as an effective advocate for maternal health within the Partnership. This should preferably be "a man from a developing country," she explained, who could dissociate safe motherhood advocacy from its damaging reputation of being simply "a woman's issue," while also affording country-level legitimacy to the Partnership. Like many others, she later expressed delight with the appointment of Dr. Francisco Songane, a former Mozambican Health Minister with specialist training in obstetrics, as the Partnership's Director.

At the level of the UN, some of the officials who had been involved in the IAG described the Partnership as a unifying force that could address institutional wrangling between the IAG's different agencies. Although the Safe

Motherhood Initiative had worked hard to present a united front on the Initiative's vision and policy priorities, areas of disagreement remained, for instance in the emphasis that different institutional members placed on emergency obstetric care versus skilled birth attendance, and on the extent to which community-based services and social interventions should be promoted alongside facility-based care. Furthermore, both institutional and funding weaknesses had made it difficult to sustain coordinated advocacy for emergency obstetric care and skilled birth attendance. Given such concerns, many hoped that the PMNCH, with an improved ability to leverage resources and coordinate global advocacy, could encourage more joined-up thinking and help disseminate a more coherent set of policy recommendations to countries.

In addition to the anticipated benefits for the safe motherhood community as a whole, some informants welcomed the Partnership as an opportunity to further their individual careers and influence within high-level policy debates from which they had previously been excluded. Indeed, many welcomed the Partnership's expanded membership because they felt that the IAG had previously been too elitist. As an academic researcher observed, "there was definitely unhappiness that it was the same group of women who had been involved since the beginning and that this club was too small and too tight." In particular, representatives of international NGOs that had formed around the issue of safe motherhood during the past decade seemed to hope that the Partnership would open the scope for their own participation in global policy debates.

6.2.2. The continuum of care

The policy paradigm that was formulated in the Partnership's early days also strengthened initial support for the Partnership among many safe motherhood practitioners, in large part because the paradigm resonated in important ways with the comprehensive agenda that had been promoted at the Initiative's start. The new policy framework became known as the "continuum of care" and was promoted as an integrated, "life-cycle" approach to health improvement, linking, in *time*, care from pregnancy through birth, newborn and young child and, in *place*, the various levels of home, community, and health facilities (PMNCH 2009*a*). The continuum of care thus implied alignment of disease-specific approaches, including specific maternal health interventions, as well as attention

to cross-cutting issues like infrastructure and human resources in the health sector. In part because it was endorsed in the World Health Report for 2005 (WHO 2005), the continuum of care soon gained credibility as a global policy framework.

Many expressed hope that the PMNCI's promotion of the continuum of care would not only combat fragmentation in healthcare planning and delivery, but also improve support for core life-saving interventions for pregnant women, which remaining lacking despite targeted advocacy for EmOC. Underwriting such hope was the fact that EmOC was now incorporated as an essential element of the continuum of care, implying that also child health specialists – traditionally proponents of selective primary healthcare – had come to acknowledge the benefits of a comprehensive, integrated health system approach. As mentioned above, there was also an expectation that growing recognition of the benefits of EmOC and skilled birth attendance to newborns and thereby to MDG 4 would further strengthen international support for these interventions.

Of all advocates, it was in particular those who at the end of the 1990s had felt reluctant to advocate for EmOC who appreciated the new continuum of care framework. As some explained, this new framework promised to revive attention to community-based care alongside, rather than instead of, the expansion of facility-based care. Moreover, it bore similarities to the original safe motherhood programmatic agenda, bringing back into focus some of the aspects that had been de-emphasised in recent years for the sake of political expediency (as discussed in Chapter 5). With maternal health interventions posited as part of a continuum of care, it became easier to discuss the interplay of community-based and facility-based interventions, including a re-appraisal of community-based contributions like TBA-training. Although the 1997 Technical Consultation had discouraged TBAs' involvement in safe motherhood programmes, many donors, NGOs and governments nevertheless continued to support them. A number of my informants therefore considered it inappropriate to ignore outright the existence of such initiatives in policy discussions and therefore welcomed the community of care's dual emphasis on community- and facility-based care. The idea of a partnership thus ultimately appeared to offer a means, even, of reconciling some of the residual tensions within the field arising

from for the earlier policy move to focus attention exclusively on EmOC (see Chapter 5).

As such, barely twenty years after the Safe Motherhood Initiative was launched as a counterweight to the influence of the Child Survival Revolution and its selective approach, the overlap between maternal and child health had come to be reconceptualised not as a threat, but as a strategy for strengthening policy concern and financing for maternal health. Within the Partnership, the newborn was posited as the ‘vital link’ between child health and maternal health that could help attract policy support for both MDG 4 and 5. Overall, it was the PMNCH’s promise to enhance institution-building, shared financing and governance structures and, especially, an integrated health systems approach, that initially made it so attractive to so many within the Safe Motherhood Initiative.

6.3. An unfulfilled promise

Despite the hopeful beginnings discussed above, once the Partnership negotiations developed and efforts got underway to work out the practical implications of its new ‘paradigm,’ a series of practical and conceptual difficulties came to the fore. With these difficulties positive attitudes gradually gave way to scepticism, culminating in widespread doubts about the success and value of the new partnership. For many within the Safe Motherhood Initiative, these developments soon became emblematic of the unfulfilled promise of integration. A number of issues stand out, which I discuss in the subsections below.

6.3.1. Global governance for MNCH

A principal reason why many within the Safe Motherhood Initiative had welcomed the Partnership was, as mentioned above, that it would help overcome challenges relating to perceived weak global-level governance of safe motherhood issues. Around two years after discussions about a partnership had started, however, a general impression that circulated in the broader global health community was that institutional and managerial problems were diverting the Partnership from effectively fulfilling its remit, damaging rather than improving the safe motherhood field’s reputation. As one WHO official observed, “my concern about those things is that strategy is sacrificed for structural considerations, which relates to ‘who’s going to host the secretariat’ and junk like that, which doesn’t really do a whole lot for mothers anywhere.” Others judged

that the PMNCH had not adequately clarified its position relative to the WHO. Another WHO representative even expressed unease that the PMNCH was overstepping its remit by offering technical advice and assistance to countries, even though, in her view, only the WHO has the credibility and mandate to gain direct access to governments at the country level. The WHO's own creation of the Making Pregnancy Safer Department in 2005 can be seen as an effort to position itself as a technical leader in the fields of maternal and newborn health.

There was also evidence of widespread confusion in the wider global health community about the Partnership's specific remit and position within global health governance. For instance, at an 'evidence session' I attended in November 2007 held as part of a UK House of Commons International Development Committee inquiry into maternal health, members of the committee were evidently perplexed about the multiple actors involved in the field and confused about the difference between the Partnership's mandate and that of its constituent members. Despite partners' efforts to clarify their respective roles, the report from the session concluded that, "it is far from clear to us how the UN divides up responsibility for different aspects of maternal, newborn and child health" (House of Commons International Development Committee 2008). The committee members were particularly disquieted by the fact that the WHO had two separate departments working on women's health, Making Pregnancy Safer and Reproductive Health and Research, and bewildered about the role of these departments relative to that of the PMNCH (*ibid.*). In conclusion, the report asserted that, "the overlapping remits between agencies has contributed to a lack of confidence in the UN as a global leader" (*ibid.*: 25).

Another area of contention concerned the Partnership's performance on its promise to enhance participation by low-income country actors in global-level health policy debates. Despite good intentions, it was external donors, rather than countries, whose position had been the most clearly strengthened within the PMNCH. Bilateral donor agencies including USAID (who had been excluded from the original IAG) and private foundations, such as the Gates Foundation, had not only been granted full membership as constituents within the PMNCH, but also prominent positions within its governing body, the Board. It is telling that the number of 'partner countries' listed on the Partnership's member list in early 2009 was 13, while 12 separate bilateral and private donors featured on the

list of 'donors and foundations.'²⁰ This prominent position of external donors signalled an important shift for the safe motherhood community, which had deliberately restricted donor membership of the IAG, in large part to protect its work from undue constraints imposed by donors hostile to women's rights. While the PMNCH enhanced direct contact with donor bodies and promised to improve donor contribution to maternal health, it also signalled a potential lack of autonomy, a theme I will develop below.

6.3.2. Continued elitism

The ability of the Partnership to address earlier concerns about elitism in policy decision-making also appears to have fallen short of expectations. While the Partnership underwent major expansion in membership – from an initial 80 member organisations in 2005 to 240 members by 2008²¹ – simple enrolment concealed a widespread perception that the Partnership had done little to address the concentration of power within a small group. “From what I understand, all the meetings that have been held so far – the high-level meetings – are kind of elitist,” commented one international NGO representative. “Even though they want to have these working groups, I don't think that there's an attempt by the Partnership to open up the groups and invite people in from different organisations that were not part of this elitist group before. I don't know what has happened with that.”

Academics I interviewed expressed a similar verdict. While on some levels welcoming the opportunity to participate in more policy-oriented work, many had very quickly become disillusioned with the Partnership's institutional mechanisms, and especially with what they perceived to be constant in-fighting and posturing during committee meetings. One academic was especially critical, alleging that the Partnership, despite its formal consultative processes, was failing to foster a sense of common purpose: “I have not talked to anybody where he or she got shining eyes when they talked about the global Partnership and where I felt ‘oh yeah, that's something new, something big, something strong where we really get together’.” Another even dismissed the Partnership as “completely

²⁰ The partner countries were: Bangladesh; Bolivia; Chile; Cambodia; Ethiopia; India; Indonesia; Mozambique; Nepal; Nigeria; Pakistan; Tanzania; and Uganda. (http://www.who.int/pmnch/about/members/devcountryconstituency_list/en/index.html, accessed 17.03.09).

²¹ <http://www.who.int/pmnch/about/en/>, accessed 27.05.08.

ineffective,” and said that she no longer planned to attend its regular meetings in Geneva. For those who had been part of the IAG, including UN agency officials, the problem was slightly different, said one original member:

It was so much easier when it was 10 members...when you have a small, dedicated, determined group that is working toward a common goal, every person feels responsibility and when you get beyond whatever the number is, I know 10 is still inside that number, when you get 50, 60, 80, you say I'm too busy, she'll do it, I'll wait, something'll happen. But when the group was that small, it was personal and everyone did their part. There was serious, absolute determination, personally and institutionally, among those 10.

Several other original IAG members made similar comments, suggesting that while the Partnership represented a necessary change, its much-expanded membership was actually translating into a loss of momentum.

6.3.3. The last of the trio

Underlying the expressions of disengagement or de-motivation reviewed above was a real sense of dissatisfaction that *true* ‘partnership’ – in the sense of mutual support and collaboration between different groups – remained a pipe dream despite the formal alliance that had been created. “Today people call these [things] partnerships, [but] it is the same thing that we had before but now we call it something different,” complained one academic. Other interviews and meetings I attended evoked a clear sense that the PMNCH was failing to resolve pre-existing turf battles over positions and influence between the maternal, child and neonatal health factions. As one NGO representative remarked on the basis of her experience of participating in one of the Partnership’s working groups:

It was sort of my hope that people would come in to these working groups with a new approach of integration and collaboration and, you know, together we can do more than each of us saying that, ‘we’re the child survival people’ or ‘we’re the neonatal people’ or ‘we’re the Safe Motherhood people.’ So, it’s very disheartening. I’m of the mind that we can all work together, we *do* want the same thing, but people’s egos are very wrapped up into it sadly.

Thus, as the twentieth anniversary of the Safe Motherhood Initiative’s creation approached, the sorts of insecurities that the movement had confronted on its own in the 1990s came to be projected onto the new partnership framework in which the movement now operated.

Evidence of maternal health's marginalisation in favour of child and, now, neonatal health was found in donors' behaviour towards the Partnership too. Up to two years after the launch of the Partnership maternal health specialists still felt that donors were reluctant to fund the maternal health-related activities. "We are the last of the trio. We are the last for funding from Gates," was one of my informants' comments. Despite donors' ostensible support for integration and for the continuum of care approach, informants directed me to evidence that many of the major donors indeed continued to favour child health and even neonatal health over maternal health or a combined approach. A UNFPA official offered two examples: first, a \$25 million investment by the Gates Foundation for child health programmes in Africa, and, second, a 'Global Business Plan' devised by the Norwegian Prime Minister to accelerate progress towards MDG 4 on child survival. As my informant saw it, these initiatives exemplified a more general lack of donor interest in maternal health, despite stated commitment to integrated approaches:

We are fighting for it [to be integrated], but the Gates funding was for child survival in Africa, the Prime Minister of Norway was for child survival and nobody else has come to the Partnership and said, 'we want to give you some funding,' we would love to have a foundation or somebody say, 'here is \$300 million for following maternal health,' and then in this case we would say, 'look, it cannot be only for maternal health, it has to cover the newborn and the child [too].' But, we don't have this. Nobody says that they want to give us money.

Although safe motherhood advocates within the Partnership were eventually successful in persuading donors to direct their funding towards maternal as well as child health, their disappointment with donors' behaviour was compounded by a perception that child health advocates within the initiative were doing little to dissuade from silo approaches to funding. Instead, a number of safe motherhood practitioners I interviewed accused their child health counterparts of using the Partnership to further their own position at the expense of the safe motherhood community.

Such perceptions suggest that for all the rhetoric on integration, partnership building was not resolving underlying and entrenched power differentials between the child and maternal health subfields. As one researcher put it, "when brought together with a child health group, [we] have always been poor relatives - that's too negative a term - always the less substantiated and less

well supported group...and the same is true in the Partnership. In the Partnership...the child's place is very strong and very powerful." She even suggested that child health experts resented having to share their resources with their poorer "relatives":

You know, I've even seen terminology, I've seen emails that probably shouldn't come to me that talk about the 'elephant in the room,' which, you know, in some ways summarises some people's perspectives of maternal [health]. I have certainly seen with some of the partners, not all, but some of the partners...that there is this attitude that 'we don't have the evidence for maternal interventions but we just have to do it.' It's recent and it's strong, there's no question and I'm not going to name names, but there are several key members – donors – within the Partnership who have, implicitly, if not explicitly, stated that point of view.

This quote highlights a pervasive view within the safe motherhood community that not only did the child survival field, being stronger, not *need* integration to survive (in the way the Safe Motherhood Initiative did), but, furthermore, that donors were only paying lip-service to maternal health, in part to demonstrate compliance with the Paris Declaration.

6.3.4. Bias against the complexity of maternal health

Safe motherhood practitioners often cited the kind of skewed donor behaviour described above as evidence of what one informant labelled "the prejudice against the complexity of maternal health." Despite the strong emphasis in Partnership advocacy materials on the continuum of care, many informants felt that in reality both donors and child and neonatal health specialists lacked genuine commitment towards the health systems recommendations they themselves considered essential for improving maternal survival, including skilled birth attendants and emergency obstetric care. Pointing to their experiences of the Partnership's committees and meetings, informants reported that child health experts still focused primarily on low-tech, community-based services directed at saving children and newborns, rather than incorporating attention to the more sophisticated services needed to reduce maternal mortality. Maternal health specialists had welcomed the focus on integration between levels of care and different stages of the life cycle implied by the continuum of care paradigm. They were therefore particularly dismayed that many influential child health experts within the PMNCH spoke about the continuum in terms of 'packages' of

disease-specific interventions rather than a truly integrated approach. Child health experts, they claimed, interpret 'integration' to mean parallel implementation of discrete interventions to facilitate their implementation 'at scale' (i.e. achieving population level-coverage), so as rapidly to achieve measurable health targets. Moreover, they alleged that child health experts pay little attention to cross-cutting issues such as the need for a functioning referral system and an adequate and sustainable workforce. As such, there was a sense in which working out what was meant by a continuum of care exposed different 'philosophical' approaches to health improvement. In other words, the tension between selective and comprehensive approaches that had divided the child and maternal health communities in the mid-1980s remained a main faultline within the Partnership too.

However, it was not only philosophical differences that were at stake, but also discomfort among certain safe motherhood specialists about the pressure they perceived from child and newborn health specialists to identify 'magic bullet' or 'innovative' solutions to maternal mortality and to reconsider low-tech, community-based public health solutions, including TBA-training, which research had indicated could be of benefit to child and newborn survival goals. Such pressure was seen as a clear indication of the child health's community limited support for a true continuum of care. One academic was particularly disappointed with the response at a Partnership meeting to her suggestion that policy materials on the continuum of care should explicitly emphasise the importance of skilled birth attendants: "I immediately received quite negative feedback from the neonatal and child people, saying that, 'yes of course you need a skilled attendant but it's a long-term initiative. We need short-term intermediate solutions.' And that's again another thing that came up in the meeting repeatedly. And I'm uneasy with that claim." Others too lamented that child health specialists advocated for more attention and research into drug-based treatments for obstetric complications like haemorrhage and infection to be dispensed by TBAs, but did not back safe motherhood advocates' calls for professional providers and facility-based services. Thus, while not disputing the theoretical effectiveness of certain community-based solutions, maternal health specialists expressed discontent that pressure to find simpler solutions diverted focus, yet again, from the need for long-term, sustained strengthening of health

systems, including improved capacity to deliver life-saving, facility-based care by professional providers. An academic researcher explained this tension:

I mean, I think of myself as being pretty balanced on this issue and that I am interested in both outcomes [maternal and neonatal mortality], but I find myself reacting to the newborn people. I have heard [one advocate], who is like Mr. Neonate, say, 'you know, blah, blah, blah, skilled attendance in countries like Bangladesh where there aren't enough providers and this, that and the other, there are things that we could be doing right now in the home to save newborns.' And you know, and this is the expression that sets me off: 'yes, we need skilled attendance, but in the *meantime*...' And that sentence just sets me off, because what 'in the meantime' means to a policy-maker is 'do nothing.'

As this quote shows, my informant felt that certain newborn health advocates were not adequately sensitive to the way in which the call for selective, interim maternal health solutions risks sidelining attention to long-term requirements.

The findings above highlight that it was not uncommon for my informants to claim that child health specialists lacked commitment to the integration project. However, others nuanced such views by suggesting that child health experts' pressure on the maternal health field to define interim solutions to accelerate maternal mortality reduction resulted not from inherent lack of commitment, but rather from their lack of adequate historical familiarity with the Safe Motherhood Initiative's enduring struggle to achieve support for health systems recommendations. One academic researcher had become convinced that better communication between maternal and child health partners is needed to dissipate the sort of tensions described above. She recalled an incident, an early Partnership meeting at which a child health specialist had made a "controversial" suggestion that antibiotics distributed by lay health workers may provide a solution to maternal mortality in countries without functioning health systems. My informant described how she successfully persuaded her colleague to be more sensitive about how he presents such alternative policy options to donors, so as not to weaken safe motherhood advocacy on the need for professional obstetric care and functioning systems:

We had dinner with him then, that same night and I think he realised – he hadn't ever been part of the discussion in safe motherhood – and all of a sudden he realised that by making these statements he was *undermining* a movement. I mean, he's a clinician himself, he *knows* that some women need a caesarean

section to save their lives. He knows that. And to him that's such a given, that he is only thinking of other strategies. But the danger with donors...and the donors that were there... [An official] from USAID was again arguing her case very strongly that there are limited resources and they need to know where to put their money. So if TBAs can make a difference, they want to know that. So [the child health specialist] who had been very controversial the first day, the second day was all of a sudden much more nuanced. And said clearly that *of course* you need emergency obstetric care and you need midwives. And *then in addition* [you can have community-based solutions]. I He was instrumental, if you like, in all of a sudden removing some of the tension...and I don't quite know where all of a sudden...we spent an evening with him, I told him about an anecdote...I think in a way the anecdote did it. I told him about the caesarean section we had done in a town in the North of Chad where there is *nothing*, you know. You are not going to train community health workers there. Your first thing is to make sure there is a hospital that can do [c-sections].

While this particular example suggests that improved communication can resolve some of the tension between maternal and child health specialists, the most pervasive view among my informants was that the differences in the respective subfields' philosophies and approaches were so profound as to be nearly intractable. On the whole, there was thus considerable unease within the safe motherhood community that the new Partnership, or even its 'continuum of care' approach, was not enough to enhance political support for the health system recommendations on EmOC and skilled birth attendants, and, in some cases, might even be undermining it – even if unintentionally so.

6.3.5. Undermining the struggle for women's rights

Compounding the concerns discussed above was profound unease among a subset of maternal health specialists, primarily informants from NGOs, that integrating safe motherhood with child and neonatal survival was having the unfortunate effect of weakening support for reproductive and sexual health and rights.

Although, the Safe Motherhood Initiative had taken a strategic decision to distance itself from the controversy that had erupted around reproductive health activists' demands for abortion in the 1990s (see Chapter 5), the majority of safe motherhood specialists supported the ideological basis of the reproductive health movement. It was therefore with dismay that they observed that certain members of the Partnership, especially newborn health advocates

were contributing to the marginalisation of reproductive health. For instance, one advocacy specialist noted that newborn health advocates “consciously or unconsciously use some of the same language that anti-abortionists use” when promoting specific policy initiatives to save the lives of unborn children from stillbirths and neonatal complications. She saw this as potentially implying a pro-life stance that is in conflict with most safe motherhood practitioners’ pro-choice position. Such perceptions led one informant to conclude our discussion on the Partnership as such: “I’m inclined to think that people have gone for this new approach because newborns are something that everyone coos over and it may be a way to kick-start new political will and get more money into the field. But I think there are risks that one ought to be aware of.”

The perceived danger of newborn health advocates’ language-use was particularly acute because conservative opposition to women’s reproductive rights, and especially access to abortion, had intensified with the appointment of US President George W. Bush in 2001 (Standing 2002; Crossette 2005). On his first day in office, Bush reinstated the 1984 Mexico City Policy prohibiting the allocation of federal funds to organisations doing abortion-related work, a policy that had been rescinded by President Clinton in 1993 (Office of the Press Secretary 2001). Under Bush the policy became known colloquially as the ‘global gag rule,’ indicative of the extent to which reproductive health activities perceived it as a constraint on their work. Within this climate of intensified political opposition to reproductive health, many perceived that the MDG on maternal health was not so much an expression of greater international commitment to maternal health as proof that the international community was renegeing on previous commitments, such as those made at the ICPD in 1994, to secure reproductive and sexual health and rights. According to informants, maternal health replaced reproductive health as a less controversial choice, in part because UN agencies’ wanted to shy away from controversy to achieve global consensus around the MDG framework.

In addition to the above-noted concerns that newborn health advocates may be feeding into anti-abortion attitudes, the new prominence of donors within the Partnership raised the possibility that these donors might punitively withhold or withdraw funding from safe motherhood work that was even marginally associated with abortion, including work on post-abortion care to

prevent deaths from unsafe abortions. USAID's position on the Partnership's Board clearly enhanced the perceived risk of funding restrictions on such work, compounded by the prospect that the Gates Foundation, as a prominent member of the board, may also push the Partnership towards a more socially conservative stance on women's health. To illustrate the reality of such perceived threats, one UNFPA official explained that, despite being part of the Partnership, the agency had already lost its financial support from the US because of its work on unsafe abortion and now feared that other donors, especially the powerful Gates Foundation, would follow suit and withhold funding. "We haven't received a single dollar since Bush," my informant explained, "so, maternal health is linked to women's health and to abortion and some donors are sensitive [to this], even... Gates – Melinda Gates is very religious, you know."

6.4. The need to protect the M in MNCH

The sort of perceptions discussed above in many ways put safe motherhood specialists in a bind. On the one hand, they were committed – institutionally, financially and conceptually – to the process of partnership building that they had initiated. On the other, there was a burgeoning perception that the new Partnership may be disadvantaging, rather than advancing, their position and interests. Fears were clearly rife that safe motherhood – both the advocacy coalition and the cause of women's health and survival through pregnancy and childbirth – was being sidelined within the Partnership. "It's a threat," a UNFPA agent told me. "I would say that we have to fight, to constantly remind people that the Partnership is for MDG 4 *and* 5."

At the time of my research, a range of different responses to this situation could be discerned within the safe motherhood policy community. Some urged vigilance, claiming that disengaging completely from the Partnership structure was unviable. "I don't think there's a choice. It's not like it's an open question, do we stay a part...there's clearly no choice in that sense," said one informant. A minority withheld judgment, urging patience given that the long-term impact of the Partnership had yet to be established. As one informant put it, "maybe we're not going to see the real benefit of this combined partnership until 2012. I don't know. But things don't change over night, so slowly it could

affect programming, I would think.” But the more common response was a self-defensive one, calling for action from safe motherhood advocates to prevent the safe motherhood issue being co-opted by the child and newborn health constituencies. An academic who had become deeply involved in the PMNCH’s committee work was explicit on this point: “We still have a question of ‘where is the M in MNCH’ within the context of the Partnership...So, I think there’s going to continue to need to be a constituency group for the maternal health issue, no question, within the Partnership and outside of it or else it’s just going to be sidelined potentially.”

An identified priority was not only to ensure focus on women relative to children, but also to actively promote policy attention to unpopular health system interventions. As the informant cited above added:

I think we need to make sure, all of us collectively, we need to make sure that the M in MNCH does not get lost. We have to be sure that, because maternal mortality is a longer term intervention and we have to look at issues of human resources and at strengthening health infrastructure, that donors and governments don’t just go for the quick-wins that are easier to do and have a quick impact, but [rather that they] have a commitment to the longer-term interventions.

This was at once a call to assert safe motherhood specialists’ position within the Partnership and to collectively protect policy priorities for safe motherhood from being sidelined.

While many of my informants perceived the need for at least some level of continued involvement with the Partnership, there was also an important subgroup within the safe motherhood field whose frustration with the Partnership was of the extent that they felt pushed to “do their own thing” rather than work within the partnership structure. This was especially the case among certain NGOs and UN agency representatives I interviewed and was a perspective that was discernable in the discussions at several international meetings I attended. Consequently, by 2007, barely two years after the Partnership’s launch at the UN General Assembly, frustration translated into a series of practices to protect the status of maternal health and mortality as a dedicated policy issue, over and above its association with newborn and child health. Such practices, which I describe in brief below, can be seen as a renewal

of the Initiative's self-management, aimed to stake out a specific space for safe motherhood on the international policy agenda.

6.4.1. A Global Fund for safe motherhood?

One example of an effort to reposition safe motherhood as a global priority independent of the PMNCH can be seen in an initiative led by UNFPA – an important member of the original IAG and also of the PMNCH – to form a dedicated 'thematic trust fund' for maternal health. Clearly modelled on the Global Fund and others like it, one of its architects described the fund as follows:

It is an appeal to donors on a certain topic and it says, 'this is what we want to do, this is what countries need to do, this is the strategy that we plan to use, please give us the financial support, we have the roadmaps for the countries for maternal health, we have the strategy, we know and they know what to do they only lack the money'.

While evidently designed to challenge donor preference for child health, the creation of such a thematic fund for maternal health alone was plainly in tension with the Partnership's pledge to align donor resources to maternal, newborn and child health. While a rational response to perceived funding shortfalls, the creation of the fund can be seen as a development that contributes to proliferating, rather than rationalising, donor initiatives, as such contradicting core elements of the Paris Declaration. It also marks a departure from past framings of safe motherhood. Whereas earlier advocates often insisted that funding was not the major impediment to achieving maternal health (rather it was organisational and managerial parameters in the health system), now advocacy specialists framed 'funding gaps' as the main constraint for achieving MDG 5.

In the same thrust as the creation of a maternal health fund, maternal health advocates from across UN agencies and prominent international NGOs in 2007 initiated a major advocacy campaign to coincide with the establishment of the thematic fund. On many levels, this campaign was informed by Shiffman's (2003; 2004; 2007) policy analysis of the factors that create political priority for different global health issues, an analysis that had been disseminated widely within the safe motherhood policy community. Shiffman's emphasis on the importance of clear messages, consensus and focusing events as ingredients of

successful public positioning was taken up by advocates trying to generate renewed support for safe motherhood as a priority issue. This campaign drew in expertise from UN agency representatives with experience from the Global Fund, as well as advocacy experts from other major global campaigns (including the Jubilee 2000 campaign for debt cancellation for poor countries). It aimed to emulate other successful global health campaigns, like the one that culminated in the creation of the Global Fund, in part by organising a series of ‘focusing events’ to promote a clear vision. As one member of the group who was involved in organising these events explained:

We are developing a very intense and very well crafted advocacy plan which starts around creating an advocacy platform to launch the Global Business Plan at the end of September, continues with the Women Deliver [Conference] where you incur it, and hopefully then use Davos and the G8 next June as the goalposts. And if it can be articulated and things go well, by the time Japan [the G8 summit] happens next year we’ll have recreated the process that led to the creation of the Global Fund.

In order to recreate, as my informant put it, for maternal health what the HIV/AIDS, TB and malaria fields had achieved with the Global Fund, the new campaign had to “position this product [safe motherhood] as an opportunity of desire so people will want to invest in it.” This statement – with its use of the words ‘position’ and ‘product,’ suggestive of the promotion of goods within a particular global health ‘market’ – is itself indicative of how well established the perceived necessity of appealing to the market-orientation of donors had become. But it also reveals that advocates sought to define safe motherhood as a product separate from what the Partnership was offering. As such, the principal aim of the main focusing events that were organised as part of this campaign was not to promote the PMNCH’s messages on integration and harmonisation, or to market its continuum of care approach as ‘global best practice.’ Instead, the aim was to position *maternal* health, rather than ‘MNCH,’ as a global priority.

The Women Deliver Conference (referred to in the quote above) was the main focusing event associated with this new campaign. The event, which I attended as both a participant and observer, drew almost 2000 delegates to London in October 2007. Although the conference was timed to coincide with the twentieth anniversary of the first Safe Motherhood Conference, ‘Women Deliver,’ rather than ‘Safe Motherhood’ was chosen as the title. This choice was

an intentional attempt to get away from the term safe motherhood, which advocacy specialists felt had been tainted by the field's difficult history and by its negative connotations with women's death. Instead, as one of the organisers explained during an interview, the term 'women deliver' was intended to draw attention to the fact that "women deliver so much more than babies." In part, such a refocusing intended to reassert women's health as a policy objective distinct from children's survival. But this was not a case of returning to the feminist and social justice premise that had formed the ideological foundations of the Safe Motherhood Initiative in the late 1980s. Subgroups within the safe motherhood and reproductive health policy communities used the conference to advocate for action on maternal mortality as a matter of human rights, but the predominant message that was promoted was that investing in women's health and survival makes *economic* sense. As the conference slogan had it – "invest in women – it pays."

To this end, the word 'deliver' was chosen for its double meaning, invoking at once women's role in delivering babies and their contribution to economic productivity. As such, it was an effort to appeal not only to public health rationales, but also to economic and poverty-reduction justifications for investment in health that in the past ten to fifteen years have emerged as an important part of the global health discourse (Standing 2002; McIntyre et al. 2006). Indeed, at Women Deliver, technical public health justifications were downscaled in favour of economic arguments. As such, earlier advocacy for the 1997 Action Points and for EmOC (see Chapter 5) were simply replaced with yet another branding of the recommended policy solutions: the "three pillars to save women's lives" (family planning, skilled birth attendance and emergency obstetric care). These pillars were presented as a global consensus, but surprisingly little mention was made of how they related to the continuum of care approach (Women Deliver 2007). The priority was clearly on forging economic rationales for donors and governments to invest in maternal health.

To this end, advocates adopted and adapted claims that had been successful in framing HIV/AIDS as a poverty-related issue, notably arguments about the impoverishing catastrophic expenditure of treatment and of the productivity costs of deaths and morbidity (see Gill et al. 2007). At the conference, safe motherhood advocates now argued that the international

community should prioritise women's health (as distinct from MNCH) in order to achieve *all* the MDGs, including the primary goal of ending poverty. Maternal health should be a priority not only for the sake of women, but also for the sake of the survival of their children, communities and the economic productivity of countries. In Chapter 8 I discuss how advocacy groups used scientific and economic data to bring about such shifts in emphasis. What is most important here is to highlight that the organisers of Women Deliver did not as much advocate for maternal, newborn and child health as an integrated set of objectives as seek to position *maternal* health as the fulcrum of efforts to achieve not only MDG 5 on maternal health, but also *all* the other MDGs.

6.5. Conclusion

In 2005, the Safe Motherhood Inter-Agency Group initiated the process of partnership formation to save itself, given a growing perception that as a single-issue movement it could not survive within the highly competitive global health field. Once again, however, the principal effect was that this new operational context provided the means for it to also reinvent itself in ways that safe motherhood practitioners might not have been able to predict. In part, the safe motherhood community embraced its partnership with old and new competitors out of necessity. However, as the PMNCH became established, unequal power relationships, donors' limited commitment to integration and different interpretations of what a 'continuum of care' entails impeded effective collaboration, as well as the development of an integrated policy agenda. The culmination of these factors resulted in a shift in maternal health experts' responses from embracing the Partnership's promise to resolve core anxieties within the field, to deep ambivalence and reservations, followed by efforts to protect the institutional and intellectual interests of the safe motherhood policy and research network. By 2007, what had started barely two years earlier as an effort to rationalise donor spending and integrate public health approaches had thus given rise to an intensified effort to single out maternal health as a priority for investment over and above joint advocacy for maternal, newborn and child health. It even culminated in the creation of a dedicated funding mechanism modelled on the Global Fund. And in order to achieve this, the importance of neonatal and child health were not rejected so much as assimilated into the core

justification for why maternal health strategies should be at the heart of global health priorities.

In conjunction with the previous chapter, the dynamics explored here thus give us a better sense of the nature of global health movements, and in particular, the complexities involved in developing and maintaining advocacy coalitions between actors with different belief systems and histories. As others have shown in studies of the policy process, the extent and structure of interdependency between actors are important determinants of their behaviour within all such inter-organisational relationships (Fenger and Klok 2001; Walt et al. 2004). Fenger and Klok (2001) differentiate between symbiotic and competitive interdependency, which variably incline actors towards cooperation and drive them apart, leading to conflict. Both of these tendencies were apparent at different times in the relationship between the coalitions that came together in the Partnership. However, competitive tensions elicited protective responses from the safe motherhood contingent, the speed and intensity of which were no doubt informed by the movement's enduring struggle to assert itself, including its previous experience of seeing maternal health subordinated to child health. Ironically, however, safe motherhood practitioners' self-defensive practices may accentuate the kind of fragmentation to global health governance, financing and policy solutions that the Partnership was intended to reverse.

The findings discussed in this chapter highlight the urgency of a critical debate about what is actually meant by terms such as 'integration' and 'partnership' within global health discourse. 'Partnership' is currently a buzzword in the global health field that has even been enshrined within the MDGs, with MDG 8 being to develop a global partnership for development, consisting not only of greater collaboration across the global North and South, but also partnerships with private companies to ensure access to drugs, for instance (United Nations 2009). The rise of public-private partnerships, another term for global health initiatives, has been depicted as "a trend with no alternative" (Richter 2004:43). Nevertheless, there has as yet been little conceptual or empirical discussion about what is meant by 'partnership,' how such partnerships are best configured or who stands to benefit from new institutional arrangements, and under what conditions. Similarly the meaning of 'integration' in the context of global health policy debates is not straightforward. Integration

can refer to policy, governance, financing strategies, research, advocacy and actual implementation of health services. Each level clearly poses a series of distinct, but inter-related challenges (Lush et al. 1999; Mayhew et al. 2000; Sundewall et al. 2009). Further critical debate of these issues is essential to avoid that the processes and benefits of partnership and integration are taken as axiomatic. As one informant put it, “who can be against integration?”

There is another connection worth drawing with the previous chapter. Like the effort to define EmOC as the strategic focus for safe motherhood policy and advocacy (discussed in Chapter 5), the process of partnership formation and the resultant practices described above can be thought of more profoundly as part of the safe motherhood field’s continuous work of self-management. Safe motherhood practitioners first loosened the boundaries around their policy community and then attempted to redraw them. Through such ‘boundary work’ they sought to demarcate maternal health as a distinct priority, and thereby prevent their policy objectives from being subsumed by the child and newborn health goals. Safe motherhood practitioners sought to position themselves in a more favourable position within the broader competition for global health resources in ways that sought to adhere to its original ideological foundations, but which inevitably entailed a not always entirely conscious reformulation of those. In the next two empirical chapters (which comprise *Part II* of the thesis) I take this analysis to a different level, by demonstrating how within these broader social and political developments, key actors (focusing on academics and advocacy specialists) have relied on the authority of scientific evidence, including statistics, to assist in this process of self-management.

Part II

7. ACADEMIC RESEARCH PRACTICES AND THE GLOBAL POLITICS OF EVIDENCE

Public health researchers, especially those based in universities in high-income countries, have come to play a crucial role within global health initiatives. Today, such academics lead scientific research on global health issues, collaborate with research groups in low-income countries and are, increasingly, consulted for technical advice by international agencies, donors and policy-makers (e.g. Macfarlane et al. 2008; McCoy et al. 2008). Meanwhile, their involvement in global health initiatives exposes them to a new set of social and political pressures, as they are also held accountable not only to the institutional and scientific demands of academia, but also to the exigencies of global health initiatives, as well as those who fund them. The prominence of academics' participation within global health initiatives in part reflects the expansion of the evidence-based movement from its origins in clinical medicine into public health research and policy, where it has introduced normative ideas about what constitutes rigorous scientific evidence (Dobrow et al. 2004; Lambert et al. 2006). Donor agendas mirror the evidence-based paradigm, such that today, evidence-based claims derived from systematic research play an important role in global health initiatives' competition for global resources and policy attention.

There has been growing concern, however, that the current global health research agenda is driven by a research culture and incentive system that does not value the kind of research that is needed to improve policy and practice in low-income countries, namely operationally-oriented health systems and policy research (Lavis et al. 2004; Travis et al. 2004; Sanders and Haines 2006). For instance, academics in high-income countries – who dominate global health research – have been said to lack the inclination, incentives and skills to conduct the sort of research that developing countries need (McCoy et al. 2008:1056). Despite such concerns, there has been relatively little attention paid to how academics themselves are experiencing and negotiating their position within global health policy and politics, or the consequences for research itself. With the

rise of the evidence-based medicine paradigm and its expansion into the policy sphere, academics are not only expected to produce a certain kind of research, but also to interpret their findings, discern the policy relevance of scientific evidence, issue recommendations and publicly endorse and advocate global 'best practice' recommendations issued by international agencies (Walt 1994; Davis and Howden-Chapman 1996; Lavis et al. 2002). Such potentially competing demands often place academics in a difficult position.

The academic subspecialty that has, since the late 1980s, emerged around an interest in maternal health in developing countries provides an interesting case of a field that has had to adapt to the changing ideas within global health about the nature and role of evidence and, notably, the expectation that a particular and narrowly defined type of evidence is needed to justify policy. The maternal health subfield is interesting because it has been particularly difficult to produce the sort of evidence that is highly valued within the hierarchy of evidence about maternal health in developing countries, and there is a widespread perception among actors within the field that such difficulties have translated into neglect of maternal health in the global health arena (Béahgue and Storeng 2008).

As academics' roles have changed, old questions about the nature of their responsibility have re-emerged and taken on new forms. Are they equally committed to public health action as they are to public health science, for example (Weed and McKeown 2003)? Is their responsibility constrained to their professional practice within the academic domain, or do they bear responsibility to respond to the growing demand for their participation in the advocacy of specific policy options (Krieger 1999)? In this chapter I argue that, for academics navigating through the complex and inter-locking pressures and accountabilities of global health research, answers to these questions are in no way straightforward. By examining both the accounts and research practices of a group of academics – primarily epidemiologists specialising in maternal health and working in international research institutes – I argue that these actors in many ways find themselves at an impasse. They are aware of the discrepancy between their research practices – which are driven in part by their aspiration towards a particular standard of evidence and demand for 'evidence-based' and ostensibly globally relevant knowledge – and the actual research needs of countries grappling with high maternal mortality, but they also find that they lack

the independence, and perhaps confidence, needed to resolve this discrepancy. This, in turn, is shaping the way in which they respond to the challenges of improving maternal health through research.

7.1. Trends in international maternal health research

In the late 1980s an academic subfield of maternal health was established in direct response to the then newly formed Safe Motherhood Initiative. As one UN agency advisor I interviewed recalled, the first Safe Motherhood Conference in 1987, “was a meeting of real country people, of researchers and donors – because we wanted to know, is it a problem, what’s the dimension of the problem and how are we going to pay to do something about it? That’s who we wanted in the room and that’s who came.” As it drew together researchers primarily with training in epidemiology and often with clinical experience, this subfield gradually established itself in reputable international schools of public health, including the LSHTM in the UK, and the public health schools of Johns Hopkins University in Baltimore and Columbia University in New York, USA. In the early years of the subfield, newly formed academic units worked in collaboration with technical advisors from multilateral agencies and existing research-based NGOs in the population and family planning field (such as Population Council). Over time, this network expanded considerably, incorporating research institutions from across the globe, including from developing countries who became essential partners in international institutions’ research, though not always on equal terms (McCoy et al. 2008).

The research practices of international academics have undergone important shifts during the Safe Motherhood Initiative’s twenty year-long history. Though always tied in with the demands of the broader Safe Motherhood Initiative of which they are part, academics specialising in maternal health have, as mentioned in the introduction, become increasingly implicated in global health politics and competition for resources and dependent on external financing to sustain their livelihoods. As part of the process to secure financing and priority for the Safe Motherhood Initiative of which they are part, they are inclined to contribute to endorsing and promoting international policy messages. These developments have impacted on their research practices, as the following three subsections serve to illustrate. These provide a brief overview of trends in

international maternal health research, starting with a discussion of maternal mortality measurement and health systems research and tracing the influence of the evidence-based medicine movement on public health research practices.

7.1.1. Maternal mortality measurement

From the start, a main priority for the new maternal health subfield was to build up a global picture of the state of maternal health and maternity services in low-income countries, since little was known about the epidemiology of pregnancy-related ill health and death outside of the industrialised west. A handful of small studies conducted in hospitals and clinics in sub-Saharan Africa from the late 1970s onwards revealed high case-fatality rates in clinical settings (e.g. Bullough 1981), but the extent of maternal mortality in the general population remained undocumented in many countries, especially in the world's poorest countries. This was a reflection of the fact that most low- and middle-income countries lacked adequate hospital information systems and systems for registering vital events and that the majority of deliveries, at least in the poorest countries, occurred outside of the formal health system (AbouZahr 2003; AbouZahr and Boerma 2005).

Owing to poor data sources from which to derive mortality statistics, the first global maternal mortality estimates published by the WHO in 1986 were produced in large part on the basis of mathematical modelling (Lopez et al. 2007). An early priority for academics was therefore to refine measurement techniques by improving the classification of maternal mortality and by developing indirect methods for estimating population-level maternal mortality through surveys, thereby bypassing the lack of population-level vital registration data (Campbell and Graham 1990).²² This early interest in improving measurement techniques was politically, as well as scientifically, motivated. Academics I interviewed recalled their assumption that more accurate and valid

²² The best known of these methodological developments was the 'sisterhood method,' an indirect technique for deriving population-based estimates of maternal mortality that asks adults during a census or survey about deaths during pregnancy and childbirth among their adult sisters (Graham et al. 1989). Because maternal mortality is a relatively rare outcome on a population level, such indirect methods require huge sample sizes to capture maternal deaths, making them both expensive and labour intensive. The intention was therefore that, with time, such surveys would be replaced with routine health surveillance systems that would enable countries to collect data on maternal mortality for use in planning and evaluation of safe motherhood programmes (Graham 2002).

measures were necessary for raising international awareness of and commitment to safe motherhood. As one prominent epidemiologist recalled:

At the time we started to move...it was always measurement, that was always the focus. It was always the belief that part of the problem was in measurement bottlenecks and generally feeling that by improving indicators and measurement techniques that we would help to address part of the problem. So the problem was neglected because there wasn't enough information, there wasn't enough information, so it was all a vicious circle. So it started with a very measurement focus.

Such ideas about the importance of measurement have also been elaborated in a 1992 article in *Social Science & Medicine*, in which the authors posit that women's health had been largely ignored in international health because of a "measurement trap," in which lack of data and lack of attention to the issue were "trapped" in a negative feedback loop (Graham and Campbell 1992).

Although maternal mortality measurement was considered important for global-level advocacy, my informants recalled that maternal health academics quite quickly came to a consensus that the expense and logistical challenges of measuring maternal deaths through large surveys were not justified and that the resources could better be spent on other research or on public health programmes. Indeed, by the early 1990s, many research groups thought that measuring maternal mortality "was pretty much impossible and definitely not an efficient use of resources" (Graham 2002:701). Research attention subsequently shifted towards the development and refinement of other sorts of epidemiological indicators for assessing the extent of pregnancy-related ill health and death and to evaluate clinical and public health interventions. First, indicators of severe or 'near-miss' morbidity were proposed as proxies for maternal death (Filippi et al. 1998). Researchers considered such indicators useful for drawing attention to the fact that maternal mortality only captured a small proportion of pregnancy-related suffering (Fortney and Smith 1996), but also for exploring risk factors for maternal mortality (given that severe morbidity from complications are on the 'causal path' of maternal death). At the time, many considered severe obstetric morbidity a more feasible outcome measure than maternal mortality because morbidity occurs more frequently than maternal death and can therefore more easily be measured in clinical settings. Since severe morbidity is closely related to maternal mortality it was assumed that being able

to detect a change in morbidity in response to an intervention signalled also a reduction in maternal mortality (see Goodburn 2002).

Second, some researchers proposed that ‘process indicators’ – quantitative indicators of the availability, access to and quality of different healthcare services – could be an alternative to health outcome indicators in the evaluation of healthcare services. This proposal was justified by the close link that was assumed to exist between the ‘process’ of providing certain services – notably the different elements of emergency obstetric care – and maternal mortality indicators. The advantage of such process indicators was that they were either available from existing recording systems at health facilities or incorporated into routine health information systems, and were thus cheaper and simpler to collect than maternal mortality data (Goodburn 2002). As such, although researchers recognised the political value of mortality data, their work was pragmatically oriented towards developing feasible measurement techniques that could help inform and evaluate programmatic practice.

7.1.2. Health systems research

Although measurement and refinement of indicators was clearly an early research priority for the safe motherhood field, it is important to note that *context-specific* research to understand the circumstances around implementation of clinical interventions in diverse healthcare settings was initially considered of equal importance. Indeed, in his 1987 Call to Action on Safe Motherhood, Halfdan Mahler (then Director-General of the WHO), was explicit that “health systems research” was needed in order to put existing clinical knowledge about pregnancy and delivery – derived mostly from Western countries – into practice within actual health systems in low- and middle-income countries:

If we are effectively to apply existing knowledge in a wide range of different conditions, much further research is essential. In each country’s circumstances the particular pattern of preventable causes of maternal deaths must be clarified, and the potentials for improvement in that country’s own context must be identified. Health systems research (operational research, as it is sometimes termed) is essential to the evaluation of feasibility and effectiveness of many recent ideas and technologies (1987b:669).

In the early 1990s, academics responded to Mahler’s call for health systems research by conducting comparative analyses of programmatic

experiences in different countries and by developing methodological tools to help countries design and evaluate their specific healthcare delivery systems (e.g. Maine 1991). Campbell and Koblinsky (1995), for instance, proposed an assessment tool for defining the data sources that countries would need to design and evaluate programmes. This entailed a number of steps in any given country: first, gaining an overview of health policy relevant to maternal health; second, assessing the magnitude and causes of maternal mortality and morbidity, and the characteristics of groups at particular risk; and third, assessing the available inputs, both in terms of services (access, quality, providers, what is provided at various tiers, etc.) and in terms of the culture and existing resources and groups (*ibid.*). The same authors later elaborated an approach to research that aimed to define different models of organising delivery care for countries with different epidemiological profiles and health system capabilities (Koblinsky et al. 1999). In other words, the focus was on identifying solutions adapted to each country's health system and political-economic context.²³

A cross-cutting feature of this early research was its methodological diversity. Research drew on epidemiological and clinical approaches, but also on qualitative investigations, sociology, history, and case study approaches, despite the fact that maternal health academics were predominantly trained in statistical and clinical disciplines, including epidemiology. On one level, these researchers' use of different methods was a practical response to the dearth of data about maternal mortality and morbidity in low-income countries. For instance, due to lack of epidemiological trend data in low-income countries, researchers trying to better understand the mechanisms of population-level mortality decline in such countries turned to historical epidemiological data from Western countries, where maternal mortality statistics had been routinely collected for at least the past hundred years. This included data from countries like Sweden, the US, England and Wales, countries that had achieved very low levels of maternal

²³ Other influential research during this period investigated the various obstacles that households and individuals experience in their quest for life-saving treatment, as captured most explicitly in an article published in 1994, entitled 'Too far to walk' (Thaddeus and Maine 1994). Focusing on the interval between the onset of obstetric complications and the outcomes of such complications, this article sought to show that delayed treatment is a major explanatory variable in many maternal deaths, regardless of underlying risk factors. It put forth the 'three delays' framework to analyse the factors that first, delay the decision to seek care; second, delay arrival at a health facility; and third, delay the provision of adequate care (*ibid.*). Such research helped to direct focus on to the importance on professionalised obstetric care to reduce maternal mortality (see Chapter 5).

mortality by the late 1930s, albeit at different rates. Researchers without specialist training in history innovatively combined such data with social history to try to build up an understanding of the most important medical, professional, social and political factors that could explain the different patterns and rates of mortality decline in these countries (Storeng et al. 2006). On this basis they drew lessons for the contemporary situation in developing countries (De Brouwere et al. 1998; Van Lerberghe and De Brouwere 2001). Similarly, case studies from a number of countries that had achieved substantial maternal mortality reduction more recently, including Malaysia and Sri Lanka, combined a range of methodological approaches to examine the mechanisms of mortality decline at the population level (Koblinsky 2003). As Chapter 5 discussed, in 1997 the IAG mobilised such analyses to justify international policy recommendations on the importance of professionalised obstetric care.

On another level, the methodological diversity of maternal health research reflected that specialists recognised that a range of methods was needed to understand the complex processes involved in maternal mortality decline. Throughout the 1990s experimental research methods became highly valued as the best way of establishing the effectiveness of not only clinical, but also public health interventions. However, maternal health researchers argued that safe motherhood strategies could not easily be evaluated using such methods. Instead, they argued, evaluating such strategies would require a range of methodological inputs, because safe motherhood programmes, including those targeting mortality from direct obstetric complications, necessarily involve all levels of the health care system rather than a single drug or procedure that can more easily be subjected to experimental study. Moreover, since the intended beneficiaries of such complex interventions are communities or populations rather than individuals, researchers argued that it was not only extremely difficult but also unjustifiably expensive to conduct large-scale, experimental evaluation research (see McPake and Koblinsky 2009).

Taking what has been discussed thus far on maternal mortality measurement and health systems research serves to highlight that, by the late 1990s, maternal health research as a definable sub-discipline had come to be characterised by substantial flexibility in its methodological approach. This, I have tried to show, was a response to the recognised complexities and

differences of implementing public health strategies in different contexts and researchers' clear desire to provide knowledge that could be usefully applied in practice. Though motivated by the analytical quest to understand how to reduce maternal mortality and improve maternal health, this research agenda was also responding to the need to make maternal health and mortality more visible within the global health field, and to enhance the position of the Safe Motherhood Initiative. As I now turn to examine, however, as standards have changed in what counts for good and credible knowledge, safe motherhood researchers have become anxious, and have had to respond to the concern that the research they produce is not sufficiently 'evidence-based.'

7.1.3. "Not enough" evidence

With the rise of the evidence-based medicine paradigm as a framework for public health research over the past decade or so, the methodological diversity outlined above has subsided, replaced in large part by an aspiration within the maternal health research community to conduct research using methods that are deemed more 'rigorous' or 'robust'. Such an aspiration reflects that within the evidence-based medicine paradigm, the credibility of research findings has come to be defined principally in terms of the methods used to produce them, rather the findings themselves (Lambert 2006). A 'hierarchy of evidence' places systematic reviews and meta-analyses of experimental or quasi-experimental study designs at its apex. The randomised controlled trial (RCT) is considered the most rigorous study design for evaluating the effectiveness of a single intervention (Sackett et al. 1996; Rychetnik et al. 2004). As the name suggests, the main principle behind the RCT is the random allocation of alternative interventions (usually clinical interventions) to different individual subjects or groups in order to control for confounding factors between treatment groups when establishing the efficacy or effectiveness of healthcare services (Rychetnik et al. 2002). Within the hierarchy of evidence, the RCT is considered to be the 'gold standard' methodology, producing the highest level of evidence (Timmersmans and Berg 2003). In the hierarchy, it is followed by observational study designs such as cohort studies and case control studies, and, at the bottom, by other observational methods such as case studies. Observational epidemiology and qualitative evidence, of the kind that played an important role in the first decade of international maternal

health research, are thus not highly valued within this paradigm (Petticrew and Roberts 2003).

The authority of objective, quantitative, systematic, and transparent knowledge is reinforced by the cultural value and prestige associated with methodological rigour (Inhorn 1995; Lambert and McKeivitt 2002). Moreover, the principles of the evidence-based paradigm have become institutionalised within the academic global health field, with both funding and the most prestigious scientific journals biased towards biomedical research and research that uses experimental study designs, even for questions dealing with public health or policy interventions (Wolff 2001). Such institutional factors are also reinforced by the fact that donors' agendas mirror the evidence-based paradigm, as I show in more detail below. Together, these changing circumstances have created strong institutionalised incentives for researchers to orient their research towards such 'gold standards'.

Within the maternal health academic environment, a principal effect of the gradual entrenchment of the 'hierarchy of evidence' as the guiding framework for assessing the quality of research has been to create anxiety about the field's suboptimal performance relative to other global health subfields. A common narrative has emerged, positing that a poor record of evidence-based policy-making has damaged the Safe Motherhood Initiative's credibility within global health debates as well as prioritisation of maternal health (Béhague and Storeng 2008). Indeed, informants commonly implied that the 'evidence base' on maternal mortality and maternal health intervention strategies is insufficiently well developed to ensure prioritisation of the issue, especially when compared with other global health initiatives. As one informant claimed, "things not getting priority because there's not enough evidence, that's definitely the case in maternal health."

Such anxiety had several dimensions. First, a major issue was the persistent difficulties researchers have encountered in improving measurement of maternal mortality. Informants widely interpreted that lack of valid data on maternal mortality in low-income countries has been a core determinant of the lack of prioritisation of maternal health relative to other health issues. This is a perception that has existed in the field since the 1990s, but that has intensified with the growing reliance on burden of disease data as a shorthand for the

importance of global health problems. It has been further reinforced by the analysis of political scientist Jeremy Shiffman (2003), who has argued that a credible indicator of the magnitude and severity of a problem is a key factor in generating political priority for a specific health issue. More generally, a common perception among my informants was that problems relating to the validity of maternal mortality data and to the sheer difficulty of collecting such data carried through and compromised the validity and credibility of research to evaluate public health strategies, in turn feeding into the neglect of those strategies. As one informant explained:

One of the problems that has plagued the Safe Motherhood Initiative has been the lack of both an easy way to estimate maternal mortality...at the national scale and also the difficulty with evaluation of the programmes, given the difficulty of the maternal mortality indicator. So...I think that [measurement difficulty] really has been a major factor in terms of the difficulties with achieving progress, has been the difficulty measuring it...‘if you can’t measure it, you don’t do it.’ That has been an enormous challenge.

Many felt that such a challenge was particularly acute because of the field’s history of policy shifts, which some informants and researchers in the broader global health community had come to see as epitomising the Safe Motherhood Initiative’s failure to adopt an ‘evidence-based’ approach (Miller et al. 2003). While few informants doubted the value of professional obstetric care as an important aspect of maternal mortality reduction – having been convinced of its value on the basis of clinical, historical and experiential knowledge – many did worry that the quality of existing evidence was of too poor to convince decision-makers. As one UNFPA advisor put it:

We keep repeating the same thing over and over. For example, I keep saying in my advocacy papers that no country has significantly reduced maternal mortality through keeping home deliveries and that all countries that have reduced maternal mortality have done so through institutional deliveries. That’s all we know. We have evidence of that in historical evidence, such as trends, but we don’t have case-control [or randomised studies]...It’s not enough.

Thus, by claiming that the existing evidence on the value of professionalised obstetric care (which is clinical, historical and observational rather than experimental) is “not enough,” my informant was implying that it was not sufficiently *rigorous* to convince the broader global health field to act. Others

implied that the absence of ‘gold standard’ evidence on public health interventions to reduce maternal mortality has been used as an excuse by donors to withhold investment from maternal health in favour of other global health interventions with more incontrovertible evidence of benefit, such as vaccines for children. The production of evidence in maternal health is thus clearly related to the kind of competitive pressures outlined in previous chapters.

7.1.4. In pursuit of the gold standard

Over the past five to ten years, researchers have tried to respond to the kind of anxieties outlined above by orienting their research practices towards the production of more robust evidence. This has entailed a number of things, first of which has been renewed attention to improving maternal mortality measurement so as to better document its magnitude using ‘valid’ and ‘credible’ indicators. To this end, in the early 2000s a prominent maternal health epidemiologist, Wendy Graham, led a morally imbued supplication for investment in measurement research, despite having earlier argued against maternal mortality measurement and in favour of the adoption of broader indicators and outcome measures. In an influential *Lancet* commentary, she argued that improved measurement is essential for meeting the MDGs and for overcoming the “scandal of invisibility” of women dying from pregnancy-related causes without their deaths even being recorded:

We must stop saying this [maternal mortality measurement] cannot be tackled and acknowledge the damage caused so far. We must recognise the risks of continuing to neglect the data needed by poor countries to inform their allocation of scarce resources, and find the funds, the tools, and the opportunities to meet these needs. We must build a sustainable evaluation capacity at the country level and a greater demand for reliable measurement of maternal mortality and severe morbidity (Graham 2002:703).

Graham’s plea, articulated within the discourse of the normative priority-setting approach incorporating burden of disease and cost-effectiveness, clearly appealed to donors: it was rewarded with unprecedented research funding to improve maternal mortality measurement through the Immpact project, which was supported by major donors such as the Gates Foundation, with DfID, WHO, UNFPA and the World Bank among 12 international contributing agencies (Christie 2002).

Graham (2002) argued that investment in maternal mortality measurement is necessary to enable rigorous, evidence-based evaluation of global safe motherhood recommendations. Similarly, a number of my informants claimed that more robust evaluations would be needed to ensure that international agencies' recommendations are in fact 'evidence-based' and thereby help to ensure the credibility of these agencies. Such attitudes underpinned a growing aspiration evident within the safe motherhood academic community to improve the rigour of maternal health evaluation research by adopting the highest possible grade of study design, preferably the RCT, preferably with maternal mortality as the outcome measure. Despite earlier concerns (noted above) that experimental study designs may be inappropriate for studying the kind of public health interventions believed to be necessary to reduce maternal mortality, by the early 2000s there was growing consensus within the field about the need to overcome the constraints relating to costs and methodology of conducting RCTs. This was seen as necessary to improve the evidence on safe motherhood recommendations and thereby encourage donors' and governments' uptake of these recommendations. To this end, key actors within the maternal health academic field framed experimental research into recommended strategies as an ethical imperative, necessary to ensure that recommended strategies are indeed effective at reducing maternal mortality and to avoid squandering limited resources (Miller et al. 2003). But an underlying motivation for such arguments was that the production of more robust evidence was also seen as an essential step in strengthening the field's competitive position relative to other emerging global health initiatives. As one epidemiologist put it:

I think the maternal health field really competes against other fields for money, no? And I think other fields like the big spenders – malaria, HIV/AIDS, tuberculosis, even child health – I think they have a better record of promoting evidence-based interventions. And the maternal health field might be at risk of being left behind and eventually left out, because that can create donor fatigue, you know, if you miss the target too often with TBA training first, risk screening....

This informant was echoing the written argument of certain maternal health specialists that programme planning in safe motherhood in the past had been "based on theory rather than proved effectiveness" (Miller et al. 2003:10). These authors made a case for the use of rigorous criteria for the selection and

evaluation of interventions under real-life conditions in developing countries as “an efficient way to identify interventions for large-scale program replication” that could “speed progress in reducing maternal deaths” (*ibid.*).

Such strong calls to strengthen the evidentiary basis of core safe motherhood recommendations have been made routinely over the past five to ten years, and have been influential in fostering an aspiration within the field to conduct such research. However, efforts to realise this agenda have come up against financial, logistical, methodological and epistemological challenges. For instance, experimental evaluations of complex maternal health interventions have remained hampered by difficulties in measuring maternal mortality because of insufficient sample sizes or poor recording methods, as well as by lack of suitable comparison groups and difficulties in assessing the effects of confounding factors (Ross et al. 2005). While cluster randomised trials have been conducted on interventions including vitamin A supplementation and reduced number of prenatal visits (Benoit et al. 2005), no experimental research has been conducted into skilled birth attendants and emergency obstetric care. Consequently there have been few systematic reviews of the evidence on strategies for improving maternal healthcare (Althabe et al. 2008). On some level, then, ‘gold standard’ evidence on maternal mortality reduction remains an aspiration.

Such impediments have not, however, weakened the field’s resolve to strengthen its evidence-based credentials. But because of the challenges mentioned above, many researchers wishing to produce ‘gold standard’ evidence have shifted their focus from methodologically complex studies of context-specific health system strategies, and focused instead on targeted clinical interventions or one subcomponent of larger health system packages that can be more easily studied with experimental methods (Béhague and Storeng 2008). This includes specific obstetric care, quality assurance mechanisms, and clinical interventions to address single causes of maternal mortality, such as the use of magnesium sulphate for eclampsia or misoprostol (a drug that stimulates uterine contractions) for post-partum haemorrhage in home birth settings (*ibid.*).

In addition to their pursuit of experimental research, researchers have participated in various other research practices to help secure scientific credibility for interventions as globally valid recommendations. Such work has included various efforts to review and synthesise existing evaluations of skilled birth

attendance and emergency obstetric care in order to distil ‘best bet’ evidence-based messages about these strategies’ effectiveness. Perhaps the best example of this is the *Lancet* series on maternal survival that was published in 2006, which reviewed existing research before concluding that midwifery-based care in health facilities – or skilled birth attendance – is the best public health strategy for bringing about maternal mortality decline (see Campbell and Graham 2006; Ronsmans and Graham 2006). The publication of this series can be seen as part of an effort to reassert safe motherhood as a specific priority of the kind discussed in Chapter 6, a competitive response to the fact that the *Lancet* had published special series on child health and neonatal health, which helped raised the profile of these health issues. At the same time, informants were quite open that the publication of the series was also an effort to draw on the scientific legitimacy afforded by the prestige of the *Lancet* in order to convince the international community of the scientific validity of investing in improved maternal health services as a strategy for achieving maternal mortality reduction, in part to overcome the absence of clear-cut scientific evidence. Academics’ participation in such ‘boundary work’ (Gieryn 1983) served not only to demarcate their own work as scientific, but also to strengthen the credibility of the broader policy community of which they form part. They considered a unified, coherent and scientifically endorsed set of messages essential to convince donors to prioritise safe motherhood over other issues. As one informant said, “I certainly have heard donors say that we will not do anything where there doesn’t seem to be agreement.”

In sum, then, maternal health researchers’ efforts to respond to the exigencies of the evidence-based paradigm – driven by academia and donors and by the need to improve the field’s position – have impacted on their research practices in important ways. First, there has been a gradual narrowing of the methodological scope of research on maternal health. Second, the practical challenges of studying complex interventions using such narrower methods have contributed to shifting research focus away from the dynamics of complex health system interventions and towards components of larger strategies. Third, and at the same time, other research practices, such as reviews of the evidence, have sought to ascertain the evidence-based credentials of global safe motherhood recommendations.

7.2. Self-critical academics

Academics' efforts to build up a particular and narrowly defined evidence base on maternal health, described above, were driven by a confluence of academic and donor-driven pressures, and by academics' own efforts to contribute to advancing the broader Safe Motherhood Initiative. These were developments many academics were both aware and critical of. Indeed, their growing pursuit of methodological rigour seems to have raised important and unresolved questions for them as to their own role in endorsing the scientific legitimacy of global policy recommendations. A core concern for many of my informants, for example, was that their efforts to strengthen the Safe Motherhood Initiative's credentials for evidence-based research and policy occurred at the expense of meeting national or even sub-national level research needs in countries grappling with maternal mortality. As one epidemiologist put it, "I think that the academic environment does push us, does value certain kinds of research over other kinds of research, and I'm not sure that is always the right kind of research although it is highly skilled and highly technical." In interviews, informants often expressed just this sort of self-critical attitude as to the nature of their research practices and the broader implications of their work. In the subsections below I review some of these doubts and tensions in more detail in order to demonstrate the extent of their self-awareness of the limitations of their research to address issues that are truly 'policy-relevant' for countries struggling with high maternal mortality.

7.2.1. The right kind of research?

It was striking that a considerable proportion of the academics I interviewed were rather critical of their field's renewed priority on maternal mortality measurement, in several cases despite their own deep involvement in research into maternal mortality. Echoing the earlier arguments of maternal health researchers reviewed above, they often reported that the cost and complexity of maternal mortality measurement outweighs its benefits. Such measurement responds first and foremost to global demand for monitoring and evaluation, without necessarily being very useful for countries trying to plan and evaluate their health services, several explained. One epidemiologist argued that even if the methodological challenges could be overcome, and funding acquired, a major

problem would persist, namely that “mortality data don’t tell you what to do.” As she saw it, “if you come out of this study and you have a maternal mortality ratio of 750 or of 600, what are the differences in implications? None. Doesn’t tell you a thing. It’s high. We *know* it’s high.” While mortality data can be important for advocacy purposes, informants expressed the opinion that it is primarily other kinds of data, including process indicators relating to the specific distribution and quality of health services at national and sub-national levels, that are the most urgently needed to improve the delivery of healthcare.

Second, many were critical that their emphasis on experimental research was pushing them towards studying interventions that lack relevance for low-income countries. Specifically, there was concern about the trend towards research into component or single-intervention strategies that can be studied using an RCT, such as vitamin A supplementation to reduce maternal mortality or the use of particular drugs to address single causes of maternal mortality, such as haemorrhage. Referring to the trial of the effect of vitamin A supplementation on maternal mortality, one of my informants explained how such trial research does not necessarily address questions that are relevant for poor countries:

We are working in the poorest areas of the world where their problem is poverty. That is the tension I have. I think these smaller epidemiological questions are not the answer. I mean, take the vitamin A trial. It’s wonderful if it works and if it’s repeated ten times say, that confirms that vitamin A is the big technical solution [to maternal mortality]. These poor countries will still not have the system in place to deliver it so for me that is the tension.

Similarly to this informant, others voiced concern that research into technical solutions is feeding into an unwelcome myth that population-level improvements in maternal health can occur without investment in infrastructure, equipment and personnel. One epidemiologist, for instance, felt that the vitamin A trial had been “very destructive because it opened up the possibility of a simple solution.” She elaborated this comment by explaining that even if vitamin supplementation is “proven” to work in the context of an RCT, it will never provide a panacea for maternal mortality: “I think even if it works [to reduce maternal mortality] I don’t think it’s going to change any of the core messages” – the need for skilled birth attendants and a functioning health system capable of delivering emergency obstetric care. As such, she was echoing the broader

concern discussed in the previous chapter that promoting interim solutions can divert attention from long-term health system development. More generally, some saw the focus on establishing the effectiveness of different clinical interventions within the context of an experimental trial as a distraction from the real need for greater understanding of policy transfer and “operational” knowledge on how to implement existing clinical and public health interventions with proven effectiveness in wealthy countries within the weak health systems of poor countries. As one informant put it:

In the core things we know what works. We know exactly how we reduced eclampsia deaths in the west [with functioning health systems]. From the technical point of view...medically speaking. [But] it's how to deliver these services to women in poor countries where you have no doctor in the hospital, you know, you go to rural Mali, you have no hospitals, that's the difficulty but from a technical point of view we know [what is needed].

Echoing this informant's distinction between medical and public health knowledge, I regularly heard academics express reservations about the call from a sub-group of maternal health academics for the field to pursue experimental research into the effectiveness of complex public health strategies. An example of such a study might be an RCT to compare the effectiveness of programmes deploying skilled birth attendants versus traditional birth attendants. The comments of these critical academics often resonated with an emerging critique within the public health and social science literatures of the limitations of the RCT design for examining the complex causal mechanisms involved in interventions whose effectiveness may be context-specific and the result of social, as well as biomedical, mechanisms (Wolff 2001; Lavis et al. 2002; Victora et al. 2004; Béhague and Storeng 2008). My informants frequently pointed to the difficulty of generalising about the results of RCTs of complex interventions beyond the context in which the trial is conducted because of the complex nature of the interventions. Thus, some have argued that although it is possible in theory to conduct community (rather than individual) randomised trials that offer a “high standard of proof” about the effectiveness of an intervention (albeit within an experimental context), the costs of such trials would be prohibitive in relation to the benefits (Koblinsky et al. 1999:399).

Some maternal health experts also had *ethical* objections towards experimental research into skilled birth attendance and emergency obstetric care. Indeed, these informants insisted that there already exists clear evidence of the benefits of skilled providers and emergency obstetric care for maternal mortality reduction, even if this evidence is not highly valued within the hierarchy of evidence. This is a view that was also expressed in a letter to the editor of the *Journal of Midwifery and Women's Health*, in which Paxton and colleagues (2003) insisted that the combined weight of numerous observational and quasi-experimental studies, historical research and clinical experience provides sufficient evidence to justify global recommendations on emergency obstetric care and skilled birth attendants. Given such lack of real scientific 'equipoise' about the benefits of these interventions, some informants deemed that it would be unethical to conduct experimental research in which some women would be randomly assigned to receive an alternative, and likely inferior, intervention.

Such reservations about the call for experimental research into complex interventions were buttressed by maternal health academics' growing appreciation that policy-makers in low-income countries may not, in fact, uncritically value research findings simply because they are deemed to be a high grade of evidence. Unlike the donors who often demand 'gold standard' evidence before committing to any given course of action, informants felt that at the national and sub-national levels policy-makers appear to be more interested in the *relevance* of research findings for their particular context than in the rigour of the *methods* used to produce them. As another informant explained:

When I go and talk to ministers and parliamentary secretaries, they say, 'I listen to you...and I hear what you are saying about skilled birth attendants and skilled care and everything, but my coverage is only 20 percent. Can you tell me how I go there? I agree with you...but can you tell me how I am going to get from 20 percent to 30 percent to 80 percent. Give me some evidence, some lessons learned, so that I can go there'.

Another informant concurred, remarking that policy-makers at national level are required to make quick judgments and filter information that responds to their "intuitive sense of what reality is." He claimed that policy-makers at the country-level largely accept as given that skilled attendants and emergency obstetric care are needed, but require context-specific guidance, rather than experimental evidence, on how to scale-up health interventions to their populations. Similarly,

based on experience interacting with policy-makers in one South American country, another informant argued that country-level policy-makers are “much more impressed” by a non-experimental study showing that a neighbouring country achieved health improvement following a real-life policy intervention than by the results of an RCT from a far-away country with a totally different context.

These findings suggest a view among some maternal health academics that experimental research is *not* always able to address relevant questions and, furthermore, that such research is not always justifiable from an ethical or financial perspective. As these findings show, academics were often self-critical that their pursuit of the kind of ‘robust’ research valued within the evidence-based paradigm – and by international donors and many international policy-makers – was occurring at the expense of research that would be more useful at addressing questions relevant for specific countries. This highlights that the universalising epistemology of the RCT is not able to capture the different needs of the multiple users of the information that it produces.

7.2.2. Oversimplifying complex realities

Compounding worries that their research practices were not addressing questions of relevance to country-level policy-makers was academics’ concern that they were being complicit in disseminating an oversimplified set of messages about safe motherhood policy, and thereby contradicting country-level policy-makers’ apparent need for context-specific guidance on implementation of health policy change. This was a tendency that academics themselves attributed to the growing pressure they faced to contribute to establishing the credibility of global-level policy recommendations. As one epidemiologist said, the “quick-winnism of the taskmasters” – development agencies and donors from high-income countries – who are “dealing with a mountain of things” and therefore need messages that speak to them directly, “has pushed a lot of people to simplify their message.” Indeed, some academics admitted that they had, on occasion, succumbed to pressure from the broader safe motherhood community, including advocacy specialists, to oversimplify the complexity of their findings when communicating these to outside audiences, including to donors. For instance, speaking about the *Lancet* series mentioned above, those participating in its production recalled with discomfort that they had been actively challenged by the editorial staff (which

included representatives from a major NGO) to present a unified and unambiguous voice on policy priorities, if necessary by overstating the certainty of the scientific evidence in the interest of creating a coherent policy message. As one epidemiologist recalled:

They wanted us to say 'look how big the problem is. Countries make no progress, yet we know what works and what needs to be done'. That's what people wanted to hear. They called it 'evidence-based advocacy'...My feeling is that it's slightly more advocacy than evidence because they want us to say 'there are so many deaths in the world, it's the indicator with the biggest inequality' etc., etc., yet the evidence base isn't there.

Such unease about overstating the certainty of scientific evidence and the validity of numbers was for many academics exacerbated by a feeling that it was disingenuous towards country-level stakeholders to gloss over the evident complexities of maternal health epidemiology and maternal mortality reduction for the sake of presenting a message with global appeal. Such tensions are illustrated by looking at academics' handling of the results of a longitudinal epidemiological study into maternal mortality trends in the demographic surveillance site of Matlab, Bangladesh, which recorded a substantial decline in maternal mortality over a thirty-year period (see Chowdhury et al. 2007). While a success story, mortality decline was documented despite low coverage of skilled birth attendants (at around 20% of all births) and the findings challenged the global validity of the recommendation that population-level access to skilled birth attendants is the most important factor in population-level mortality decline. Subsequent in-depth analysis of the Bangladeshi data attributed the documented maternal mortality decline to a range of factors, including a fall in abortion-related deaths, better access to emergency obstetric care and community-based delivery care systems, as well as other policies that expand access to education and more affordable health services, improving access for the poor (Koblinsky et al. 2008).

For academics, the Bangladesh findings in no way invalidated the general importance of skilled birth attendants, but the research did reinforce their views that searching for an elixir to the problem of maternal mortality is inherently futile given the complexity of maternal mortality decline. Yet, while the range of context-specific factors that help to explain maternal mortality reduction in Bangladesh were acknowledged in scientific articles, in international forums such

complexity was often downplayed so as not to compromise the clarity of the message that deploying skilled birth attendants is the best ‘evidence-based’ recommendation for countries to adopt. One academic who had been intimately involved in the Bangladesh research admitted that it was for this reason that the study team had been particularly “cautious” about the way they presented the findings in international forums and that she herself felt compelled to back the message on skilled attendants to contribute to a coherent global recommendation. This was despite the fact that she personally believed – and the data clearly suggested – that maternal mortality reduction is “much more complex than skilled birth attendants.” The presentation of the research results was thus clearly socially enacted. More generally, others worried that the credibility and authority of the Safe Motherhood Initiative as a whole, including of key agencies like the WHO, would be seriously undermined if the movement continued to insist on the ‘evidence-based’ nature of global recommendations without acknowledging and documenting context-specific variation. As one researcher put it:

If you look and see, I mean, WHO and the international community are coming out and saying ‘skilled attendance for all’, and refusing, I mean refusing to ever talk about context. So you go to Nepal where you get eight percent skilled attendance and you say ‘skilled attendance for all’ and you go to, you know, Egypt and say ‘skilled attendance for all’. It’s a ridiculous, pointless, stupid thing to say in a country that absolutely has no ability to achieve that goal, and if you are going to say this is our goal in every country, but recognising this is where we are, and in five to ten years we should shoot for it, then [that would be ok]. But they will never take that step, or they haven’t yet... I think the WHO has a pretty weak leg to stand on because this far down the road we still don’t have the evidence that we need to have a convincing story. I mean, you see the stuff coming out of Bangladesh. We do *not* understand why maternal mortality decreased.

As this comment suggests, academics were clearly frustrated by the way in which they saw themselves being complicit in international agencies’ oversimplified representation of scientific evidence.

These findings suggest that many academics experienced a tension between their perceived responsibility to draw out the implications of their research for national- and sub-national level practice and the pressure exerted on them by the broader safe motherhood community to give scientific legitimacy

and credibility to global safe motherhood policy recommendations. It was clear that many felt deeply uneasy that issuing policy advice was fundamentally at odds with their idealised view of the academic's role, especially when such advice was issued on the back of uncertain evidence. "We should be impartial and we should take all the evidence and say somehow what that evidence tells us, but we shouldn't come with a particular mandate or a particular role to play," said one epidemiologist, while also acknowledging the pressure that constrains the realisation of such an idealised position: "It is difficult because people say 'make a recommendation' and tell us what to do, [but] as soon as you start giving recommendations, people think you've got an axe to grind."

7.3. Playing the game

Above I have argued that academics clearly identified a discrepancy between their research agenda and the evidence needs in countries struggling with maternal mortality, and on this basis questioned their own role in backing global-level recommendations that simplify the reality of maternal mortality reduction. Yet, on the whole they did not address such discrepancies in their work. Indeed, the two have come very much to co-exist within the academic subfield of safe motherhood. I would argue that a main reason for this is that academics in international institutions, despite their elite status, found themselves without much independence or power to address the sort of discrepancies identified above. Such lack of independence can be seen to have several different dimensions.

First of all it is important to take into account that these academics were working within a research culture that on different levels favours 'gold standard' research and, conversely, discourages the sort of operational, health system research that many of my informants said was needed to inform the actual implementation of safe motherhood policy. For one, as academics frequently explained, implementation research is not considered "cutting edge" within universities, where publication practices, promotions and status are aligned with the dominant hierarchy of evidence. Academics were also constrained by a new set of expectations relating to academics' accountability through the production of a certain kind of highly-valued research that is seen to promote not only academic credibility but also economic efficiency in public health practice,

similarly to the audit culture described by Strathern (2000) with reference to UK university life more generally. Thus their obligations to their profession and to their topic came into conflict, with the result that their own intellectual freedom of movement was undermined.

Academics' growing dependency on external donors, including private donors, to fund their research reinforced their lack of independence to pursue research practices that were more directly aimed at the needs of specific countries and set other constraints too. Such donor dependency operated in direct ways, for instance through dependency on donors to sustain academic livelihoods through grants, but also indirectly, through academics' dependency on the survival of the Safe Motherhood Initiative as a whole to sustain their specialist field of research. Particularly academics in 'soft funded' positions, required to raise their own salaries and research costs through external grants, had few incentives to challenge the bias of the external donors whose funding patterns favour clinical research and gold standard methods. Of all donors, the Gates Foundation was said to be the most notorious for its explicit preference for 'innovative' technological solutions to health issues and a marked reluctance to fund much needed research into the implementation of existing interventions.

In addition to a bias in favour of research into technological solutions, there was a clear perception that it was only through producing 'gold standard' research that academics could help to persuade donors and international policy-makers to support the Safe Motherhood Initiative's recommended strategies. In part, this was perceived to be a self-inflicted situation. As one informant said, "we've sort of killed ourselves by always arguing that you needed trial evidence, you needed rigorous evidence. Now the policy-makers need that same language, of rigorous evidence." It was clear that many now found it difficult to resist this pressure. Despite claiming that process indicators are both more feasible and more informative outcome measures, one academic even claimed that only studies using "hard outcomes" – in other words mortality outcomes – have the power to influence the high-level donors who set the terms of policy debates. "That's the only way you get the attention of the [World] Bank and the big people," he insisted "If you just go and say 'well, we changed a bit of behaviour' they say 'oh thank you'. But if you can actually say 'we're hitting the Millennium Development Goal,' then it hugely raises you up the agenda."

The perceived pressure to produce a particular kind of evidence was so strong that some academics admitted that they would participate in conducting an RCT into skilled birth attendance despite their own strong reservations about the value of such work if that is what it would take to convince donors of the value of investing in such care. An epidemiologist I interviewed explained:

That's the struggle that I'm having because I am so convinced of the argument [about the value of skilled birth attendants]...but we need to think, what makes policy-makers shift? Do we need another beautiful trial showing that TBAs [traditional birth attendants] make no difference [to maternal mortality decline]? I would say I hope not, but unfortunately quite a few people [are calling] for trials of community health workers, you know to see what they can contribute. And the donors [are] taking note. And if we've gone that far then I would say...God, what a waste of money. But maybe we have to play the game, I don't [know]...I feel uncomfortable about it.

Such comments highlight an interesting development, whereby academics who are critical of a system nonetheless may feel obliged to mould their research into the terms of the system in order to get by and contribute to the broader goal of the global health movement in which they are, in effect, active participants. Such 'blending in' may be an effective strategy for survival, but it comes at a clear cost to the perceived usefulness of the knowledge that is produced as a result.

It was also clear that many academics felt too intimidated to challenge decision-makers in the high-level global health policy sphere, including certain prominent donor agencies, because they felt that these were working from within a frame of reference entirely different to their own. Some bemoaned that the Gates Foundation's business-oriented approach to global health in particular made it almost impossible to challenge its relative neglect of health systems. One epidemiologist, for instance, complained that the Gates Foundation's representatives tend to talk of public health interventions as "products," while reducing health systems to "pipelines" for getting products to consumers. She suggested that this business-oriented view of global health is so entrenched within the Foundation as to make it virtually impossible to partake in constructive discussions about maternal health with Gates' representatives, despite the Foundation's efforts to consult academics about future priorities for maternal health research. Recalling with exacerbation one meeting at which a Gates' representative had enthusiastically called on the maternal health research

community to identify “a bed-net for maternal health,” she dismissed this explicit demand for a technical fix to maternal mortality, modelled on the insecticide-treated bed-nets used to combat malaria, as evidence of profound lack of appreciation of the challenges of reducing maternal mortality. Yet, my informant admitted that she had not publicly challenged this view or insisted on the importance of implementation or health system research. When I asked her why not, she replied, “oh I can try to argue that, but they are not going to listen...they are looking for cheap solutions, they are looking for the vitamin A pill.”

7.3.1. Lack of expertise and authority

While various academic and donor-driven pressures constrained academics’ ability to address the identified discrepancy between current and ideal research practices, other factors also played a role. For one, given their clinical or epidemiological training, many academics lacked the confidence that – even if the professional impediments were removed – they would be able to take forward a research agenda that would be more appropriately directed at countries’ policy and programmatic needs. One informant, for example, distinguished between “technical knowledge in health,” which can be fairly specific, and “development-related knowledge,” which is “more about how to spend money to achieve things in a system that isn’t your own.” She admitted that she was unsure, for example, that epidemiologists *can* actually help to answer these development-related questions. Part of the allure of epidemiology was plainly technical. One epidemiologist described the pleasure of her work in terms of finding patterns in data and rather mundane tasks such as cleaning a data set to eliminate error. To some extent, the research question was irrelevant – “it could be about anything – the colour of socks in the underwear drawer” – and, although she claimed to be interested also in the “big questions” to do with how systems function she questioned whether her technical skills were up to the job of addressing such questions. “Sometimes I even think, is this what I should be doing at all? This field? If the big questions are about [health system] issues, maybe I should be working much more on something where the questions are much more [narrowly about descriptive] epidemiology,” she admitted. It was clear, then, that at least for certain academics, some elements of the broader problem were felt to be outside their own epistemological remit.

For many academics based in Western research institutions, such insecurities were compounded by a concern that they lacked the credibility and legitimacy to offer advice to policy-makers or programme managers working “on the ground” in low-income countries. This was in part because of the physical and social distance separating them from these actors and in part because they felt they lack the context-specific knowledge needed to interpret the practical significance of findings for a given health system and political context. These were concerns shared by others (non-academics) within the safe motherhood community. But, interestingly, for one policy-advisor from a middle-income country, this was not just a question of a lack of knowledge about any one particular country or region, in other words a case of the academics having insufficient geographical understanding. It was also a more deeply rooted issue about the specific forms that the professionalisation of academics in the global North in particular has taken. During a recent period as a guest fellow at an American university, for example, the informant cited above had observed that, unlike academics in many Southern settings who interact socially with policy-makers, academics in high-income countries tend to be separated from the policy-making domain, both in their own countries and in the low-income countries where their research is based. She felt that this is because these academics’ work tends to be concentrated very explicitly on achieving academic advancement. Referring to the US university she was visiting, she remarked that, “there I have found that most of the academics haven’t seen a policy-maker in their life or had any exchange at all, and they don’t even talk across disciplines... People are in their own worlds, chasing money for their own projects and then working very hard to get the deliverables.” While this policy advisor perhaps underestimated Western academics’ sensitivity to the knowledge needs of policy-makers in low-income countries, she rightly observed the formative role that institutional and professional pressures can play in impeding the relevance of international research for national and sub-national practice.

7.3.2. Carving out a new niche for research

A number of informants rationalised their own, recognised inability to bring forward a research agenda that is truly relevant to countries’ needs by designating the kind of work that would be required as being outside the academic role. For instance, one academic queried how researchers could contribute to the

“mission” of reducing maternal mortality without actually going to countries, living there and working alongside ministries of health, but quickly dismissed this option by saying, “that wouldn’t be a researcher role, that would be a development role.” By contrast, some academics seemed to be able to address the sorts of tensions discussed above precisely by effectively dissolving the demarcation between ‘development work’ and ‘research’ and explicitly orienting their work towards country-level, rather than global, evidence needs. But it was also clear that those who felt more confident that they were addressing country-level research needs had achieved this position in part by redefining the “researcher” identity. “We are not really researchers here,” said one of these academics. “We are more committed and involved in the development of the health system, and we use science to help develop, say in a more rational or efficient way, the health systems.” This kind of perspective was expressed by academics based at European research institutions with relatively secure livelihoods, who were not as dependent on external funding as the majority of my academic informants. They described their model of research as one that, when compared with mainstream international research, is more responsive to countries’ *own* priorities and that fosters a truly collaborative and equitable approach with national-level research partners “in the driving seat.” This entailed a deliberate policy of prioritising the links between research and national-level policy over the production of formally recognised scientific research, even if doing so meant forfeiting international prestige and major grants, as well as access to global-level policy spheres. The emphasis was on working directly with Ministries of Health to study and evaluate government-run programmes from an operational perspective. Rather than the research question being driven by the choice of a particular method, such as an RCT, this was a model of research that started from the research question and then identified appropriate methods to answer it, I was told.

In order to advance this vision of collaborative research, such health systems-oriented researchers defined “capacity building” of partners in developing countries as a priority, and were quick to add that they rejected the typical model of academic collaboration: research designed and led by Northern institutions and executed by partners in the South. Instead, they emphasised the importance of investing sufficient time in building up social relationships across

the North-South divide to ensure that research questions are truly relevant to those they are intended to benefit (see also McCoy et al. 2008). Moreover, country-based knowledge and programmatic experience were considered to be of equal, if not higher, importance to formal academic credentials, such that one research institute even had an explicit policy to recruit only researchers with at least five years of field-based experience from low-income countries. This was in part to ensure a level of 'operational' expertise that would ensure the researchers' credibility in interactions with policy-makers.

While this sort of collaborative research model may be highly valued by the vast majority of the academic maternal health specialists I interviewed, the majority of academics in fact lacked the financial and institutional support to pursue such a model of research, and may also have been discouraged from doing so by their own professional interest in developing an internationally recognised research career. Disengaging from global health politics was thus not a realistic option, and they had to find other ways to realise their objectives while working within the domain of global policy and advocacy. Some academics, for instance, were in the process of revising previous attitudes about a strict demarcation between academic objectivity and social engagement. Others were considering whether they should educate themselves about the processes of policy-making and how decisions are made or even take on a more active role in campaigning for policy change. One informant spoke of the need to harness academics' technically-based authority in order to exert greater influence over global-level research agendas. Others were also revising their previous attitudes about the separation between academic work and policy-oriented advocacy, suggesting, for instance, that there is a need for academics to become more active participants in defining the global health research agenda, and to challenge the normative attitude that experimental evidence is always best. As with the work of international policy formulation and advocacy explored in the previous chapters, the sustained pressure of practical and political objectives is thus beginning to bring about a series of changes in the very nature of work undertaken by safe motherhood academics.

7.4. Conclusion

By paying attention to academics' own perspectives and practices, I have aimed to demonstrate that academic researchers working in international institutions and affiliated with global health initiatives today find themselves in an ambivalent position. Academics associated with the Safe Motherhood Initiative, for example, find themselves caught between sometimes competing demands from the academic sphere, from global-level donors and from international, national and even sub-national level decision-makers.

Over the past decade, the confluence of the evidence-based medicine movement and the growing prominence of donors in setting the global health research and policy agenda has contributed to an international research culture that has pushed academic research towards pursuing a narrower definition of evidence and that does not provide the incentives to pursue more operational health system and implementation research, despite the fact that academics recognise that such research is needed to improve actual policy implementation at the country level (Béhague and Storeng 2008; Béhague et al. 2009). Indeed, this research culture has developed despite burgeoning debates within the academic community about the need for health policy and systems research that can generate knowledge on improving the delivery of existing interventions and about the need for better alignment of international evidence needs and country-level research priorities (Haines et al. 2004; Freedman et al. 2006; Costello et al. 2007; Kapiriri et al. 2007). It is this contradiction, or paradox, that in fact best captures the nature of academic work within safe motherhood today.

Of course, the role of academic incentive structures and the biomedical bias in research systems has been previously recognised. But the findings here draw particular attention to the way in which such questions are impacted by academics' own positioning within disease-specific global health initiatives that compete for funding and political attention, and the potential impact of such relationships on academics' independence to pursue the research that they think is needed to improve health. Academics' involvement in global-level politics and growing reliance on donor (including private donor) funding exposes them to the 'high policy' domain, but also appears to curtail their academic independence in a variety of ways. As others have commented, it is problematic that the immense influence of donors such as the Gates Foundation, with its very particular

approach to health, tempers the open and critical attitude of academics who hope to receive funds from the Foundation (Strouse 2000; Walt and Buse 2000; People's Health Movement et al. 2008).

But then again, at the same time as my informants recognise the limitations of the current international research culture, they are also complicit in the establishment and normalisation of these attitudes within the broader global health field; as I have tried to show, they have little choice but to be. It is for this reason that many of them evince the sorts of tensions, or ambivalence, towards not only evidence itself, but towards their own engagement with evidence. While academics, like other safe motherhood practitioners, continue to seek ways of resisting the trend towards interim, 'magic bullet' approaches to the problem of maternal health, in responding to the pressures they confront within their own professional sphere – the need to work on 'cutting edge' research, or the need to be seen as 'policy relevant' – they thus also come gradually to produce knowledge that is itself more readily applicable to such vertical, rather than horizontal, approaches.

8. EVIDENCE-BASED ADVOCACY

In the previous chapter I examined some of the ways that academics have been co-opted into the global health policy and advocacy domain. I tried to show that they in fact felt deeply ambivalent about gearing their research practices towards global policy and advocacy demands, sometimes at the expense of country-level relevance. But though they found the emergence of ‘evidence-based advocacy,’ for example, to be inherently problematic, they nonetheless ultimately embraced it as a way of responding to some of the broader pressures confronting the field. My aim in this chapter is to examine how a contrasting group of actors, safe motherhood advocates working within international NGOs, actively draw on and embrace the authority associated with evidence to variously generate support for issues, change the way that issues are framed, identify policy agendas and solutions, and hold policy-makers accountable to their promises (see Sanders et al. 2004; Pollard and Court 2005). Moreover, I seek to examine how ‘evidence-based advocacy’ has come to replace the sort of explicitly value-based and feminist claims that formed the basis of advocacy at the Safe Motherhood Initiative’s beginning.

By ‘evidence-based advocacy’ I mean the deliberate and strategic use of scientific evidence – such as health statistics, evaluation of public health programmes and descriptive analyses of health services – to influence global, national and sub-national policy processes. This includes both efforts to raise safe motherhood as a priority issue and to influence the formulation and implementation of specific policies. Recourse to the authority of science now routinely underpins the full range of international advocacy groups’ activities, including knowledge ‘translation’ and diffusion, evidence production or research, direct lobbying of decision-makers and capacity-building in the use of evidence among national and local counterparts. As such, safe motherhood advocacy groups embody a trend towards reliance on different forms of evidence in the work of NGOs more generally (Epstein 1996; George 2000; Pollard and Court 2005).

In order to critically examine this development and its implications for the Safe Motherhood Initiative, I analyse the accounts and practices of a subgroup within the broader safe motherhood field that I term advocacy specialists. These are actors who, based primarily in NGOs in settings such as London, New York and Washington, D.C., direct their work towards improving maternal health (and sometimes reproductive health more broadly) in developing countries. I start by briefly examining some of the reasons why ‘evidence-based advocacy’ has come to play an important role in their work, before examining some of the specific ways in which they mobilise scientific evidence in their work. This entails examining first advocacy specialists’ efforts to influence ‘agenda-setting’ for safe motherhood and, second, the multiple ways in which they use scientific data and authority to influence the formulation and implementation of specific policies aimed at improving maternal health. By examining these various uses of evidence, I aim to demonstrate that advocacy specialists are not constrained by the dictates of the evidence-based medicine paradigm – and its associated professional pressures – in the manner of academic researchers (discussed in the previous chapter). Instead, they mould their use of evidence in creative ways, adapting it to the stage of the policy-making process they are trying to influence and to the target audiences they seek to persuade. As such, they deliberately rely on the political and social meaning, as much as the scientific credibility, of scientific evidence. While on many levels clearly enabling for advocacy groups, the final section reflects on whether embracing evidence-based advocacy risks unduly depoliticising calls for priority to safe motherhood.

8.1. Why evidence-based advocacy for safe motherhood?

Which factors help to explain why there has been a trend towards an explicit, evidence-based foundation for the advocacy conducted by international NGOs specialising in safe motherhood? A first important answer to this question relates to the general rise in the authority of objective, and especially quantitative, knowledge in all areas of global health. Like academics, many advocates identified a recent surge in global health debates for evidence of effectiveness and cost-effectiveness, explaining that they were today faced with the challenge of having to provide quantitative or other incontrovertible evidence of the likely benefit of any given policy change they were advocating. As one informant

explained, in the past “donors never wanted indicators and then they wanted results and everybody started asking ‘what are you using your money for.’” Many felt that the demand for evidence was higher in the maternal health field than in other sub-fields, with evidence needed to compensate for a lack of inherent political appeal of the safe motherhood issue relative to other global health issues that “have a totally different appeal than maternal mortality for the big donors” (such as family planning in the past, with its ties to population control and the more recent interest in threatening infectious diseases). Illustrating this view, one informant gave the example of funding discrepancies between programmes promoting abstinence as a strategy to combat the HIV/AIDS epidemic, for which there is little evidence of effectiveness, and safe motherhood programmes: “How many billions of dollars have gone to abstinence in the last six years? What’s the evidence there? You can’t take a fraction of that money to save a woman’s life unless you have the evidence.”

The notion that evidence is needed to compensate for low political appeal is not unrelated to informants’ perception that the original feminist ideological basis of the movement has been discredited. “I think everybody’s afraid of getting the feminist label because it turns so many people off,” explained one informant from a New York-based women’s health NGO. Another similarly complained that the fact that safe motherhood advocates have tended to be women has put the movement at a disadvantage relative to other health movements:

I think HIV really captured the attention because of the push that there was behind it. Both donors and money-wise...I mean the first people who got behind it were males in the US! I mean, what stronger voices...can there be? And this [safe motherhood] is a story about mothers and children. I mean, if we women talk about it, we’re whining, about a topic that is, you know, not interesting...you know, it’s part of life.

Advocacy specialists, tired of being dismissed by high-level, often male, policy-makers as “a bunch of feminists,” have understandably turned to more ‘objective’ and ‘scientific’ claims to strengthen their own credibility in a policy sphere dominated by male doctors and economists, who, as they perceive it, have little tolerance for a female-dominated advocacy community. Being able to authoritatively talk about the evidence on maternal health epidemiology and intervention strategies was essential for these groups to get a seat at the table at

high-level policy forums, as the female director of one prominent women's health NGO explained:

Women's lives are dispensable in one way or another. The only way we are going to have safe motherhood is in fact if a political movement can have enough influence to get the resources allocated, but not just the money. It's to be at the table to say 'this is what women's lives are like, these are our suggestions about how you can best go about, in very specific country settings, how you can go about saving women's lives.'

As this comment highlights, being able to present descriptive evidence and evidence relating to context-specific policy options was seen as an essential component of any *political* movement to achieve support for the issue, as well as to enable advocates' own access to the forums in which decisions are made.

Advocacy specialists also found scientific evidence an expedient tool because of the transnational nature of the safe motherhood field. Theirs was work that was often directed not only at international agencies, bilateral and private donors, but also at national-level decision-makers. Capturing some of this broad scope, one NGO, for instance, divided its activities into those "in the States," "in the courts," "worldwide" and "on the Hill" (a reference to Capitol Hill in Washington D.C.). Working in such varied domains often involved communicating across not only linguistic, but also ideological and religious divides, a process that informants felt can be greatly facilitated through use of "neutral" evidence. Statistics in particular, they suggested, are less prone to get lost in translation than are arguments that are more explicitly rooted in a particular ideological or political framework. "You don't know who you're going to alienate with these words and how they are translated into local language," explained one informant. "There are many languages that don't even have a word for feminism and so it's perceived as imposing Western values on something and stirring things up socially that should be a more generic, internal process." For many advocacy specialists, the impetus to back up ideological claims with statistics is thus demonstrative of Porter's (1995:ix) notion that quantitative evidence has become favoured among the ways of establishing authority because of its characteristics as "a technology of distance." As in Porter's historical analysis of the relationship between quantification and authority, for safe motherhood advocacy specialists numbers provide summaries of complex events and transactions, conveying results in a familiar, standardised

form that can be understood far away and, crucially, across linguistic and ideological divides.

Reinforcing the factors discussed above was an ingrained conviction among many of my informants that they have a social responsibility to use knowledge to bring about social change. Whereas academics expressed ambivalent attitudes about the use of research in policy, most advocacy specialists were adamant that knowledge of all sorts, including scientific evidence, is a tool for bringing about social change and that those harbouring such knowledge, including academics, have an obligation to ensure it is put to uses that are in the public interest. This was a view that one informant traced to the specific experience of the late 1960s when scientific knowledge was “abused” in the interest of developing advanced warfare:

I came up in the late 60s, I was in graduate school doing my dissertation in the late 60s and because that was the era of the Vietnam war and there was a lot of debate about how science, scientists, academics in their work had been exploited by the CIA and the Defence Department in order to conduct what most people felt was an immoral war. So there was a lot of debate around the issue of what responsibility does an academic have for the way his or her work is used by people in government. I came away from that era convinced that academics had to accept responsibility for what happened with the work they generated and how it was used. And so I think academics have a responsibility not to be neutral in the policy world but to provide an interpretation to the best of their ability, as otherwise someone else will use their...and if that happens and they have not themselves said what they think their data means for public policy then I think they have shirked their responsibility. I don't think academics can get off the hook because they're being objective.

What this informant was suggesting was that is not sufficient to leave scientific evidence un-interpreted because there is always the danger in such an event that users of the information without the requisite understanding become misusers of that information. As such, many informants saw conducting evidence-based advocacy as part of a broader process of exercising a social responsibility to prevent misuse of evidence.

Having briefly reflected on some of the main reasons why evidence-based advocacy has become a prominent part of safe motherhood advocacy groups' activities, the next two main sections examine in more detail different ways in which advocacy specialists deploy scientific evidence to influence the

policy process. The first of these sections demonstrates their use of scientific evidence, particularly statistics, in 'agenda-setting' for safe motherhood, while the second section examines how they use evidence to influence the formulation and implementation of specific policies aimed to improve maternal health. These are, of course, inter-linked activities, yet looking at them in terms of 'agenda setting' and 'policy formulation' conforms with my informants' own demarcation between the different stages of the policy process they sought to influence. By presenting the data in this way, my aim is to draw attention to advocacy specialists' acute awareness that, as one informant put it, "research plays a different role at different stages of the public policy process."

8.2. Agenda-setting

Generating priority for safe motherhood on the policy agendas of the broader global health field (comprising international organisations and donors, but also national governments) was the primary remit for many of the advocacy groups that I visited and consulted during my research. Informants from these NGOs identified 'agenda-setting,' including documenting and bringing attention to a specific problem, as one of the most important ways in which they could influence the policy process. In doing so, they drew explicitly on frameworks used in policy studies, including Kingdon's (1984) agenda-setting framework and Shiffman's (2003; 2007) work on agenda-setting within safe motherhood, in particular. There were a number of ways in which advocacy groups mobilised scientific evidence in order to ensure priority for safe motherhood on different policy agendas and they often scaled and adapted the evidence they used to fit different target audiences.

8.2.1. The use of mortality data in agenda-setting

As mentioned in previous chapters, vital statistics and 'burden of disease' data have played important roles in advocacy for maternal health (recall, for instance, the 'measurement trap' and academics' emphasis on improving measurement of maternal mortality). Indeed, in his call to action on safe motherhood in 1987, Mahler (1987b:668), then Director-General of the WHO, said that, "sound estimates based on new data...are at the foundation of our current understanding and concern" about safe motherhood in low-income countries. The tendency to equate the magnitude of mortality, and to a lesser extent,

morbidity, with the importance of a health issue has a long history, reflecting that high mortality problems were considered important because the potential to save lives was correspondingly high (Armstrong 1996). This tendency has, of course, been reinforced with the rise of selective primary healthcare and the proposal that high mortality health problems should be targeted for intervention, and further by the growing dominance of the 'burden of disease' framework for priority-setting propagated by the World Bank since the early 1990s. In recent years, Shiffman's (2003; 2007) assertion that having a credible indicator of the severity of the problem is a key condition for ensuring political priority for a given health issue has further reinforced many safe motherhood practitioners' conviction of the importance of statistics in advocacy.

Advocacy specialists relied heavily on the use of mortality statistics in their various agenda-setting efforts, perhaps particularly in their attempts to raise awareness and commitment to improving maternal health and survival in countries with high maternal mortality. While this entailed a range of different strategies, their use of health statistics is particularly illustrative of the role of evidence in advocacy work. For advocacy specialists, the value of mortality statistics as an advocacy tool was not simply its role in raising awareness about a previously unrecognised problem – indeed, they countered, maternal mortality is now well-recognised across the globe – but rather to galvanise action by relying on the highly emotive and polemical nature of such numbers. The contested nature of numbers has been evident throughout the history of the Safe Motherhood Initiative, with the publication of statistics on maternal mortality almost inevitably raising a furore, especially at the national level.

On a basic level, advocacy specialists explained that because government officials often respond to the publication of international statistics by claiming that they are "too high," such estimates have the power to create a reaction, as governments wish to dissociate from the implied suggestion that a high maternal mortality estimate means that their country is 'underdeveloped' and their government unable to provide its citizenry with adequate healthcare. According to my informants, simply publishing a league table over national MMR (maternal mortality ratio) estimates has, in the past, played an important role in creating an impetus for action, as national governments have sought to avoid comparing unfavourably with other countries that they considered to be less socially or

economically advanced. For instance, informants recalled that the publication in the late 1990s of an MMR estimate for Morocco that appeared significantly higher than previous estimates caused political outcry not because of the absolute magnitude of the estimate, but because it made Morocco's MMR appear similar to that of a sub-Saharan African country. As my informant explained, "Morocco certainly doesn't consider itself African...So giving them an MMR of 600 that looks like Burkina Faso will not go down well." As such, 'high' maternal mortality was a relative, rather than an absolute value, determined according to how national statistics compared to those of other countries. "They don't pretend that it [the MMR] is zero or ten," said one informant, suggesting that health authorities in low- and middle-income countries do not tend to deny that maternal mortality is a public health problem in their particular countries. "What is important is that if you are in Burkina Faso, the rate is much lower than in Niger and in Mali and less than in Senegal and less than in Benin," he said, underlining the way in which MMR has come to be seen as a marker of national-level performance and inter-state competition.

On another level, maternal mortality statistics invoked contests over the authority to define the validity of numbers between international organisations and actors – who often produce the statistics – and national health authorities and politicians. For instance, in several countries the publication of UN MMR estimates that were higher than the nationally-produced estimates was used to variably challenge the credibility of the government and of the UN agencies who produced it, in one country even sparking a key parliamentary debate about maternal health. As one informant recalled:

I worked on the first WHO estimates of maternal mortality, which were highly controversial and led to a UN embargo against the document and 11 – I can't even remember how many – UN ambassadors came and formally launched complaints against UNICEF and three or four ministers of health almost lost their jobs. It was completely ridiculous. Anyway, in Morocco, this number came out, and it was higher than the number they were working with, and it made it into the newspapers. The opposition took this up and said, 'thank God there are international agencies who will tell us the truth about our women who are dying, the government is clearly lying to us'. And this issue was debated in parliament. I don't know that it has affected policy at all but it certainly caused a big political brouhaha.

From advocacy specialists' perspectives, statistics' ability to create such "broohaha" was exactly where the power of the numbers lay, because it showed that the numbers had the power to arouse a sense of political accountability for safe motherhood. Contrary to Shiffman's assertion, however, it was not the scientific validity or credibility of the indicators *per se* that sparked a reaction, but rather the symbolic and political connotations of the numbers, which, in turn, rest on a shared understanding of the *meaning* of maternal mortality as an indicator of the social development of a particular country. "For the politician, it is how he is judged. Because unconsciously people concentrate on the numbers," said one informant. This stems, he suggested, from the fact that maternal mortality has become "sufficiently part of the collective conscience to appear as part of the Millennium [Development] Goals," with widespread recognition that maternal mortality is an important indicator of the performance of the health system, with the health system, in turn, being an indicator of the social performance of a country.

The argument that it was the wider symbolic value, rather than scientific credibility, of the numbers that galvanised a response is illustrated by the fact that the political reactions to discrepancies between international and national data occurred despite generalised knowledge of the fact that the WHIO estimates were produced using a different statistical method. Though, according to informants, most people knew that the difference between the international and national estimates was in fact a statistical artefact rather than a "real difference," the new estimates still served as a "shock to the system" of national health authorities. According to one informant, maternal mortality statistics have a specific power to raise such a reaction, even more so than other mortality indicators, suggesting that despite the perceived neglect of maternal mortality, there is "something special" about this kind of death such that being confronted with the numbers creates a visceral reaction. "It's not the numbers...clearly, some deaths are more important than others. It's a different kind of death that people react to differently."

On the basis of such an understanding of the power of numbers, advocacy groups relied heavily on maternal mortality statistics in their advocacy materials, including policy briefs, websites and other published material, as well as in their various media communication activities. Their use of statistics was

moulded to fit different audiences. While MMR league tables were considered important in high-level political forums, improving public support for the issue of safe motherhood often entailed other, more creative uses of epidemiological data. Judging that the level of MMR has little intuitive meaning to non-experts, advocacy specialists explained that using different kinds of numerical expressions to describe the risk of pregnancy-related death can help people interpret and draw meaning from the numbers. For instance, referring to individual-level lifetime risk rather than the ratio of deaths within a population is a way to engage individual perceptions of risk and thereby overcome the difficulties of getting individuals to identify with and react to population-level mortality estimates. As one informant described:

It's interesting because when you talk with people one to one and you say, for example, that one out of every six women in Afghanistan die in pregnancy and childbirth compared to one in every 30,000 in Sweden or Norway, people are absolutely horrified, shocked and, I also think that they're – particularly women in the developed world who've been pregnant, who've had a baby – can really identify if you say to them, 'think about what it would have been like for you to give birth in rural Africa, 15-20 km from the nearest health facility, with no doctor, no nurse, no midwife, no clean water, what would have happened to you and to your baby? Think about that, as that's how the majority of births take place in the world, at least in the developing world.

As this quote suggests, creative use of epidemiology (of the kind that anthropologists have noted in other domains (e.g. Gifford 1986; Kaufert and O'Neil 1993)) offered a way to communicate complex ideas about risk in a way that could enhance popular interest in and support for safe motherhood. Informants considered such public support important not just to create a sense of 'global' solidarity and awareness of health inequalities, but also to ensure public pressure on politicians in low-income countries and to ensure public support for donor-driven initiatives among the public in donor countries.

8.2.2. "The numbers alone don't make the case"

Although, as the last sub-section demonstrated, advocacy specialists recognised and drew on the power of maternal mortality ratios to create political reactions, they were also clearly aware that such numbers alone are not sufficient to secure safe motherhood's place on the global health agenda. In high-level global health

debates in which burden of disease frameworks dominate priority-setting discussions, for example, advocacy specialists recognised that maternal mortality alone could never compete with health issues accounting for a larger proportion of the global ‘burden of disease.’ Although national-level agenda-setting often relied on communicating the idea that the number of maternal deaths is too high, advocacy specialists clearly felt that their international advocacy was hampered by the fact that the numbers were *too low* to prompt decision-makers to prioritise the issue (despite their stated commitment to do so) (cf. Adams 2005). As one informant said,

The fact is you really have a struggle because if you compare the number of deaths there are half a million maternal deaths compared to 10 million infant and child deaths per year. You know, people say it’s nothing compared to some of the other issues so you really do have to frame it in a different way as the numbers [of maternal deaths] alone don’t make the case.

The growing currency of economic justifications for public health priorities reinforced this perception that burden of disease data and numbers alone do not make the case for safe motherhood, not least because it is often ministers of finance and private donors rather than ministers of health that set overarching global health priorities. Such actors, informants claimed, are not so much swayed by burden of disease data as by economic justifications. Thus, while appealing to underlying interpretations of the social meaning of numbers can be effective at certain levels of the policy process (as discussed above), and social justice arguments can mobilise popular support, different justifications were required once advocates found themselves needing to appeal to these particular decision-makers. As one informant observed, “you can mobilise a certain constituency group just by talking about the ethical and injustice issues, but for these hardcore decision-makers who look at economic factors, that kind of appeal doesn’t necessarily carry the day.”

The pervasiveness of such perceptions helps to explain why so many advocacy groups were increasingly mobilising economic justifications, of the kind I discussed briefly in Chapter 6, to bolster their calls for priority to maternal health. For instance, they sought to appeal to the idea that investing in women’s health has benefits for productivity and macro-economic well-being. This objective in fact underpinned the shift in emphasis from ‘mothers’ and safe motherhood to ‘women’ that took place at Women Deliver in 2007. According

to one informant, it was in part because it was not possible, due to methodological limitations, to 'prove' the impact of maternal health on macro-economic well-being that advocacy specialists shifted their arguments to be about women in general instead of mothers. As one informant explained:

Maternal health is not enough in terms of numbers to destroy an economy. I mean, 1,000, 2,000 maternal deaths in a country will not change much in the economy of Ethiopia or Nigeria. So, it's not a very strong argument. Women's health in general, the female workforce needs to be strong and well fed and productive and so on. Women are the nurses, the teachers, the workers in factories, the farmers and so on. So, women's health can have an [impact on] the economy, but not maternal health alone. The numbers are too small.

Many advocacy specialists were also driven by the pressure they perceived to demonstrate the 'cost effectiveness' of investments in safe motherhood, in part so they could combat the observed trend of donors using cost-effectiveness arguments as an "excuse" to invest in other health issues rather than maternal health. One informant, for example, was dismayed that the reporting requirements of the donors reflected an expectation that safe motherhood practitioners should be able to account precisely for the number of lives saved from any donations, which is difficult to do when it comes to maternal mortality. The effect, my informant suggested, is that donor resources are displaced from maternal health:

They want to see exactly where their \$500,000,000 went. How many maternal lives were saved? How many children were saved? Depending on what indicators you use – but it's all quantitative now – so they're going say, 'oh, well for every million dollars we reach 30 million children – but we only affect the lives of maybe 50,000 mothers, well that's not very cost-effective so lets go for the children,' and that's what's happening.

My informants' fears that donors were swayed by the greater immediate return they could expect from child survival efforts were compounded by their perception that even proving that maternal health interventions could save women's lives in a cost-effective manner would not be sufficient to convince donors to shift their priorities. As one informant put it, "saving women's lives is not enough." It was on the basis of such perceptions that some advocacy specialists sought to redefine the "benefit" of maternal health interventions as being broader than simply reducing maternal mortality. For instance, advocacy

specialists sought to demonstrate that maternal health interventions are particularly cost-effective because they also improve child survival and health, and even economic productivity (as discussed briefly in Chapter 6). In making such arguments, informants inevitably came up against the fact that little relevant quantitative evidence exists to demonstrate such benefits. As a substitute, they turned to qualitative data to demonstrate not only the benefits of investing in maternal health, but also the costs of failure to do so. A specific example of such an effort is the use of case studies, as described by one informant in the run-up to the global Women Deliver Conference in 2007:

...there's a case study that we're going to be using for some of the background documentation for Women Deliver, of a family in Afghanistan, where a husband and wife, they had at least two kids already, wife gets pregnant, gives birth to twins and then dies. The eleven-year-old girl gets pulled out of school to basically play mum. The thirteen-year-old son also then gets pulled out of school because the family is really struggling and can't support themselves. The twins, which she had given birth to, are both sick and are fed on goat's milk etc. and one of them dies after a series of illnesses. The eleven-year-old daughter gets married off, gets pregnant, has obstructive labour, baby is born, has brain damage and she develops an obstetric fistula so husband rejects her and sends her back to her father. This is what happens when a mother dies - you can trace the consequences so it's so much more than just the death.

The use of such non-quantitative data to appeal to decision-makers who are often said to favour 'hard outcomes' and unambiguous evidence in itself marks an interesting development in light of the quantification of evidence. But despite recognising the higher value that is often afforded to quantitative data, informants also insisted that such case studies nevertheless have the potential to have an important political impact. Some even claimed that it was when combined with qualitative data that could "put a face to the numbers" that experimental and other quantitative evidence was the most powerful. Furthermore, qualitative data could help to explain complex relationships that could not easily be delineated through quantitative analyses alone. As such, this use of data suggests that advocacy specialists felt that pure numbers themselves are not, after all, wholly sufficient for communicating the meaning of these numbers in a way that could persuade international decision-makers dealing with many competing issues.

8.3. Policy formulation

The sort of flexible attitude to the use of evidence displayed in the agenda-setting activities discussed above was apparent also in advocacy specialists' efforts to influence the formulation and content of specific policies and plans aimed at maternal health, as well as to influence the actual implementation of such plans. As I show in the sub-sections below, they aimed to influence policy formulation by strategically communicating evidence, using evidence in direct lobbying, influencing the definition of targets and indicators used by international agencies and donors to measure progress, and by participating in monitoring and evaluation activities.

8.3.1. Translation and communication

Many advocacy groups specialised in the communication of scientific evidence to decision-makers and the wider public, reflecting the growth within the evidence-based movement of a veritable industry specialising in the transfer and translation of evidence between research and policy. Such communication involves synthesising, 'translating' and disseminating scientific evidence to key decision-makers in international agencies, donor bodies and stakeholders at the national level who are involved in drafting policy and programme standards and procedures.

A key aspect of this process is "translation" of otherwise inaccessible scientific evidence into terms and language that different target audiences would be able to understand. Translation is often needed, informants explained, to overcome academics' poor presentation skills and their reluctance to simplify or even interpret what their findings mean for policy and programmatic practice. Several of the "translators" I spoke with described collaborating with academics in producing policy briefs summarising scientific articles, but they also often criticised academics for being reluctant to simplify their findings for ease of presentation. For instance, one advocacy specialist derided academic colleagues within the Safe Motherhood Initiative for always insisting that policy briefs include the uncertainty bounds around statistical findings, claiming that academics fail to realise that policy-makers do not understand, and indeed are not concerned with, confidence intervals. As she saw it, "if you give them confidence intervals then the number you've given them is meaningless."

Another informant similarly suggested that academics within the field have in effect impeded the effectiveness of advocacy by being excessively open about the scientific uncertainty of their data. She even admitted – after I reassured her of the anonymity of my interviews – to feeling that the safe motherhood research community “has been plagued by an excess of honesty and ethical rigour” when it comes to evidence. Academics in other global health subfields, she said, have been much more appreciative of the politics of evidence. Referring to researchers from the child health field, she observed:

If you get them away from the conference over a couple of glasses of wine they’ll say, ‘oh yeah, our numbers are not any more valid than yours, it’s just that we [don’t] publicise the differences and we come out with the numbers and we assert them strongly and...people accept them.’ The Safe Motherhood community never did that. We were never assertive enough, whether it was because we were women, I don’t know but we were never, kind of, out there.

For such reasons, advocacy specialists felt that it was especially important to enhance the communication of evidence about maternal mortality to ensure that decision-makers were aware of it. While sometimes faulting academics for their “fanaticism” when it came to the way they were communicating evidence, many of them were nevertheless sensitive to academics’ fears about potential oversimplification of evidence-based claims. Advocacy specialists explained that they strive hard to achieve a balance between accurately presenting scientific findings and “getting it down to a sound-bite” to enable effective communication. On the whole, they judged that they managed to achieve this by drawing on their combined scientific and communication expertise. As the president of one of the NGOs I visited in Washington, D.C. told me, flipping through one of her organisation’s most recently published reports on maternal health:

When we do a press release for a publication like this, we will go back and forth and back and forth until we get just the right balance between the need to communicate and the need to be true to the science. It’s not easy and we struggle with it every time we put something out. But I think the fact that [because] we have people with a passion to communicate and people with a passion to the science, committed to the same goal, which is to have an impact, we end up with a very strong product. There is no statement in this, which would make any of our research staff uncomfortable. This is one powerful communications piece.

As such, effective communication was in no way seen to be irreconcilable with maintaining scientific integrity.

The research evidence that was disseminated to influence policy formulation often derived from the academic domain, but it is important to note that advocacy groups also drew on research findings that they had themselves produced. In fact, most of the advocacy groups I visited conducted some research, whether secondary analysis of existing data or primary qualitative and quantitative research. Often this research aimed to produce knowledge not available within the scientific literature, such as research on unsafe abortion, which few academics had the independence to conduct. Although seeking academic validation for this work – for instance through publishing it in academic journals – was an important component of securing its credibility, an informant from one US research NGO insisted that publication in scientific journals “is something we do to validate the other publications that are for more of a lay audience.” Communication to non-experts was the ultimate aim, she added, showing me a report her NGO had recently produced, and pointing out the white space surrounding the text, the charts and graphs and pullouts that make the document readable before explaining that, “behind it and giving it legitimacy with policy makers and the press who are often arbiters of science, are these peer reviewed journal articles.”

For advocacy specialists, such validation was important, but an underlying premise in conducting research was that the findings could be applied to policy and practice in a direct and immediate way. This, as one informant’s comment shows, was seen to set NGO research apart from academic research: “unlike a fair amount of academic research, this is research that is always linked to a policy objective.” While they were critical of what they saw as academics’ tendency to pursue research without any real appreciation for how the findings would be used, a number of my informants from NGOs did recognise that they were in many ways freer than academics to pursue a policy-relevant advocacy agenda. “This is not a publish or perish kind of atmosphere,” said one informant, explaining that this leaves research NGOs in a better position to determine questions on the basis of political relevance rather than methodological design. Furthermore, a number of NGOs had their own endowments that enabled them to pursue research topics that are sometimes not an option for academics, such

as abortion-related research. At the same time, they were adamant that they were in no way seeking to supplant academic work and tried to keep to what they saw as their own comparative advantage. For instance, while they might conduct secondary analysis of statistical data or research to map 'unmet need' for different health services, they left complex evaluation research to academics.

8.3.2. Lobbying

While much of advocacy groups' communication work involves 'translation' and dissemination through written outputs, their effective use of evidence as an advocacy tool can also depend on their inserting themselves very directly into the high-level arenas in which the content of policy is negotiated. For instance, one American advocacy group prided itself on having developed strong personal links with key politicians that enabled its members to directly influence the uptake of maternal health concerns within key political debates about US international development policy. As the director of this NGO described to me:

We meet on a regular basis with Hilary Clinton's staff, with Harry Reid's staff, with Nancy Pelosi's staff and sometimes with the Speaker herself and we feed them this kind of information. We help them draft legislation and report language, we help them structure hearings, we act as expert witnesses at those hearings, we identify other people who can speak, so we have a very direct input. But we are bringing something unique to that process because we are bringing scientific evidence.²⁴

As this quote suggests, my informant attributed the success of such lobbying to skilful networking with prominent US politicians and others within elite policy networks, but also to the effective combination of scientific *and* political expertise.

While it had been possible for several of the international NGOs I visited to develop strong links with prominent policy-makers in their own countries (primarily the UK and the US) and with international organisations and donor bodies, they were not always in a position to directly influence national-level policy debates in countries grappling with high maternal mortality. They therefore often relied on what one informant labelled "local policy champions." These were individuals, sometimes from regional or national subsidiaries of the

²⁴ At the time of this interview, in June 2007, Hilary Clinton was Senator for New York, Harry Reid was leader of the Senate Democrats and Nancy Pelosi had recently been elected Speaker of the United States House of Representatives.

NGO, who had more direct access to national-level policy spheres and who were therefore seen to be in a good position to carry out evidence-based advocacy at this level. Speaking about such local ‘champions,’ an informant from a New York-based NGO explained how important it is to “flood them with evidence” from the international domain and explain how they can use this evidence to achieve legitimacy and exert influence on those in the Ministries of Health and donor institutions in their own settings. As she explained, “I say, ‘these are the talking points if you’re going to go to USAID or if you’re going to a reproductive health meeting or Safe Motherhood meeting...this is why it’s relevant to your country.’” To a similar end, another NGO organised training workshops to instil the tenets of evidence-based advocacy in the practices of their local partners in sub-Saharan African and South Asian countries. As a representative from this organisation told me, “What we try and do in that setting is to help our research partners to use science, or translate their findings into policy-friendly or media-friendly language and then help the partner understand how to better review scientific evidence in advocacy.” The goal, she explained, is “to help scientists to become better advocates and make advocates more evidence-based,” both with the underlying aim of advancing maternal health-specific policy. Through such workshop the US-based advocacy group hoped to give their local partners enough training to put them in a position of being able to leverage resources, and “keep on hounding the new Minister of Health or the new regional, local people that can influence policies and be part of the policy-making process.”

8.3.3. “What you measure is what you do”

In addition to such efforts to directly influence policy-makers, it is interesting to note that certain Western-based NGOs also intervened in the overtly technical debates over the use of evidence within the policy formulation process itself. One example of this is the way in which they participated in technical meetings and sought to influence the definition of the indicators used to measure progress towards various international agreements and goals, including the MDGs. Driven by the maxim that in public health practice “what you measure is what you do,” shaping the choice of indicators was considered a good way to indirectly influence the formulation of policy and its subsequent implementation. Advocacy specialists had observed that performance indicators can in themselves create powerful incentives at both national and sub-national levels, because they

are often embodied in the reporting requirement and implicit and explicit conditions that donors impose on countries in exchange for financial and technical assistance. The objective of advocacy groups was to ensure that stated commitment to maternal health would actually be translated into concrete policy plans and action for achieving maternal health improvement.

Perhaps the best example of such technical intervention is the way in which international advocacy groups in 2005 succeeded in adding a specific target on reproductive health under MDG 5 on maternal mortality. This can be seen as an indirect way of re-orienting policy towards the broader reproductive health agenda that advocates felt had been further marginalised over the past five to ten years. While the inclusion of maternal health among the MDGs in 2000 suggested high-level commitment to women's health, many advocacy specialists interpreted it as a sign that the international community, under the influence of the US Bush administration and other conservative forces, had reneged on the previous commitment made at ICPD in Cairo in 1994 to ensure women's sexual and reproductive rights in a broader sense. The previous commitments were scaled back, they explained, to the less controversial goal of improving *maternal* health and reducing maternal mortality (as mentioned in Chapter 6).

In contrast to the ICPD, where NGOs had been very active in setting the agenda, civil society had been largely excluded from the process leading up to the definition of the specific Millennium Development Goals. In one informant's estimation, they were excluded in large part because the Secretary-General of the UN at the time, Kofi Annan, was very intent on producing a consensus document that all UN member countries would endorse. When they found that international goals and targets on reproductive health had been excluded from the MDGs in favour of a narrower goal on maternal health, many within the women's health advocacy community initially wanted to lobby for the inclusion of an additional goal on reproductive health. However, driven by a belief that it is performance indicators – rather than the goal itself – that are the most influential in driving the formulation of actual policy and programmes, key advocacy specialists convinced the wider NGO community to focus their efforts instead on lobbying for the inclusion of an additional target relating to reproductive health under MDG 5. This new target was to be included alongside

the original target (to reduce the maternal mortality ratio by three quarters between 1990 and 2015) (United Nations 2009).

The decision to focus on defining the targets rather than lobbying for a new goal was thus deeply pragmatic. Advocates compromised, scaling down their original objective and replacing it with a more politically feasible option. In order to do so, they infiltrated the technical working groups that had been convened to define the targets for measuring progress towards the MDGs. In this forum, they argued that the maternal mortality target for MDG 5 could not, in fact, accurately assess progress towards the goal, since MDG 5 calls for improved maternal *health*, rather than simply reduced maternal mortality. Indeed, advocates claimed, it would in fact be possible for countries to meet the target, but miss the goal of improving health (see also Crossette 2005). On this basis, they thus successfully called for an additional target for mapping progress towards improved maternal health: “universal access to reproductive health care” (to be measured through an indicator on contraception). Being able to partake in technical discussions about performance indicators thus proved a particularly successful strategy for achieving influence in a high-level policy domain from which advocacy groups had initially been excluded.

8.3.4. Monitoring and evaluation

Such technical competency not only enabled advocacy groups to influence the definition of targets – with targets recognised as important drivers of policy change – but also to participate in the further work of monitoring and evaluation to ensure compliance with such internationally recognised targets in actual policy formulation and practice.

Perhaps the most prominent example of such an effort is a global project known as the ‘Countdown to 2015’ that was formed as a ‘supra-institutional initiative’ in 2005.²⁵ The overarching aim of the Countdown is to use statistics on the “coverage of health interventions proven to reduce maternal, newborn and child mortality” to monitor and hold countries accountable for their progress towards the Millennium Development Goals (MDGs) on child and maternal health. According to the Countdown’s website, the expectation behind this effort is that simply drawing attention to such data will stimulate “better and

²⁵ <http://www.countdown2015mnch.org>, accessed 23.07.09.

stronger efforts at the country level.” This is similar to the way in which mortality statistics have been used to raise safe motherhood on the global health agenda, but focusing more explicitly on statistics pertaining to the provision of health services rather than maternal mortality per se.

The same principle underpinned one advocacy group’s use of health statistics and UN-endorsed global guidelines on the provision of maternal healthcare to hold governments and international organisations and donors to account for their obligations to secure the human rights to health and life enshrined in various human rights treaties, implying also an obligation to ensure access to essential life-saving care. To this end, certain advocacy groups gathered and analysed health statistics that they used to reveal discrimination in the distribution of health outcomes or access to life-saving healthcare within a population. These statistics would then be presented to governments or international actors in order to demonstrate the shortfall in their commitments to ensure access to healthcare, for instance. According to informants, the effectiveness of such work relies fundamentally on the pre-existing political currency of the data that is used. As one representative of one NGO told me, an NGO can gain credibility by using statistical data and technical recommendations that have been validated by an external authority such as the WHO. Using evidence that has already “gone from science to policy,” such as WHO-endorsed recommendations on emergency obstetric care, confers authority to NGOs, since it offers “a norm that you can present to governments and say why are you not complying to this basic norm, it’s not exactly a norm, it’s not a binding norm but a *neutrally accepted* standard by a reputable body.” For advocacy groups, a benefit of relying on such accepted standards and externally-validated evidence is that they can avoid resorting to confrontational human rights. Instead, using more neutral statistics can engage governments in more productive discussion about how to identify priority interventions to ensure the progressive realisation of rights to healthcare.

A possible criticism of such use of indicators is that the indicators, being externally set, may encourage policy responses that do not align with country-level priorities. The indicators may also correspond to targets that are in reality unattainable. Moreover, as one informant acknowledged, not all countries have an “information-oriented” culture in which good governance is equated with

transparency and the use of statistics – as it often is in donor nations and within international organisations – meaning that performance indicators may lack credibility at the national level. Indeed, several of my informants acknowledged that uncritically exporting ‘target culture’ to low-income countries may simply push health authorities to pay lip service to international reporting requirements in order to appease the donors and NGOs who demand data to monitor compliance with set targets. On the other hand, some felt that the potential positive benefits outweighed such risks. As one informant saw it, “you could take a cynical view which is that these are imposed and therefore they take the path of least resistance to get some consultant from the outside to get the numbers and they submit them. On the other hand, on a more positive, optimistic note, one could actually say that it is encouraging a culture of understanding of what’s going on.”

Indeed, echoing the Countdown initiative’s rhetoric, members of the rights-based NGO referred to above insisted that their use of statistics to enforce accountability was not intended to be punitive, but was rather a way of stimulating reflection and debate on how governments can actually go about addressing the violation of rights identified through the use of statistics. “It is not about banging on the table and fighting for your rights,” said one informant. “It’s not just a question of the numbers. It’s about how public health systems are designed to address maternal health, and whether women’s rights are front and centre in those systems.” In such ways, statistical indicators came to be seen as a tool for offering practical guidance to policy-makers, because the indicators could be used to identify where policy efforts should be directed to redress rights violations.

In sum, it seems that it was to a large extent through their ability to manipulate scientific evidence and data, and to deploy this strategically within various policy domains, that advocacy specialists felt that they were able to exert an influence. As one informant herself concluded our discussion, “our experience, we think, demonstrates that if you have solid scientific evidence and you communicate it very strategically to ‘change agencies,’ that you can over time have an impact on policies and programmes.”

8.4. Depoliticised advocacy

Although informants clearly found that they were better able to influence policy through the use of science, there are also potentially adverse consequences associated with the growing reliance on purportedly objective burden of disease data and economic arguments in global health advocacy. While informants celebrated the effectiveness of their own evidence-based advocacy and the political advantages this had conferred, they also recognised, and to some extent lamented, that evidence has to a large extent become the only, or at the least the most legitimate, way to present an argument and achieve credibility in global-level spheres. Furthermore, some regretted that this heavy reliance on evidence prevented them from mounting principled or moral arguments against policies and positions they disagreed with (or, vice versa, to counter arguments against those policies they themselves supported). As one advocacy specialist reflected, “I think it suggests the importance which policy-makers and the public attach to evidence-based policy, that people on the left no longer feel that their moral position or an emotional position is sufficient to justify a particular policy.” By people on the left, this informant was referring in fact to most safe motherhood advocates. At the same time, my informant claimed that “people on the other side” – which for her means the conservative right – have started producing and using scientific claims of questionable scientific standard (sometimes termed “junk science”) to back up their moral and religiously-based opposition to women’s health issues. Safe Motherhood advocates, she felt, were being careful with the way they pitch evidence, claiming to do so in a responsible way, but others were doing so in an irresponsible way, one that was, in fact, entirely morally-enframed.

Nowhere has the contested use of evidence in advocacy been more clearly demonstrated than within the controversial abortion debate, and the emerging tendency among pro-life activist organisation to document through purportedly systematic research the allegedly adverse mental and physical health consequences of abortion. Such research forms part of their effort to legitimise on scientific grounds their religious or moral opposition to abortion. Several informants dismissed these studies as being of poor quality, but despaired that pro-life politicians are perfectly prepared to use such ‘junk science’ to justify their policy stand. To counter this, one safe motherhood group I visited had even

gone so far as to set up a “rapid response system” to challenge, on scientific rather than moral or political grounds, the arguments of those with politically opposed perspectives. The system is designed to identify studies into spurious links between abortion and adverse outcomes, such as women’s mental illness. Once identified such studies are subjected to a systematic methodological critique to debunk the credibility of their purported evidence-based claims. This critique is then written up and circulated in summarised form to policy-makers, the press and other advocacy groups, or even to “key people up at Capitol Hill” if it seems likely that the study in question might be used in a floor debate around a piece of legislation. The speed of response is crucial, explained an informant who had helped develop the rapid response system, “because if a study like that gets legs and it starts disseminating itself then it’s very hard to correct that misinformation so we want to be able jump on it right away and we want to smash it before it gets any traction.”

Such responses may work, but by engaging – on an evidence-based level – with political opponents such as pro-lifers, they also unintentionally endow their opponents’ arguments with a legitimacy that my informants believe they simply ought not have. In this they recognise that far from ridding policy of ideologically-motivated advocacy the growing use of evidence has contributed instead to obfuscating the political and ideological basis of some policy advice (e.g. anti-abortion) and simultaneously made it more difficult for others to make their evidence count when the users of those policies (such as certain policy-makers) are themselves ideologically motivated and choose between competing evidence claims, not on scientific but on ideological grounds.

But while evidence-based advocacy surely has the potential to depoliticise advocacy, a subset of actors used objective evidence precisely to re-politicise the debate about maternal health. Notably, statistics played an important role in the dissemination of the idea that surviving pregnancy and childbirth is a fundamental human right, since effective medical interventions exist to prevent such deaths. Specifically, some advocacy specialists used descriptive epidemiological indicators of health outcomes and service provision to challenge the public, as well as expert communities, to reconceptualise the issue of maternal mortality not simply as a public health problem or as a even women’s rights issue, but as a fundamental human rights issue (see e.g. Freedman 2001;

Cook and Dickens 2002; Freedman 2002; Yamin and Maine 2005; Gruskin et al. 2008).

According to a representative of one such group, maternal mortality illustrates well how public health problems can be thought of as human rights issues: “an individual avoidable death becomes a human rights issue when that death is evidence of a wider, more systemic failure of the government to adequately address structural problems that result in a pattern of [maternal mortality]” (Freedman 2002:156). Informants were upfront about the challenges of using rights-based language in certain countries, with one claiming that in a country where women until very recently delivered in the secrecy of their own homes, “you take a rights-based approach and you speak into a desert.” By contrast, insisted other informants, statistics can greatly facilitate the process of communicating the idea that maternal mortality results from discrimination against certain groups, a fundamental principle within the rights-based conceptualisation of maternal health. As one informant explained, “if you look at a country where you have a middle class that’s able to give birth safely but then you see very high rates of maternal mortality among minority groups, immigrant groups, then it is clear you have a discrimination issue and that’s not a difficult rights argument to make.” Advocates wanting to make these arguments were often impeded by data shortages, however, and therefore appealed to epidemiologists to design data collection tools that can allow for analyses of inequities. As such, some safe motherhood advocates have begun to adopt the political strategies of their opponents whilst being careful not to abuse the evidence they present. In this, it seems to me that they are in fact finding ways to adhere to the moral imperatives they believe in, whilst on the surface continuing to formulate their arguments in a technical way.

8.5. Conclusion

Safe motherhood advocates today embrace and seek to capitalise on the authority, legitimacy and influence that science and statistics give them in high-level policy spheres, and the way in which the language of evidence and numbers enables them to exert influence on actors across social, geographical and ideological divides. Whereas the evidence-based medicine paradigm assumes a universally valid hierarchy of evidence, here I have argued that, in practice,

advocacy specialists operate with a more nuanced hierarchy of their own, in which the level and type of scientific evidence are not considered universally valid, but rather scaled and adapted to fit different audiences and stages of the policy process. While my informants emphasised that evidence must be – as far as possible – reliable and convincing, they also recognised that in certain contexts evidence-based knowledge claims, and especially statistical forms of knowledge, carry great weight in global health policy, even when nobody defends their validity with real conviction (Nichter and Kendall 1991; Porter 1995; Hacking 2007). As Kielmann (2002:118) has remarked, “despite widespread recognition that collecting data on illness and death in low-resource settings is fraught with technical and logistic difficulties, these numbers have tended to acquire a public life of their own and have come to constitute authoritative knowledge in health policy and planning decisions.” Similarly, in the case of advocacy for safe motherhood, it has often been the broader social and political meanings of objective claims as much as their inherent scientific credibility that have imbued ‘evidence-based’ advocacy claims with the power to create a political response.

The growing prominence of international advocacy NGOs within global health governance suggests a need to develop greater understanding of how such groups influence policy and the sources of legitimacy upon which they draw (Doyle and Patel 2008). Previous work from other subfields has demonstrated how instrumental various civil society groups can be in using evidence to influence policy change. For instance, Epstein’s (1996) study of the AIDS movement in the US shows how AIDS activists, through acquiring scientific literacy, were not only able to create political commitment to HIV/AIDS, but also to alter the regulatory frameworks around the approval of HIV/AIDS drugs so as to expedite their own access to treatment. Similarly, George (2000) has described how the advocacy coalition working against sterilisations in India gained legitimacy through becoming conversant in technical language and by participating in international forums and exploiting their social links with research organisations. When set against these cases, safe motherhood advocacy appears peculiar in that it has relied so heavily on Western women advocating on behalf of women in poor countries who are assumed, often rightly so, to lack the voice to do so themselves. Advocacy specialists, through inserting themselves in global-level elite policy networks, have become able not just to subvert dominant

agendas through obtaining their own scientific literacy, but also to structure and manage their own practices partially within these agendas. While other commentators have been sceptical of the ability of advocacy groups to influence 'high' policy agendas that are dominated by the ideology of donors (Brock and McGee 2004, cited in Pollard & Court 2005), safe motherhood advocacy specialists' use of evidence and their waging of 'advocacy' at the level of technical debates does seem to have facilitated their access to and influence in high-level spheres and secured their own reproduction.

However, while advocacy groups can infiltrate and shape technical debates, on the whole this rarely involves any explicit challenge to dominant ideology or frameworks that had set the terms of these debates in the first place, including the heavy reliance on burden of disease and cost-effectiveness as proxies for determining the relative priority of different health issues. Although embracing evidence-based advocacy is clearly a pragmatic response to altered political realities, fostering the heavy reliance on purportedly objective claims – rather than challenging the basis upon which global-level decision-making often takes place – may have negative consequences. Indeed, safe motherhood advocates may be perpetuating or extending the dominance of a technocratic approach to priority-setting focused on burden of disease and cost-effectiveness evidence that on many levels disfavours maternal health and safe motherhood interventions. Interestingly, some advocacy specialists appear to be critical of this tendency and are using statistical evidence in creative ways as part of their efforts to bring about a re-framing of maternal mortality as a human rights issue that governments and the international community have a responsibility to address.

The findings presented in this chapter also underline the extent to which technical expertise has come to be seen as a prerequisite for political influence. This has implications for how we evaluate the key justifications behind the growing reliance on NGOs within global health policy debates, namely that they give a voice to marginalised people in the policy process and enhance democracy through their membership of consultative or decision-making bodies of international health-related organisations (Seckinelgin 2005; Doyle and Patel 2008). Has the trend towards evidence-based advocacy enhanced participation, or is it instead perpetuating an elitist and technocratic approach to global health policy-making? It is clear that international advocacy groups are acutely aware of

the way in which authority has become increasingly inseparable from scientific expertise – and the ability to communicate such expertise effectively. Indeed, an important part of their work involves diffusing ideas about evidence-based practice to low-income countries, as a way of influencing the policy process at national and local levels. Yet, whether this has the desired effect of ‘empowering’ local stakeholders remains to be established, as does the extent to which the internationally-produced evidence-base that is disseminated through advocacy work actually accords with national and local needs, priorities and political realities.

9. CONCLUSION

In this thesis I have sought to understand the making of the Safe Motherhood Initiative as an example of one of many so-called global health initiatives to have emerged over the past ten to twenty years. My main overarching aim has been to explore how safe motherhood practitioners have come to understand the problems that are credited for the field's stymied status, and how their 'diagnoses' and situational analyses have informed their subsequent practices. Drawing on in-depth interviews with over seventy actors within the field, participant observation and document review, I have provided an historical and ethnographic account of the Safe Motherhood Initiative's struggle for identity, authority and priority within the increasingly fragmented and competitive field of global health. I have tried to examine just how – and with what consequences – the Safe Motherhood Initiative as a 'policy community' has sought to influence the global health policy process, so as to raise awareness about women's health and maternal mortality, secure global health resources, and further ensure the actual uptake of the Initiative's own policy recommendations.

9.1. Summary and discussion of main findings

The findings were presented in two main parts, which acknowledged the historical arc of the safe motherhood movement's development, while allowing me to focus thematically upon some of the key dynamics at work. In *Part I* (Chapters 3-6) I thus examined the Safe Motherhood Initiative's own particular policy vision in relation to the broader debate about comprehensive versus selective approaches to public health, and the different ways that debate has been expressed over time. In *Part II* (Chapters 7 and 8) I paid in-depth attention to how research practices and advocacy for safe motherhood have responded to the debates discussed in *Part I* and, in particular, to the normative priority-setting frameworks and definitions of evidence that have emerged during the past few decades. By structuring the thesis in this way, I have sought to give an account of safe motherhood that is historically dynamic, sensitive to the differing

perspectives of some of its key protagonists (be these academics, advocacy specialists, or policy advisors) and capable of providing a nuanced conceptualisation of a global health movement ‘in the making.’

9.1.1. The tension between comprehensive and selective approaches

The first specific objective of my research was to analyse how the tension between comprehensive and selective approaches to public health has impacted on safe motherhood policy debates and policy shifts since the Initiative’s launch in 1987. This entailed situating the emergence of the Initiative and its particular policy vision within the broader context of global health.

The common narrative of the history of safe motherhood policy told by the Initiative’s own practitioners in the scientific literature and in various policy domains holds that the Safe Motherhood Initiative’s progress has been hampered by the strategic missteps the Initiative made in its early years, including the promotion of a broad agenda encompassing social, economic and health policy change (e.g. Starrs 2006). Today, we are most commonly told, strategies are more appropriately targeted at emergency obstetric care and skilled birth attendants. This narrative implies a gradual retrenchment of an idealistic, comprehensive vision, in favour of a more rational, selective approach.

Interpreting such accounts, however, can be complex. While they provide a useful, shorthand history of a professional community and its key events and debates, they also, inevitably, reveal a particular way of telling that history. It can be seen as a version of history constructed by long-standing participants in the debate that serves to validate their current policy positions, as part of their broader struggle for legitimacy and policy support (cf. Fujimura and Chou 1994). As such, rejecting past policy recommendations as mistaken on the one hand oversimplifies the past, but on the other hand serves to legitimate the strategic policy focus of the present. In conducting an historical ethnography, I have sought to draw attention to some of the contradictions that emerge in the common narrative, as well as to the factors that it obscures. For instance, ethnographic research reveals that the process of international policy development for safe motherhood has been neither linear nor particularly rational, but can be better understood as a process that is fundamentally social and political and, at times, highly contested. For the international-level actors

involved – whether as researchers, policy advisors or advocacy specialists – the process has in fact entailed considerable negotiation, and, for many, compromise.

The Safe Motherhood Initiative was created in the midst of a polemical debate about competing concepts and approaches to public health. In Chapter 3, I described how the Safe Motherhood Initiative emerged out of practitioners' underlying conviction that a comprehensive primary healthcare approach – incorporating social and medical, preventive and therapeutic approaches – would be the best strategy for low- and middle-income countries to adopt in order to improve women's health and survival through pregnancy and childbirth. As I elaborated on in Chapter 4, such a comprehensive approach is a vision that the Safe Motherhood Initiative has, ever since, struggled to realise, as it has come up against political-economic impediments, as well as ideological resistance from powerful actors preferring a selective approach to global health.

One important response to the lack of uptake of the original comprehensive strategy has been the Initiative's recommendation that safe motherhood programmes should be targeted at averting deaths from obstetric complications through professional, obstetric care, including emergency care. In Chapter 5, I showed that this dramatic shift away from the combined social and biomedical focus of the original safe motherhood agenda did not result from genuinely new technical insights about maternal mortality reduction, as has often been claimed. Instead, I argued, it resulted from a repackaging and 'branding' of core health system recommendations to enhance their appeal to market-oriented decision-makers favouring disease-based approaches to public health, one that was emulated on the successes of the Child Survival Revolution in promoting GOBI.

While the past five to ten years have seen debate about the need for 'integration' and 'alignment' of selective programmes, this period has also seen the proliferation of disease-specific global health initiatives and the rise of private philanthropy. This proliferation has altered global health financing, governance and policy-making in important ways, in part by atomising it. As a result, as I discussed in Chapter 6, the safe motherhood policy community has not only continued to be torn between a desire to integrate with other disease-specific coalitions and a need for self-preservation, it has also come to internalise some of these basic contradictions in global health.

The way in which the chapters in *Part I* together challenge the notion of policy development as a rational process has implications for how we think about the role of international actors and specifically communities like the Safe Motherhood Initiative in the 'policy process.' If the policy process is thought of as long-lasting and emergent, it becomes possible to see the work of safe motherhood actors as being to connect and modify what Walt, Lush and Ogden (2004) have referred to as the different "iterative loops" involved in the transfer of policy from international organisations to national jurisdictions. The main role of international organisations is in international agenda-setting for specific issues, followed by policy formulation in the form of global guidelines. In what Lush and her co-authors describe as a first, "bottom-up" loop, international actors take up, adopt and adapt lessons from research and clinical practices developed in one or more countries, or indeed from other sub-fields of public health. In a second, "top-down," marketing-oriented loop they then mobilise support for particular policies by marketing and promoting them (*ibid.*).

Walt and her co-authors developed this notion of interacting, iterative 'loops' to account for international policy on infectious diseases, but it can help to make sense of the work of the Safe Motherhood Initiative too. As we have seen, in the run-up to and early years of the Initiative, international-level actors formulated a broad set of recommendations on the basis of clinical and public health lessons. These were derived in large part from the experience of Western countries in reducing maternal mortality, as well as from new epidemiological and clinical research from low- and middle-income countries. The recommendations were also underwritten by an ideological commitment to improving women's status and ensuring 'health for all.' The formulation of these original comprehensive recommendations can be thought of as the 'bottom-up' loop in the development of international safe motherhood policy that has taken place over the past two decades. The gradual work that then went into promoting these recommendations to the international health and development community, as well as to national stakeholders, can be seen as the 'top-down,' marketing-oriented loop. Here, the original complex and comprehensive safe motherhood proposals were simplified and branded so as to achieve more broad-based appeal and uptake, first as ten Action Points at the 1997 Safe Motherhood Technical Consultation, then as EmOC and more recently as the '3

pillars of saving women's lives' at the Women Deliver Conference of 2007. The role of research-based knowledge in this stage has been not so much to guide policy solutions as to legitimate simplified and 'branded' international policy guidelines.

However, we also need to take stock of the fact that while the 'marketing' of policy has changed in response to broader dynamics in the global health field – and may indeed improve global-level support for safe motherhood – the practical and applied implications of changes in the branding of safe motherhood policy may be underappreciated. When rebranded messages – for instance on EmOC or the continuum of care – are conveyed from international organisations to those implementing programmes in low-income countries, they can appear unclear, ambiguous and open to misinterpretation (I Hussein and Clapham 2005). For programme managers, the frequent change in branding strategy and messages can feel like “sinking in a sea of safe motherhood concepts” (*ibid.*:294).

The changes in concepts and terminology belie that the core, underlying principle that most safe motherhood actors have sought to convey – that maternal mortality reduction depends on ensuring women's access to life-saving obstetric care delivered within a functioning health system – remains much the same as it was twenty years ago. Nevertheless, in the process of the gradual simplification inherent in policy marketing or branding, the very meaning and significance of the term 'safe motherhood' has been modified and to some extent redefined. Safe motherhood, originally devised as a catch-all term for an initiative that aimed to improve women's status and health through comprehensive policy change, has, in effect, become gradually redefined as a more technical effort to avert deaths from obstetric complications. This has occurred despite the fact that the Initiative's practitioners, on the whole, have retained an ideological commitment to advancing women's rights and to developing comprehensive, accessible and affordable health systems. This redefinition of safe motherhood has been contested by some subgroups within the Initiative, at times creating factions, even as the Initiative's constituent groups constantly struggle to come together as a coherent whole. Ultimately then, the Safe Motherhood Initiative not only represents a single instance of the broader fragmentation or 'atomisation' of public health into disease-specific initiatives, but an example of

what we might call the 'vascularisation' between different sub-groups that takes place within individual global health movements as a response to that wider fragmentation of the international health field.

9.1.2. Appeals to scientific authority

The second specific objective of my research was to examine how, and on what terms, research practices and advocacy have responded, and are in part constrained by, the sort of tensions and debates I identified in *Part I*. This included attention to how research and advocacy have adapted to the gradual rise of more normative approaches to establishing global health priorities and for defining what counts as 'evidence.' In Chapter 7 I therefore traced a shift in academic research practices away from methodologically diverse health systems research and towards the pursuit of a more narrowly defined concept of evidence, focusing heavily on maternal mortality measurement and experimental evaluations of healthcare interventions. Such a gradual narrowing responded, on the one hand, to the adoption of the evidence-based medicine paradigm as the main framework for judging academic performance, but was reinforced by the way in which this paradigm has come to be mirrored in donor agendas. This, in turn, reflects a preoccupation with monitoring and evaluation of global health investments to ensure value for money.

The findings presented in this part of the thesis served to demonstrate that academics struggle to reconcile the contradictory pressures emanating from academia, donor agencies, advocacy specialists and country-level policy-makers. This has left them feeling deeply ambivalent about their identity and querying what their contribution to global health should be. Advocacy specialists in international NGOs, by contrast, embraced the authority and political power of scientific evidence and statistics in their efforts to encourage political priority for safe motherhood and in their lobbying for specific policy change. In Chapter 8 I showed how they often tailored their use of evidence in creative ways according to the stage of the policy process and the target group they were seeking to influence, something they saw as critical to convincing policy-makers and donors to support the Initiative and its goals.

These chapters show different forms of 'boundary work' at play, through which academic and advocacy actors sought to demarcate their practices and positions as scientific rather than ideologically driven (Gieryn 1983). Of course,

there is nothing inherently new about such appeals to scientific authority. The historical work of both Daston (1992) and Porter (1995) reminds us of the social origins of often taken-for-granted notions such as objectivity. Both these authors show how systematic and transparent knowledge and quantitative knowledge in particular became equated with objectivity and, in turn, with authority first and foremost because it served social ends. The rising authority associated with quantitative knowledge relates to the fact that it enabled the need for communication that arose as a result of greater interdependence between different, and sometimes distant, communities (*ibid.*). Porter (1995) further argues that quantification in particular came to be associated with social authority in response to eroding levels of trust in individual expert knowledge. As such, the emergence of quantification in the domains of bureaucracy and science did not derive so much from the wish to make better decisions but rather from the need for a response to institutional disunity and external pressures (*ibid.*). For Porter, the key to understanding the continued widespread “trust in numbers” is thus that it minimises the need for intimate knowledge and personal trust. Much the same can be seen within the Safe Motherhood Initiative. While the tendency to invoke scientific expertise to achieve social authority may not be new, it has doubtless taken on new ferocity within the current context of global health. As I have shown, appeals to scientific authority and legitimacy are at the heart of the strategies through which the Safe Motherhood Initiative has sought to position itself as a viable competitor for global health resources.

It is sometimes claimed that the growing reliance on evidence that characterises global health policy is enabling to scientific experts, in part because the status associated with scholarly expertise and professional training is empowering for those individual experts who are consulted or co-opted into policy-making (Stone 1999). While this may be the case for the advocacy advisors I interviewed, who used scientific knowledge to achieve direct political influence, some academics clearly did *not* feel enabled and in fact struggled to reconcile their role as academics with that of advocate or policy advisor. Instead, the blurring of roles experienced by many academics raised a series of unresolved questions about how they should act. It is not clear, for example, how academics are to balance the global demand for coherent, simplified messages with their desire to accurately communicate evidence that is highly complex, nuanced and

context-specific. How should they balance their conviction that the major research challenge for improved maternal health is operational health system research, with the intense professional pressure to produce ‘cutting edge’ experimental research into single interventions?

While proponents of evidence-based policy might argue that basing policy on evidence reduces undue ideological interference and hence ensures more objective, and even fairer, allocation of resources (Klein 2000), my findings suggests the need to nuance such claims. Rather than ridding advocacy and research of ideological influence, the turn to more ‘objective’ justifications for public health action does not as much eliminate as *obfuscate* the ideological and deeply political basis of decision-making. This may mean that these ideological and political foundations are suspended from open and critical scrutiny. The reliance on objective or evidence-based arguments may also have entrenched a deeply technocratic and elitist approach to inherently political policy debates, as scientific expertise – which is in no way equally distributed globally – has come to be equated with political influence. The picture that results is complex. Boundary work may benefit individual actors and groups who can derive legitimacy and authority from appearing ‘scientific.’ However, we have also seen that such boundary work can encourage research and advocacy practices that may be counter-productive to the Initiative’s enduring struggle to mobilise political support for the notion that health system development is essential to realising women’s right to avoid preventable death during pregnancy and childbirth.

9.1.3. Self-management

It is in order to explain why safe motherhood actors engage in these sorts of potentially counter-productive practices that I have, throughout the chapters, tried to conceptualise the movement’s history as one characterised by continual self-management. As I have shown, individual actors contribute to the safe motherhood policy community’s self-management through strategies that aim to pursue their common policy objectives and to secure the survival of safe motherhood as a successful global health alliance. Indeed, the very inception of the movement can be seen as a competitive response that grew out of a perceived need to protect women’s health and maternal healthcare from

becoming subservient to child survival objectives and the dominance of selective primary healthcare (see Chapter 3).

As I have demonstrated across the chapters, over the past two decades, the safe motherhood policy community has sought to position itself within the rapidly changing institutional and ideological landscape of global health, in order to ensure its own reproduction and to secure a place for safe motherhood on global and national policy agendas. As global health has changed, with a shifting balance of power that has seen UN actors gradually crowded out in favour of individual donors, NGOs and global health initiatives, the safe motherhood movement has also had to adapt itself. It has done so principally by seeking to strengthen the credibility of its own policy proposals (e.g. Chapters 5 and 7), establishing new institutional structures and funding mechanisms, seeking to identify new champions (Chapter 6) and by elaborating more sophisticated research (Chapter 7) and evidence-based advocacy (Chapter 8). The safe motherhood policy community has thus in many ways come to model itself on the global health initiatives that have, since the turn of the millennium, been increasingly successful in attracting both public and private financing and in influencing health policy agendas, and it has done this even as it purports to be fundamentally quite distinct from them.

In modelling itself on other apparently more successful global health initiatives, notably the Global Fund, the Safe Motherhood Initiative has, understandably, sought to generate political priority for its own objectives. According to Shiffman and Smith (2007), political priority is present when public statements of support for a particular health issue are made and when the level of resources that political leaders and donors allocate to a particular area is considered commensurate with the severity of the problem. By this measure of success, the safe motherhood community appears to be moving in the right direction. For instance, in recent years the field's reinvigorated advocacy campaign has indeed fed into the creation of a number of dedicated, global initiatives to enhance progress towards maternal health-specific goals. These include the 'Global Business Plan' that was initiated by the Prime Minister of Norway in 2007 (pledging one billion dollars over 10 years to achieve MDGs 4 and 5), and a Gates-supported Maternal Health Task Force formed in 2008. Maternal health most certainly has a higher public profile now than it did at the

Initiative's start and even than it did a few years ago, at least at the global level and in important donor nations. In the UK, for instance, Sarah Brown, the wife of Prime Minister Gordon Brown, is now an ambassador for the advocacy NGO the White Ribbon Alliance for Safe Motherhood, and an outspoken champion of safe motherhood issues in the media. The Initiative has thus on some level clearly succeeded in strengthening its position as a global health initiative approaching that of the public-private initiatives that have been catapulted to global prominence over the past ten years (even if the volume of funding pales in comparison to some of the other, major global health initiatives, such as the Global Fund).

Such successes are today widely celebrated as evidence of greater political priority for safe motherhood, not least because of the implicit assumption that they will translate into health improvement in low-income countries. But a causal link between political priority for specific health issues and improved health indicators assumes that the policy responses or services enabled by prioritised global health initiatives are in fact appropriate to the challenge. As I discuss below, there are growing concerns within the public health community that this may not always be the case. Instead of translating into stronger health systems and better health outcomes, ostensibly successful global campaigns such as those highlighting HIV/AIDS and child survival may in fact come to illustrate the limits of disease-specific global campaigns within the poorly functioning health systems of low-income countries. Given the current concerted efforts to achieve political priority for 'safe motherhood' as a global health issue, it seems crucial therefore to critically assess the extent to which political priority for disease-specific global health initiatives is likely to translate into health improvement.

It is too soon to judge the effects of new donor-driven global initiatives dedicated to maternal health, which have only recently come under way or are still in the planning stages. Much will depend on how activities are implemented and funds disbursed. Nevertheless, in reflecting on these questions, it is instructive to look briefly at what can be learned from the experiences of other global health initiatives that are widely deemed to be more successful at generating political priority. Is the emergence of strong global health initiatives such as the Global Fund, GAVI and PEPFAR – and the 100 or so other global health initiatives that have also been established around diverse global health

issues – really such a desirable trend? How are we even to know whether such initiatives contribute to their stated goals to improve health? And what lessons might they provide for the Safe Motherhood Initiative?

9.2. The effects of global health initiatives on health and health systems

Perhaps the most commonly cited benefit of strong global health initiatives is that they are very good at attracting money and attention, even for neglected global health issues. A clear indication of this financial prowess is that development assistance to health has increased four-fold since 1990, a rise that is almost exclusively attributed to the emergence of public-private partnerships and global health initiatives, including the Global Fund, GAVI, PEPFAR, and the World Bank's Multicountry AIDS Programme (Ravishankar et al. 2009). But how do such initiatives impact on health outcomes and health systems?

While the Global Fund's website claims that 4,000,000 lives have been saved through Global Fund-supported programmes,²⁶ most commentators have been more cautious in attributing mortality decline directly to the activities of global health initiatives. They have focused instead on documenting their benefits for access to health services. One recent review of the existing literature on the effects of global health initiatives for HIV/AIDS lists rapid scale-up in HIV/AIDS service delivery, greater stakeholder participation, and channelling of funds to non-governmental stakeholders (mainly NGOs and faith-based bodies) as among the benefits of such initiatives (Biesma et al. 2009). Another review similarly notes the expansion in HIV/AIDS services in many countries, along with improvement in infrastructure and laboratories and, in some cases, primary healthcare services (Yu et al. 2008). Others further claim that strong global health initiatives contribute to reducing out-of-pocket expenditure on healthcare in developing countries by subsidising access to essential medicines (Banati and Moatti 2008). Banati (a representative of the Global Fund) and Moatti even claim that disease-targeted programmes allow for better use of scarce resources in health systems by reducing mortality among healthcare personnel and the incidence of infectious diseases through prevention interventions, as well as by limiting hospitalisation rates for treated individuals (*ibid.*).

²⁶ <http://www.theglobalfund.org/en/>, accessed 10.11.09.

Despite such reported benefits, a number of negative effects have also been indicated. The first large-scale assessment of the effect of global health initiatives on country health systems (conducted by the WHO's Maximising positive synergies group – incorporating scientists from 30 nations and representatives of the WHO, UNICEF, UNAIDS, GAVI, the Global Fund and the World Bank) was published in the *Lancet* in June 2009. An editorial in the same journal itemised some of the “troubling harms” documented by this review:

...deepening inequalities in health services, reduced quality of services because of pressures to meet targets, decreases in domestic spending on health, misalignment between GHIs [global health initiatives] and country health needs, distraction of government officials from their overall responsibilities for health, the creation of expensive parallel bureaucracies to manage GHIs in countries, the weak accountability of a rapidly expanding GHI-funded non-governmental sector, and increased burdens on already fragile health workforces (*Lancet* 2009a:2083).

Others note similar concerns, including that global health initiatives' emphasis on improving access to treatment sometimes implies inadequate attention to whether expanded services are accessed in an equitable manner (Hanefeld 2008). More generally, Walt and Buse (2000) have warned that global health initiatives may exacerbate inequalities or disadvantage the poor, both globally and within countries, in part because they focus their activities on countries that offer a reasonable chance of success. Furthermore, there is evidence that resources are diverted from routine health services to support donation programmes and that scarce personnel are “siphoned off” from other healthcare services to better jobs in vertical HIV/AIDS programmes (Yu et al. 2008). Such effects on personnel no doubt have adverse consequences for general health services, including for maternal healthcare, which depends so heavily on professional and ‘skilled’ providers. Some authors have even gone so far as to argue that decline in African health standards in the maternal and child sector, as an index of the general functioning of a health system, is a “direct result” of Global Fund policies, such as “the competitive recruitment of its own staff and consequent neglect of other services” (Italian Global Health Watch (OISG) 2008:44).

Reaching clear-cut conclusions about the effects of global health initiatives on health systems is complicated by the relative dearth of systematic

empirical research into their effects and the polemical nature of the debate. For example, despite presenting mixed evidence, the WHO-led review that claims to be the most authoritative assessment of the issue to date concludes on a positive note. Its authors argue that with a few adjustments to the way in which global health initiatives are run, such initiatives may offer critical opportunities to improve “efficiency, equity, value for money, and outcomes in global public health” (World Health Organization Maximizing Positive Synergies Collaborative Group 2009:2137). However, critics question the credibility of the review, alleging that it is potentially biased because it relies on global health initiatives’ own analyses (McCoy 2009). Moreover, it is debatable whether all the effects identified as *positive* in current assessments of the evidence are in fact so. For instance, that global health initiatives channel funds to non-governmental stakeholders is not an unequivocal benefit. As anthropologists have documented, the “velvet glove” of privatisation associated with the expansion of private and NGO healthcare provision in developing countries can indeed improve access to care, but can also have other harmful effects, including undermining local control of programmes and contributing to growing local social inequality (Pfeiffer 2004). The widespread assumption that NGOs funded by global health initiatives have the legitimacy to represent the interests and priorities of people in the countries in which the initiatives work is also contentious (Doyle and Patel 2008).

Fears about the negative effect of global health initiatives relate not only to their impact on health systems and outcomes, but also to the fact that a global health ‘architecture’ comprised of many, parallel initiatives means that *governance* for health has become very fragmented. More than a decade ago, health policy analysts Buse and Walt (1997) drew attention to the “unruly melange” of numerous disease-specific initiatives operating within a competitive global health sphere. They also queried the weak representation of recipient countries on the governing boards, technical, advisory or grant-giving committees of global health initiatives (Walt and Buse 2000). Since then, the influence of state and UN actors has gradually ceded to the World Bank, private donors and NGOs (Lancet 2009*a*). A main concern for some critics has been that global health initiatives undermine the WHO’s role as an inter-governmental, representative organisation able to act as an accountable leader for international health action. This concern

stems from the fact that global health initiatives are largely unaccountable to governments or inter-governmental agencies and the fact that they are strongly influenced by corporate ‘partnerships’ (Gostin and Mok 2009). According to one critique, the consequence of the resulting lack of leadership is that Ministries of Health (especially in donor-dependent countries) are forced to operate in a “circus of multiple and uncoordinated demands from global institutions, donor agencies and international NGOs” (People’s Health Movement 2005:20). Others worry about the potential of high volume global funds to disrupt the policy and planning processes of recipient countries, for instance by distracting governments from coordinated efforts to strengthen health systems and by introducing “re-verticalisation” of planning, management and monitoring and evaluation systems (Oliveira-Cruz 2008:2; Biesma et al. 2009). More generally, the work of these initiatives points to a tension between emphasis on local ownership, integrated service provision and system development (as has been attempted through funding mechanisms such as sector-wide approaches and direct budget support), and the pursuit of measurable outcomes, specific objectives and short-term efficiency (McPake 2008).

To counter criticism that disease-specific activities may be damaging national health systems and producing unsustainable health gains, today’s global health initiatives claim that they undertake a range of efforts to specifically strengthen health systems. GAVI and the Global Fund, as an example, have elaborated specific mechanisms for funding health systems using “cross-cutting” solutions (Banati and Moatti 2008). The WHO’s Maximising Positive Synergies Collaborative Group – which includes representatives of the major global health initiatives – recommends that health system strengthening should be a higher priority for global health initiatives, and, in a statement issued in June 2009, promises to implement changes to this effect (Lancet 2009*b*).

Yet, the notion of ‘health system strengthening’ remains vague, with different global health initiatives operating with divergent underlying assumptions about what it actually is, and how it might improve health (Marchal et al. 2009). On the basis of a detailed review of the health system strengthening strategies published by various global health initiatives, Marchal and his co-authors (2009) judge that most such strategies are in fact selective, disease-specific interventions. They therefore warn that the stated commitment to health

system strengthening within the existing institutional structures of global health initiatives may undermine, rather than accelerate, progress towards the long-term goal of producing an effective, high-quality, and equitable health system (*ibid*)

The debate about the effects of global health initiatives is thus clearly polarised, in many ways mirroring the debate about selective and comprehensive approaches that permeates the Safe Motherhood Initiative's history. Further research into their effect is needed to inform the future development of global health initiatives and to encourage critical reflection on the question of whether continued strengthening of such initiatives is indeed a desirable trend. Such research needs to adopt a longer-term perspective than has been taken in existing studies in order to take on board well-founded concerns not only about the immediate effectiveness, but also about the *sustainability* of disease-specific global health initiatives that rely heavily on private finance, especially in times of economic turmoil (e.g. Le Loup et al. 2009). Will gains such as improved access to antiretrovirals, improved case detection of tuberculosis and coverage of insecticide-treated bed-nets be sustained over time?

It is too soon to answer these questions, but the experience of the Child Survival Revolution, as a precursor to contemporary global health initiatives, suggests grounds for caution. In the early 1990s, many credited GOBI (UNICEF's intervention package consisting of growth monitoring, oral rehydration therapy, breastfeeding, and immunisation) with drastically decreasing child mortality in low-income countries. According to UNICEF, the under-5 mortality ratio fell from 118 per 1000 live births in 1980 to 94 in 1990, and immunisation coverage expanded rapidly (UNICEF 2001). Although the immediate success of GOBI was remarkable, the gains in immunisation coverage were not, in fact, sustained over time. Indeed, in an editorial published in 2007, McCoy, Sanders and Kvåle (2007*a*) argued that the subsequent collapse of health systems has contributed to many countries suffering reversals or significant slowing of child survival gains, noting that in sub-Saharan Africa immunisation coverage has stagnated at around 55% since 1990 (see WHO/UNICEF/ World Bank 2002). With the 'new' child survival revolution oriented around the MDGs, McCoy and colleagues (2007*a*) have therefore warned against repeating the mistakes of the past of pursuing high immunisation coverage and mortality reduction through vertical programmes, without simultaneously building up the

health systems necessary to sustain high vaccination coverage and health improvement. This is a warning that the new global initiatives targeted at MDG 5 should also take heed of.

9.3. The way ahead?

Given the issues discussed above, the safe motherhood community should be cautious about continuing its current emphasis on issue-specific, global-level advocacy to establish itself as a more viable competitor for global health resources. On the one hand, such strategies seem to be enhancing political priority for the issue of safe motherhood, and enabling the reproduction of the safe motherhood community as a specialist expert community. On the other hand, we may question whether such issue-specific advocacy is the best strategy for achieving long-term, sustained progress towards the Initiative's core goal of health system strengthening to ensure women's access to life-saving care.

The risk of safe motherhood-specific programmes damaging overall health systems may be less pronounced than that associated with some of the stronger global health initiatives, primarily because safe motherhood programmes are unlikely to attract the volume of resources needed to set up parallel health systems of the kind associated with donor-driven HIV/AIDS programmes, for instance (Goodburn and Campbell 2001). Safe motherhood programmes will therefore by their very definition have to rely to a considerable extent on government-run health services, rather than parallel, vertical services (*ibid.*). Yet, and perhaps precisely because of this, the safe motherhood field might nonetheless question whether its search to establish itself as a competitor to other disease-based initiatives ultimately serves to sustain a global health architecture that may, for the reasons discussed in the previous section, further fragment and weaken existing health systems. Any such further fragmentation will likely have repercussions for precisely the kind of integrated, inter-linked healthcare that maternal health specialists insist is necessary for maternal mortality reduction.

Pursuing an alternative course of action is not straightforward. For one, as this thesis has shown there clearly continues to be pressure on the safe motherhood community to define alternative health policy responses to the unpopular message on health system strengthening. In a recent article, for

example, Prata and colleagues (2009:131) urge the safe motherhood community to face “the reality” of weak health systems and to identify interventions that “require minimal treatment/infrastructure and are not dependent on skilled providers.” In a similar vein, donors constantly call for ‘innovative’ approaches to solve the problem of maternal mortality, which for the most part implies simple solutions that do not depend on a functioning health system. But, as my informants frequently insisted, innovation is not what is most urgently needed to improve maternal health. Rather, what is needed is better knowledge and experience of overcoming context-specific ‘bottlenecks’ to the scale-up of complex health system strategies. The widespread consensus that exists on this point within the maternal health community points to the importance of pushing this message, while resisting the demand for over-simplified messages that, when ‘over-marketed’ and ‘oversold’ (Ogden et al. 2003), risk undermining the sort of health system strengthening the field is trying to achieve. But how might maternal health specialists go about doing this?

A first option is for safe motherhood practitioners to redirect some of the energy they are currently investing in creating ever more campaigns, initiatives and funds dedicated to safe motherhood (of the kind are described in Chapter 6), towards constructive debates about how to reconfigure current institutions and initiatives, so that they are more conducive to overarching health system development goals. Practical steps towards this end might include renewed efforts to clarify the remit of existing institutions, such as the Partnership for Maternal, Newborn and Child Health, so that it does not undermine, but rather enhances, the credibility of UN institutions and enables them to become more representative of low-income country needs. It would perhaps be better for the safe motherhood community confront and attempt to resolve the competitive tensions inherent in this ‘partnership,’ rather than concede to the failure of integration and pursue the creation of new institutions that may only contribute to further fragmentation of the global health field.

Furthermore, rather than calling for the dedicated funding mechanisms to scale up maternal health-specific interventions alone, safe motherhood advocates would do well to push further, along with other global health advocates, for a public reassessment of the heavy reliance on disease-specific public-private partnerships to disburse international financial assistance to the

health sector in low-income countries. Maternal health specialists could also contribute to the call for further alignment of development assistance, for instance by putting their weight behind advocacy for reforming the Global Fund so that it addresses not only disease-specific goals, but health improvement and system strengthening in a fuller sense (Costello and Osrin 2005; Cometto et al. 2009).

Through research and advocacy, the field can also help to document the way in which activities aimed at health improvement in specific areas may, at the national or even sub-national level, impact on cross-cutting issues such as human resources for health and infrastructure. Safe motherhood practitioners can further help to uncover the way that success as measured in improvement in one outcome, such as access to HIV/AIDS services, may mask unintended impacts in other areas, such as in access to maternal health services. A case for monitoring maternal health outcomes and indicators as part of broader assessments of global health efforts can be made once we accept that maternal health indicators serve as a “litmus test” for the functioning of the health system as a whole (Graham et al. 2004). In addition to documenting negative effects, researchers and advocacy specialists can also play a more instrumental role in communicating the positive lessons derived from case studies of successes in health system strengthening at national or sub-national levels, and thereby help to challenge the sense of despondency that prevails because of the seemingly intractable difficulty of improving maternal health outcomes. Meanwhile, they can also draw attention to context-specific aspects of health improvement (see Koblinsky and Kureshy 2009; McPake and Koblinsky 2009).

By communicating constructive lessons from in-depth case studies that incorporate epidemiological analyses, maternal health specialists may also help to challenge the uncritical acceptance of the present research culture and normative ideas about evidence that, as Chapter 7 demonstrated, skew the international research agenda away from research to address the challenges of implementing and scaling up effective interventions. There is a need for more openness in the global health community as a whole about the inadequacies of experimental methods for addressing policy-relevant research questions pertaining to complex and context-specific health policy change. This includes a need to promote greater inclusion of social science and more operational forms of research tied to

real-life programmatic practice within evaluation frameworks (Napolitano and Jones 2006; Bennett et al. 2008; Koblinsky and Kureshy 2009; Manandhar et al. 2009). One way of promoting such change is to investigate, expose and challenge donor priorities in research and programming, as McCoy and colleagues (2009) have done for the Gates Foundation. By conducting similar analyses, maternal health practitioners can help to create more open debate around the limitations of a narrowly defined evidence base, which on many levels is reinforcing, if not legitimating, donors' apparent preference for disease-specific, discrete and biomedical interventions whose health impact can easily be documented. At the same time, it is important to acknowledge that many academics presently avoid taking forward such debates because it is in the interest of their careers not to do so. Indeed, researchers will not in reality be in a position to challenge unrealistic expectations for scientific certainty and rigour unless they gain more independence, including from private donor agencies who are increasingly influential in setting the research agenda. Academic institutions as a whole clearly need to play an important role in securing such academic independence.

While I have focused here on the way in which the safe motherhood community can contribute to addressing some of these factors, it is important to acknowledge that bringing about change will require not only collaboration with, but also parallel contributions by, other existing coalitions within the global health field. Child and neonatal health experts, for instance, also have a responsibility to consider the unintended repercussions that may result from the disease-specific activities that they in many cases continue to promote, and to consider more carefully that the success of global health efforts cannot be assessed through improvements in one health outcome alone. Health system experts, while often struggling to gain funding and recognition for their own work, may be in a good position to help bridge the gap between different issue-specific coalitions, given their greater independence from disease-specific initiatives. Perhaps more importantly, the actions of issue-specific advocacy coalitions will not come to much unless donors, including private donors, and international institutions also start to alter their behaviour and deliberately revise their fixation on what Freedman and colleagues (2005:998) have termed "short-term and short-lived successes."

Of course, the findings of this thesis confirm that there are important social, political and institutional impediments to advancing a health systems agenda within research, advocacy and policy development. Underlying international, donor-driven political and academic cultural pressures have to date largely persuaded maternal health specialists to adhere to current normative models of evidence production and programming oriented towards disease-specific targets (Béhague and Storeng 2008). Weak health systems, current priority-setting mechanisms based on uncritical support for disease ranking and cost-effectiveness measures, and uncoordinated and conflicting donor agendas all impede the development of coherent policy agendas to align disease-specific goals and health system development (Mayhew et al. 2005; Walt 2005).

There is some cause for hope, however. There is presently a certain momentum for change and signs that a sort of mid-course correction is under way. First, there is growing dissatisfaction with neoliberalism as the ideological basis for global health and development. Such dissatisfaction underpins the revival of social justice and human rights-based approaches to public health (Gruskin et al. 2008; People's Health Movement et al. 2008), as well as the reversal of some of the most heavily criticised neoliberal health policies, such as user fees for healthcare (Ridde and Diarra 2009). Dissatisfaction with neoliberalism has also been accompanied by renewed attention to the social determinants of health, as seen with the WHO's Commission on the Social Determinants of Health (2008), and to the role of health in development and poverty reduction. Second, health systems are again on the international health policy agenda, despite contested interpretations of what is meant by health system strengthening (Bloom and Standing 2008; Legge et al. 2009). Positive signs of a change in emphasis also include that the World Health Report for 2005 called for "coherent, integrated and effective health systems" to improve maternal and child health (WHO 2005), while the 2008 World Health Report strongly encouraged a revival of the comprehensive primary healthcare principles elaborated at Alma-Ata 30 years earlier (WHO 2008).

The global health community must seize this momentum to ensure a greater place for health system strengthening and attention to social determinants of health on the global health policy agenda. Safe motherhood advocates may be in a particularly opportune position to take forward this agenda, given the high

level of consensus within the movement that such factors are essential to achieve improved maternal health and survival. As I have shown in this thesis, the maternal health field appears to have a relatively high level of critical awareness of its own history. While this is in part due to the fact that they are using this awareness to help refashion themselves continually in response to external pressures, such self-awareness could also be used as a resource to reflect critically on how they can resist these pressures and help to revive support for its own, original aims.

In order to generate further broad-based support for such a revival of its own original vision, however, safe motherhood advocates face not only the challenge of creating commitment in donor countries to address a health issue that overwhelmingly affects distant strangers. They also face the challenge of generating support for policy change whose benefits may be as distant in time (because building health systems is not a quick-fix solution) as in geography. They also need to persuade the global health community, governments and the public that, as one of my informants memorably put it, “the least a health system should be able to deliver is a baby.” Messages on the need for health system strengthening are clearly difficult to ‘sell’ to donors and governments who are impatient for quick-fix and immediate solutions to save lives. Yet, doing so is essential because concentrated efforts to improve maternal health in selective geographical areas (of the kind that some donor-funded initiatives are currently pursuing) or through ‘innovative’ strategies that bypass the health system, are not on their own likely to bring about sustained health improvement.

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Appendix: Information sheet and consent form

Information sheet

Study title

“The Safe Motherhood Field: An Historical Ethnography”

Investigator

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What is the overall objective of the study?

The objective of this ethnographic research is to examine the history of the safe motherhood movement at the global level, including:

- Examining historical representations of global safe motherhood research and policy developments
- Delineating the main actors in the global safe motherhood field and charting their diversification over time and changes in the distribution of power within their networks
- Identifying changes in the relationships between the safe motherhood field and other public-health sub-fields, including child health and reproductive health
- Uncovering the strategies and practices deployed by these actors in constructing safe motherhood discourse

Is participation voluntary and can I withdraw at any time?

Participation is voluntary. You are free to refuse to join this study and may withdraw at any time without giving any reason. If you choose to participate, you may choose not to answer certain questions.

What will happen to participants?

You will be interviewed about your knowledge and experience of the safe motherhood field, including research and policy. You will also be asked give your permission for the interview to be recorded

What inconvenience of discomfort will this involve?

Participation in the study will require that you take the time to participate in interviews and/or focus groups, although this will be limited to no more than two or three hours of your time. If you do not feel comfortable answering specific questions that arise you can refrain from doing so without having to provide any explanation to the interviewer. You are free to terminate your participation in the study at any time.

What risks are involved?

There are no specific risks involved in participating in the study.

What will happen if something goes wrong?

If, during interviews, you find the questions being posed intrusive we will stop the interview. If you are not happy with the interview process or would like to make a complaint, please contact the investigator.

Who will be responsible for the confidentiality of the material and its use and disposal at the end of the study?

The investigator will have sole and ultimate responsibility for protecting your confidentiality in the material and its use. All your contact details will be destroyed at the end of the study.

How will data be collected, handled and stored?

Interviews focus groups and informal discussions and will be recorded on audio cassettes (if you grant permission) and/or written field notes and interview transcripts. All the information obtained during interviews, focus groups or in related informal discussions will be treated in confidence, and care will be taken so you cannot be identified from details in reports of the study. Your address will

be kept in strict confidence and your name will not be revealed or associated with any written materials. You will be given a unique identification number that will be used instead of your name in all records. Your address will not be stored with any other information associated with you. Information will be stored carefully to prevent anyone not associated with the study from gaining access to it.

Should you wish to not be quoted directly or have any personal data regarding your background or identity appears in any public reports or analyses ensuing from this research, you are free to request that this be the case. In the event that direct quotes are used, should the investigator be in doubt as to whether your identity can be discerned in any written documentation, you will be provided you with the passages in question to check whether you prefer these portions to be deleted.

What are the financial arrangements of participation?

No payment will be made to you if you choose to participate.

Which ethical committee has approved the study?

London School of Hygiene and Tropical Medicine, U.K.

Consent form

Study title

“The Safe Motherhood Movement: An Historical Ethnography”

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Statement of consent

I have read the information sheet concerning this study [or have understood the verbal explanation] and I understand what will be required of me and what will happen to me if I take part in it.

My questions concerning this study have been answered by the investigator.

I understand that at any time I may withdraw from this study without giving a reason without any consequence.

Choose one of two options (delete as appropriate):

I agree to take part in this study under the conditions of anonymity and confidentiality outlined in the attached Information Sheet.

I agree to take part in this study, under the conditions of anonymity and confidentiality outlined in the attached Information Sheet, but with the additional condition that I not be quoted directly and that no personal data about me be presented in any analyses.

Signed.....

Date.....