INVESTING FOR LIFE: MAKING THE LINK BETWEEN PUBLIC SPENDING AND THE REDUCTION OF MATERNAL MORTALITY

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Report based on a three-day exploratory dialogue in November 2004 between experts and activists from the fields of maternal health and applied budget analysis, convened by the International Budget Project, Fundar Center for Analysis and Research, and the Population Council Latin America & Caribbean-Regional office, with support from the John D. and Catherine T. MacArthur Foundation.

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Design: Mono Comunicación S.A. de C.V.

Printed in Mexico
Fundar, Centro de Análisis e Investigación
Popotla 96 - 5, Tizapán San Ángel
México D.F.
www.fundar.org.mx

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I. Executive Summary

Each year, more than half a million women around the world die from the complications of pregnancy or childbirth. In many parts of the world, people assume that maternal death is simply a fact of life. The truth, however, is that maternal mortality is a tragedy that can be prevented. While most of the complications that give rise to these deaths cannot be avoided, the fact that women die from these complications usually can. Doing so requires a serious, coordinated and deliberate effort on the part of governments, health care professionals, and civil society advocates to articulate effective policies and ensure those policies are backed by clear budget commitments.

In November 2004, a small group of maternal health and budget advocates and researchers met in Mexico City to explore the potential for using budget analysis to strengthen civil society efforts to reduce maternal mortality. The event was convened by the Washington D.C.-based International Budget Project, Fundar Center for Analysis and Research in Mexico, and the Population Council, with support from the John D. and Catherine T. MacArthur Foundation. The meeting took the form of a dialogue aimed at building understanding across the two fields and exploring the potential for developing a strategic alliance to mutually strengthen their work. This report is an effort to capture the dialogue that took place in those three days, and the ideas and initiatives that emerged from the discussion.

The Joining of Two Movements

Since the early 1990s, civil society organizations in many developing and transition countries have been working to understand, analyze, and influence government budgets. Civil society budget work, as it has been termed, is growing dramatically in Africa, Asia, and Latin America, catalyzed by the trend toward democracy in several countries of these regions. Bound by a common commitment to inclusive budgeting, transparency and social justice, budget groups have carved an important niche promoting effective civil society engagement in public policy by producing timely, credible information on the impact of government budgets on the lives and well-being of low-income and poor people.

Similar growth has been seen in the field of maternal health and safe motherhood. The international conferences at Cairo and Beijing marked a significant shift toward a reproductive health and rights paradigm, advancing the debate and moving governments toward a new vision regarding sexuality, pregnancy and maternal health. The United Nations General Assembly's recognition of maternal health–and specifically the reduction of maternal morality–as a key goal for the millennium represented another critical advance. Research and advocacy organizations around the world have continued to monitor progress toward the Millennium Development Goals, pressing for more and better information to hold governments accountable for their commitments.

Recently activists from both fields have begun to consider the possibilities for combining the long-standing experience of the maternal health community with the analytical approaches that applied budget work offers. Their interest was inspired by a successful collaboration between budget analysis and maternal health groups in Mexico, a case that is outlined at the end of this report. The idea for the Mexico City meeting was conceived by a small group of individuals representing the convening organizations, who worked together with maternal health experts from Family Care International and the Averting Maternal Death and Disability Project at Columbia University to plan the dialogue.

The Challenges: Resources, Equity and Effective Service Delivery

The Mexico City discussion centered around three challenges that maternal health experts planning the meeting considered to be fundamental for reducing maternal mortality: human and infrastructure resources required for skilled care; equity in access to services; and effective and efficient service delivery. Participants agreed that until governments get these pieces of the strategy in place, progress toward reducing maternal mortality will be limited. For each topic, a maternal health specialist was asked to describe the problem and strategies used to address the challenge, either generally or in a specific country context. Each presentation was followed by comments from a budget specialist who

outlined how budget analysis could be used to enhance these approaches, or described a similar case in which budget analysis had been employed effectively.

In the area of human and infrastructure resources, the multiple levels of infrastructure needed to make skilled care universal, combined with the complexities of ensuring that adequate human resources are in place, require more comprehensive and multi-dimensional policy responses than many governments realize. Budget analysis offers new tools for strengthening assessment of government responses to resource needs.

The challenge of ensuring equity in access to services is similarly complex, as shown by the cases of Ecuador and Mexico. Both countries are committed to ensuring universal access to health care for women and children, promises that have been translated into policy and budgetary allocations. In both cases, however, the ultimate success of the programs has been undermined by a failure to ensure that populations in need have access to essential services, such as emergency obstetric care. In the case of Mexico, budget analysis was used to go a step further, revealing that the formulas for distributing funds intended to provide critical services for needy populations actually perpetuate rather than correct the underlying inequities.

Finally, the difficulties involved in ensuring effective and efficient service delivery were illustrated using the case of India where, despite a fairly equitable distribution of public health facilities, there are significant disparities in the distribution of human resources and access to emergency obstetric care resulting from policy and management failures in the health system. In Uganda, a community monitoring system was established to address similar concerns by tracing whether funds were reaching the intended communities and whether the services that those funds supported were effective. The Uganda case demonstrates that it is not only the amount of money spent that is important, but also whether the funds are allocated to programs that can make a difference, and whether those funds ultimately arrive where they were intended to go.

Exploring the Link

During the dialogue, it became clear that the prospect of uniting budget analysis with work to reduce maternal mortality offers numerous advantages for both fields. For budget analysts, the clarity of purpose shared by maternal health advocates can add depth to budget work. For maternal health advocates, budget analysis offers new analytical tools, new allies, and a powerful new language for dialoging with policymakers.

As advocates look for ways to combine budget analysis with maternal health strategies, they should consider various levels or potential entry points for their work. The first level of work is where policies are designed and structured, and where money is allocated. At this level, research and advocacy projects can play an important role in ensuring that the right policies are in place and backed by budget commitments. A second entry point is for advocates to assess whether issues of equity and effectiveness are being taken into account in the allocation of funds across departments, levels of government, regions and programs. The third level of analysis focuses on one or more of the numerous programs that can help reduce maternal mortality if done well. Budget analysis at this level can confirm whether the funds are getting to the people and purposes for which they are targeted, and whether those programs or services are making a difference.

Ultimately, making the link between budget work and maternal health advocacy is not about identifying a single project or methodology, rather it implies opening the door for multiple explorations between people who care about the issue of maternal mortality. Budget analysis is a tool to expand information, encourage debate, and promote accountability by showing whether government promises are being translated into sound policies and appropriate allocations. Indeed, some of the most effective budget analysis projects emerge in countries where budget information is very limited or difficult to access. Civil society budget work can make important contributions in these situations by opening up the debate, organizing existing information in a way that is more accessible for other researchers and advocates, or pressing for greater transparency.

II. Introduction

Maternal mortality is among the oldest problems of humanity, one that in many parts of the world seems untouched by scientific advancement or exponential increases in global wealth. Important advances have been made, with countries such as Sri Lanka and Malaysia demonstrating that the problem can be addressed effectively through a combination of effective, appropriately sequenced technical interventions, strategic smarts, and committed resources. Fortunately, the reduction of maternal mortality has been identified by governments around the world as a key goal for the new millennium. But the problem does not lend itself to easy solutions. For this reason, civil society activists and experts around the world have a critical role to play in producing knowledge about effective strategies and what is needed to achieve these global goals.

Public spending is of critical concern in the fight to reduce maternal mortality because, quite simply, sufficient and appropriately-allocated public resources are essential for ensuring that effective programs are in place. There are a growing number of civil society organizations around the world dedicated to analysis and advocacy to ensure that public funds are being used in ways that protect and advance the rights of poor and marginalized populations. They do so by providing reliable information and solid analysis to empower the work of committed individuals in and outside government.

In November, 2004, a meeting was convened in Mexico by the Washington D.C.-based International Budget Project, Fundar Center for Analysis and Research in Mexico, and the Population Council, with support from the John D. and Catherine T. MacArthur Foundation, to explore the potential for using budget analysis to strengthen civil society efforts to reduce maternal mortality. The meeting agenda was constructed as a dialogue among a small group of maternal health and budget activists as a first step toward building a strategic alliance between researchers and practitioners in these two fields. Participants came from Nigeria, South Africa, Indonesia, India, Mexico, Ecuador, the United States, and the Netherlands, many with limited knowledge of the other field but with a common hope the dialogue would offer new strategies or tools, or simply an alternative perspective that might shed new light on the issues and challenges at hand.

The meeting had multiple sources of inspiration, the first being a previous dialogue convened in January 2002 in Cuernavaca, Mexico by Fundar and the Mexico City office of the Ford Foundation, for the purpose of exploring how budget analysis could be used as a tool for advancing economic, social and cultural rights. A second important source of inspiration was the success of Mexican budget and maternal health organizations in increasing public expenditures for reducing maternal mortality. This experience led to a series of preliminary meetings and the formation of a planning committee with participation by key individuals from Family Care International and the Averting Maternal Death and Disability Project at Columbia University, in addition to the convening organizations. These individuals all dedicated significant time and energy to develop the methodology and agenda, giving form to the idea. Finally, the encouragement and support of the MacArthur Foundation was critical for making the meeting possible.

The dialogue began with broad overviews of the two fields by Lynn Freedman, Director of the Averting Maternal Death and Disability Project at Columbia University, and Warren Krafchik, Director of the International Budget Project at the Center for Budget and Policy Priorities. These sessions were followed by a more in-depth look at a case study of how efforts to reduce maternal mortality in Mexico were strengthened by budget analysis. Subsequent sessions focused the discussion on three major challenges for addressing maternal mortality: human resources and infrastructure; equity in access to health services; and the effective and efficient delivery of services. For each of these three topics, a maternal mortality expert began by describing the challenge and the strategies currently used to address that challenge, followed by a second presentation from a budget specialist on how budget analysis might be used to complement these existing strategies. The meeting concluded with a series of discussions to identify opportunities for working together and move those ideas forward in the form of specific projects.

This report represents an effort to capture the dialogue that took place in those three days and the ideas and initiatives that emerged from the discussion. It is a synthesis based directly on the comments of the individuals present and the written presentations they provided. The meeting produced numerous ideas about how to take this connection to another level. The aim of this report is to broaden the discussion to an even wider group of people who hopefully share the objectives of those present at this meeting, and provide guidelines for other activists looking for new strategies to reduce maternal mortality.

III. Maternal Mortality - A Problem We Can Solve

The purpose of this first session was to introduce the field of maternal health to non-experts. A presentation by Lynn Freedman of Colombia University outlined major policy issues and alternative approaches for reducing maternal mortality. She described international conventions, commitments and alliances established around these goals and progress in meeting the targets.

It is a simple fact that women have been dying from complications in childbirth since the beginning of time. Each year, more than half a million women die from complications in pregnancy or childbirth, the vast majority of them in developing countries. For each death, another 30 to 50 women suffer short or long-term disability due to the same complications. Complications of pregnancy and childbirth, experts note, are the leading causes of disability and death in women between the ages of 15 and 49 in developing countries–above AIDS, hunger, disease, or war. And, while these numbers alone are disturbing, the most startling fact of all is that the principal causes of these deaths are known, and are either preventable or treatable.

The task of reducing maternal mortality is a technical challenge, but not only. It is also inextricably linked to the social, cultural and political forces in any given society. Fortunately for the world, the importance of this goal has been agreed upon by the international community, and clear targets and indicators have been defined. That said, the complex web of factors that affect maternal mortality do not lend themselves to easy solutions. They require comprehensive strategies in which questions of social, economic and cultural barriers to accessing care must be recognized and addressed.

The Technical Challenge

Maternal mortality is defined as death in pregnancy and childbirth (including from abortion) or within 42 days of the termination of pregnancy, from any cause related to pregnancy or its management. The two most common methods for measuring maternal mortality are: annual number of deaths in a given country; and number of deaths per 100,000 live births in any given year or maternal mortality ratio (MMR). These are very different measures, however. A country can lower the number of maternal deaths by lowering the number of pregnancies without changing MMR or the risk of death once pregnant. The second measure, MMR, looks at the safety of being pregnant or giving birth in a given place.

From a technical standpoint, three important facts underlie all efforts to reduce maternal mortality. To begin with, the principal causes of maternal mortality are known and are treatable. Approximately 75 percent of all obstetric deaths result from just five causes: hemorrhage, hypertensive diseases, unsafe abortion, infection, and obstructed labor. The second fact is that treatment can save lives; most serious obstetric complications cannot be predicted or prevented, but they can all be treated. Finally, it is a known fact that access to emergency obstetric care (EmOC) provided by skilled individuals is critical for saving lives. The World Bank estimates that full use of existing interventions, especially comprehensive emergency obstetric care, would reduce maternal deaths by nearly 75 percent. Together, these facts mean that the vast majority of maternal deaths are unnecessary; we know how to prevent them, but we aren't doing it.

Statistics show dramatic disparities in maternal mortality around the world, with 98 percent of deaths occurring in developing countries, primarily in Africa and South Asia, and deep disparities within countries as well. The differences are evidence of disparities in access to health services as well as underlying realities of social exclusion, often related to wealth, ethnicity and other social divisions. What this means is that while the complications that cause maternal mortality may be medical in nature, the reasons women die from these complications are directly linked to issues of inequality and limited access to information, empowerment and resources.

According to many experts, an ideal scenario would be one in which every birth is attended by a skilled health care professional, every woman has access to EmOC, and referral systems are in place to ensure that women who need emergency care get there in time. Knowing how to solve the problem in a technical sense isn't enough, however. Converting knowledge into practice requires a serious, coordinated and deliberate effort on the part of government, health care professionals, and advocates. It requires political will, opportunity, effective strategies, and creative alliances.

The Strategic or Political Challenge

An important international advocacy initiative was launched in 1987 in the form of the Safe Motherhood Initiative, a partnership between governments, donors, technical agencies, non-governmental organizations, and women's health advocates in more than 100 countries. The partnership was formed with the objective of raising awareness of maternal health, mobilizing resources, promoting research, and advocating for policy change. Since 1997, the coalition has focused its efforts on two primary strategies: skilled care and emergency obstetric care.

Skilled Care — Each year, an estimated 60 million women in developing countries give birth without the support of a skilled birth attendant, a marked contrast to the developed world where skilled care is virtually universal. The reasons for this deficit are many. At the health system level, developing countries commonly face a shortage of skilled attendants, particularly in rural areas, and health workers often lack the skills needed to save lives in cases of serious complications. In addition, many health care facilities do not have the equipment and supplies needed to provide crucial services. Other factors include long distances between populations and health services, and the fact that many poor women are unable to pay the cost of transport, service fees, drugs or supplies. At a societal level, women often lack empowerment within the family to make decisions, or hesitate to utilize the services because of social and cultural norms. These challenges are numerous and complex, but they represent a critical starting point for any strategy to reduce maternal mortality.

The Safe Motherhood Initiative's focus on skilled care for all women has led to a series of questions about how to define good care and what affects quality of care in a facility, debates which are important for defining good policy. At the level of experts and practitioners, for example, skilled care is understood to encompass the broader context or supportive environment in which the care provider works. For governments, the focus often narrows to providing resources just for personnel training without addressing the inadequacies of the environment in which they work, meaning that public expenditures directed at skilled care may or may not have the impact desired.

Emergency Obstetric Care — The emphasis of emergency obstetric care (EmOC) shifts the focus to women who experience life-threatening complications by working to ensure emergency care is available, accessible and utilized. Some policy makers have confused EmOC with a focus on high-risk women, leading them to place scarce resources into risk screening. In fact, most complications occur in low-risk women, making risk screening an ineffective strategy for reducing maternal mortality. Instead, the first step is to ensure that functioning basic and comprehensive EmOC facilities are available to all women.

Partnerships and Opportunities

The experience of the Safe Motherhood Initiative gave rise to another international advocacy initiative in 2004 called the Partnership for Safe Motherhood and Newborn Health. This new effort represented an expansion of the Safe Motherhood Initiative both in terms of partner organizations and objectives, which now include newborn health. As a sub-set of the safe motherhood strategies, the effort to reduce maternal mortality continues to be a principal component of the coalition's focus.

In September 2000, the Partnership's objectives received an important political boost when members of the United Nations General Assembly issued the Millennium Declaration. The document set out eight critical goals for advancing social and economic development around the world, with goal number five (MDG5) focused directly on improving maternal health. The reduction of maternal mortality is now a key goal embraced by governments around the world, with a clear target and indicators defined by United Nations documents.

The Partnership seized the opportunity to help governments set good goals by identifying health services that should be available, and devising policies and programs to move toward those goals. MDG5 represents an important opportunity for advocates to monitor progress toward this global goal, and assess whether the appropriate strategies are in place and public funds are being allocated as needed to achieve the targets.

The agreement of world governments to the goals set out in the Millennium Declaration underlines the fact that the issue of maternal mortality is one of fundamental rights. The International Covenant on Economic, Social and Cultural Rights establishes, "Every person has the right to the highest attainable standard of physical and mental health," making it clear that access to health care and the conditions that make good health possible are entitlements, not privileges. Governments aren't required to comply with all of these obligations overnight, but they are committed to "progressive realization," a standard that calls for concrete and deliberate steps forward with the maximum available resources. The obligation of "progressive realization" represents a critical entry point for maternal mortality advocates to work with budget analysts to define what this standard means in terms of public expenditures, and to hold governments accountable.

Supporting Materials:

Strategic Advocacy and Maternal Mortality: Moving Targets and the Millennium Development Goals, by Lynn Freedman, Gender and Development, Vol. 11, No. 1, May 2003.

Skilled Care During Childbirth Policy Brief: Saving Women's Lives, Improving Newborn Health, Safe Motherhood Inter-Agency Group, New York: Family Care International, 2002. http://www.safemotherhood.org

Safe Motherhood Fact Sheets: The Safe Motherhood Initiative; Skilled Care During Childbirth; Maternal Mortality; Good Quality Maternal Health Services; Maternal Health: A Vital Social and Economic Investment; Safe Motherhood: A Matter of Human Rights and Social Justice; Unsafe Abortion, Measuring Progress; Unwanted Pregnancy; Adolescent Sexuality and Childbearing; Every Pregnancy Faces Risks, Safe Motherhood Inter-Agency Group, New York: Family Care International, 1998.
http://www.safemotherhood.org

Beyond the Numbers: Reducing Maternal Deaths and Complications to Make Pregnancy Safer, World Health Organization, 2004.

Who's Got the Power? Transforming Health Systems for Women and Children, United Nations Millennium Project, Task Force on Child Health and Maternal Health, 2005.

IV. Applied Budget Analysis - A New Tool in the Kit

Warren Krafchik, Executive Director of the International Budget Project (IBP), introduced applied budget work by describing its growth around the world, the types of organizations that specialize in this area of work, and the goals and methods that unite them. He also described the social and policy impact of budget work, and the emerging alliances between budget groups and civil society organizations in other fields.

The budget is a government's most powerful economic policy instrument, and therefore its major opportunity to influence income distribution and poverty. Though the budget has traditionally been the product of one of the most closed decision-making processes, a new international public finance consensus is emerging that promotes transparency and effective oversight. The most exciting progress in budgetary oversight in recent years has been the efforts of civil society organizations to understand, analyze and influence public budgeting.

The Rise of Civil Society Budget Monitoring

The growth of civil society budget work refers to a specific subset of civil society organizations hereafter called budget groups. Most groups operate independently of their country's government and political parties, and as a result provide unique oversight and information contributions to public budgeting. The work undertaken is policy- and impact-oriented, highlighting the impact on the poor. Budget work is a way of conducting research that is of direct and timely relevance to current policy decisions. Groups therefore strive to achieve analysis that is timely, accessible and accurate.

Applied budget work has proved a flexible instrument to civil society organizations in a variety of countries and circumstances. It first flourished in middle-income countries, but since 2000, a second wave of organizations has emerged in low-income countries in Africa, South and Central America, Southeast Asia, and Central Asia.

A diverse range of civil society organizations, from policy-oriented think-tanks to membership and community-based organizations, have used budget work to forward their objectives. Some groups were established specifically to advance budget issues, while others have adapted budget work to strengthen their existing policy and advocacy work. Several groups have been successfully developed within an academic environment and a couple of groups have been initially supported from within the public sector.

Budget work can be used in an array of political systems of government. The work has thrived within Commonwealth and Parliamentary systems–despite the inherently closed nature of the budget process in these systems–and has also proved useful in Presidential systems. Although budget work has taken root most easily in established and emerging democracies, it has shown resilience under autocratic regimes and in cases where there is paucity of data, extensive corruption and political turmoil.

Types of Civil Society Budget Work

Over the past decade, budget groups have used a variety of methods and approaches. Different types of organizations will gravitate towards one or more of these approaches depending on their skills, operating environment, opportunities and constraints.

Advancing budget literacy –Many groups first enter budget work by undertaking activities to make the budget and budget process more understandable to citizens. Groups may typically start this work by producing accessible guides to the budget, by providing introductory training on the budget, and by creating opportunities for deepening debate. Both budget guides and training serve to build an audience and allies, develop capacity within the organization, and broaden the base of knowledgeable observers of the budget.

Budget process and system studies — Assessing the budget process and budget system is a critical task for independent researchers. The budget system and process can dictate both policy outcomes and the scope of participation in the decision-making process. One area of research has evolved in response to poor transparency and weak accountability in developing countries. Several institutions - including the International Budget Project and partners, the International Monetary Fund and the OECD - have developed methods to assess transparency and participation standards in budget and fiscal performance. The benefit of these types of studies is that they often provide a comprehensive picture of transparency that is otherwise not available, and enable oversight groups to consider strategically where they should invest their energies.

Analyzing budget policies — Of the many interrelated ways to examine the implications of the budget, five deserve mention. Macroeconomic analysis assesses the impact of the budget on growth, inflation, unemployment and other macro-variables. Sector analysis focuses on an important area of the economy or budget to which the government allocates resources. Population group analysis evaluates the impact of the budget on demographic groups. Budgets and rights analysis explores the linkages between budgets and the achievement of economic, social and cultural rights. Revenue analysis focuses on the implications of public revenue policies for poor and low-income families.

Tracking expenditure and revenues, and assessing the impact — Analyzing the executive's budget allocations is not sufficient to assess the quality and impact of spending. Budget groups have designed methods to monitor the flow of resources from the national treasury through layers of government to the intended destination. In many cases, this expenditure tracking is undertaken by community-based monitors that collect new data. Several budget groups are currently testing methods to track revenue flows to the government, focusing on intended receipts from extractive industries. Budget groups have also developed and adapted methods to measure the impact of government expenditures. Citizen report cards and other approaches generally rely on citizen perceptions to gauge the quality of expenditure and impact. Finally, one area of opportunity in budget tracking (and budget work in general) involves the linkages between budget groups and Supreme Audit Institutions (SAIs).

The Impact of Budget Work

There are many examples in which budget groups are beginning to have major impacts on improving governance and reducing poverty. In Mexico, for example, Fundar Center for Analysis and Research recently undertook a successful campaign to hold the government accountable to a major policy commitment to reduce rural maternal mortality. The Uganda Debt Network has successfully worked to eliminate corruption by monitoring the delivery of government resources to schools and hospitals, and to pressure for a reprioritization of funds towards HIV/AIDS treatment. MKSS, a group working at the sub-national level in Rajasthan, India, has helped establish a community-based auditing system to fight village-level corruption, through which it has galvanized a massive Right to Information movement in India. Finally, the interventions of The Institute for Democracy in South Africa (Idasa) have influenced the design of the country's new financial management system, and have also helped to open the budget process and strengthen the oversight role of the legislature.

Challenges to Budget Work

Despite these promising developments, the growth of applied budget work faces significant internal and external challenges.

Transparency and participation in the budget process — In general, access to budget information remains a challenge for most budget groups, although the scale of the challenge differs tremendously between countries. A related and larger problem is the lack of accurate, timely, and comprehensive data on budget execution. The third and most significant problem is the execu-

tive's failure to facilitate public discourse and understanding of the budget. Nevertheless, there are two positive points to mention here. First, several countries have developed open budget systems in a relatively short period of time, indicating that progress on these matters is feasible. Second, budget groups have been able to produce useful and powerful analytical work with relatively little data.

Analytical and advocacy skills — Applied budget work demands an unusual mix of skills. Effective practitioners are required to master both public finance techniques as well as policy and advocacy skills. In most cases, potential civil society budget activists lack one of these skill sets.

Sustainability — It takes several years for a budget group to build the analytical legitimacy, advocacy savvy, and networks to become a serious player in the public finance arena. Based on the current cohort of budget groups, approximately five to six years of initial investment is required before significant influence can be expected. This means that prospective budget groups require several years' commitment from donor organizations if they are to have a real chance at building budget work capacity. Additionally, financial assistance to establish and sustain budget groups is lacking in the countries that need it the most - those with autocratic governments and opaque budget systems.

Alliances with other oversight institutions — Civil society will not be able to build an effective budget oversight system alone. Given the scale of financial oversight problems in developing countries, an external oversight partnership involving civil society, the media, legislatures, the SAI and the judiciary in different combinations offers the strongest chance for systematic change. The potential for an oversight partnership exists between budget groups and other oversight institutions, though such partnerships are a challenge to initiate and sustain.

Civil society cohesion — Budget work poses important challenges to civil society cohesion. First, budgets often involve difficult choices between sub-sets of the poor and marginalized, which can pit sectors of civil society against each other. Second, the nature of budget work can potentially split civil society into technocrats on the one side and grassroots activists on the other. These tensions can be overcome with conscious and effective coalition building that is the basis for stronger advocacy.

Relationships with government — The first civil society budget groups emerged in countries with histories of democracy, or where progressive political transitions were underway. In many cases, however, civil society budget efforts often have to confront political environments that are corrupt, or that have civil servants who either closely guard vested interests or do not understand the issues. In some countries, at least initially, the government might be openly hostile to civil society budget work. Over the long-term, credible analysis and effective advocacy will mean that the government cannot ignore civil society and may become more receptive to it. While it may take a while for such openness to develop, examples from countries as far apart as Croatia, Kazakhstan and Zambia have tended towards at least a grudging acceptance of civil society's ability to add value to public finance.

Supporting Materials:

A Guide to Budget Work for NGOs, The International Budget Project, Washington, D.C., December 2001. http://www.internationalbudget.org/resources/guide/index.htm

Can Civil Society Add Value to Budget Decision Making? A Description of Civil Society Budget Work, by Warren Krafchik, http://www.internationalbudget.org/resources/library/civilsociety.pdf

Opening Budgets to Public Understanding and Debate: Results from 36 Countries, October 2004. http://www.internationalbudget.org/openbudgets/index.htm

Latin American Index of Budget Transparency: A Comparison of Ten Countries, November 2003. http://www.internationalbudget.org/themes/BudTrans/LA03.htm

Dignity Counts: A Guide to Using Budget Analysis to Advance Human Rights, a joint publication of Fundar Center for Analysis and Research, The International Budget Project, International Human Rights Internship Program, 2004. http://www.iie.org/IHRIP/Dignity_Counts.pdf

Promises to Keep: Using Public Budgets as a Tool to Advance Economic, Social and Cultural Rights. A Conference Report, by Jim Shultz, January 2002.
http://www.internationalbudget.org/themes/ESC/FullReport.pdf

A Taste of Success: Examples of the Budget Work of NGOs, The International Budget Project, October 2000. http://www.internationalbudget.org/resources/success.htm

V. The Challenges: Resources, Equity and Effective Service Delivery

The following sections focus on three major challenges to reducing maternal mortality. In planning the meeting, maternal health experts believed it was important to center the discussion on these fundamental issues, which include:

- human and infrastructure resources required for skilled care
- equity in access to services
- effective and efficient service delivery

For each topic, a maternal health specialist was asked to describe the problem and methods or strategies used to address the challenge, either generally or in a specific country context. Each presentation was followed by comments from a budget specialist who outlined ways that budget analysis could be used to enhance these approaches, or described a similar case in which budget analysis had been employed effectively.

In the area of human and infrastructure resources, Petra ten Hoope-Bender discussed the multiple levels of infrastructure needed to make skilled care universal, a reality that requires comprehensive and multi-dimensional policy approaches. The task of ensuring that adequate human resources are in place is similarly complex with relevant expenditures found in many different areas and levels of government. Joel Friedman responded by outlining the types of questions and tools that budget analysis offers to strengthen an assessment of government responses to resource needs. He described where researchers or advocates might find the relevant information in the budget, and how they could begin to assess the allocations. Budget analysis initiatives, he emphasized, should always keep an eye on the big picture, meaning the various factors that directly and indirectly affect the budget and funding available for maternal health.

Challenges related to equity in access to services were described by David Acurio using the case of Ecuador, where an important 1994 law sought to guarantee universal access to health services for women and children under the age of five. The program offers many innovative features, namely its accountability and participation mechanisms. But the country's maternal mortality rate remains virtually unchanged, demonstrating how the failure to ensure that populations in need have access to critical services, such as EmOC, can undermine results. Helena Hofbauer showed how budget analysis was used to address similar challenges in Mexico by identifying the inequities in government budget allocations and delivery of services. In this case, analysts studied budget allocations between departments and levels of government, between programs, and between regions, and found that the distribution of resources was not consistent with areas of greatest need. They are able to show that the formulas behind these allocations perpetuate the equity problem rather than solving it.

Finally, the problems related to effective and efficient service delivery were illustrated by Dileep Mavalankar using the case of India where, despite a fairly equitable distribution of public health facilities, there are significant disparities in distribution of human resources and access to emergency obstetric care. He demonstrated that these problems are symptoms of policy and management failures that serve as barriers to effective care delivery. Zie Gariyo showed how a budget group in Uganda responded to similar concerns about service delivery by establishing a community monitoring system to trace whether government funds were reaching the targeted public and whether the services that those funds purchased were effective. He explained that it is not only the amount of money spent that is important, but also the quality of the expenditure. More money is only useful if it actually reaches the targeted population and is allocated to the types of goods and services that really address the problem.

Each of these six presentations is described at greater length in the pages ahead. The presentations by the maternal mortality experts provide important insights into the complexities of the three areas identified as principal challenges to reducing maternal mortality, and the successes and limitations of efforts to address those problems around the world. The responses by budget specialists offer a glimpse at the possibilities for employing budget analysis techniques as a new tool for taking on these challenges, and lessons on how this work can be most effective.

Human Resources and Infrastructure Required for Skilled Care

Petra ten Hoope-Bender of the Partnership for Safe Motherhood and Newborn Health described the difficulties countries face related to human resources and infrastructure for providing skilled care. She began by emphasizing that maternal health should never be understood as a stand alone issue. To the contrary, it is intrinsically linked to a variety of conditions such as female education and ability to make decisions about one's reproductive health. This reality, together with the multiple levels of resources required to make skilled care universal, make it important that strategies to get the resources in place be comprehensive and multi-dimensional.

Infrastructure Needs

Infrastructure requirements exist at various levels, many of which may not seem relevant to reducing maternal mortality at the outset but are, in fact, critical. At the household level, for example, basic education is an important determinant of whether women access skilled care. At a community level, a woman needing emergency care may be dependent on access to joint resources to cover costs or organize emergency transport. Outside the community, at the district or municipal level, basic health facilities often exist but are not fully prepared to perform the surgical interventions or other procedures required of an EmOC facility. Widely accepted norms establish how many basic EmOC facilities should be available for every 500,000 people. These norms must be adapted for rural areas, however, where travel times are often longer, transportation options scarce, and road conditions poor, making services far less accessible.

Infrastructure requirements at the national level begin with a functioning health system that can effectively deliver equipment, drugs, human resources, referral systems, auditing, monitoring and evaluation, and data collection. To develop and maintain such a system is often difficult, particularly for the many countries that rely heavily on international donor funds to underwrite health infrastructure and services. These funds tend to be unpredictable, leaving in-country infrastructure vulnerable if the system is not able to absorb irregular resource flows.

Human Resource Needs

With the goal of ensuring that all women ultimately have access to skilled care during birth and the postpartum period, attention must also be given to human resource needs. The first step is to define who skilled attendants are, what they should be able to do, and what other elements should be in place for their work to be effective.

Maternal health experts at the international level have done significant work to answer these questions and propose a set of global standards. It is commonly accepted, for example, that doctors, midwives and nurses can all be trained to be skilled attendants, meaning capable of performing life saving measures and referring the woman to a next level of service in the case of emergency. In areas where community health workers and traditional birth attendants are more prevalent, these individuals should be linked with skilled attendants who can complement their services if needed.

The World Health Organization's Making Pregnancy Safer (WHO/MPR) program has calculated that some 350,000 to 400,000 additional skilled attendants are needed to achieve the MDG5 target of 90 percent coverage. Some experts consider these estimates to be misleading, however. Meeting participants noted that a country like Mexico is listed as requiring no additional skilled birth attendants despite significant need in rural and disadvantaged areas. These discussions notwithstanding, the WHO/MPR effort provides practical information to guide policy efforts and the allocation of public resources. The next step is to calculate what it would cost to achieve these goals.

These targets represent potential entry points for national-level advocacy groups, particularly if such groups can contribute to recalculating human resource needs at the national level and the cost of meeting those needs. With an additional focus on skilled care and EmOC more generally, such efforts can provide the international community with a more comprehensive perspective and establish more precise country-level targets.

For countries with significant infrastructure or human resource deficits, the complexity of this challenge can be daunting, leading governments to focus merely on training existing personnel or building a few more hospitals. For some countries in Africa and Asia, the challenge of reaching the human resource targets is even more difficult as developed countries draw away thousands of trained health care workers each year to improve their own skilled care ratios. In Malawi, for example, an estimated 80 percent of nurses graduating each year leave the country to work elsewhere. In order to slow this "brain drain" and keep people in the countries where they are needed, appropriate incentives must be in place, starting with a functioning health system.

Advocates can help keep the focus on comprehensive strategies. In the human resource area, this may mean examination of basic education, pre-service and continuing education for skilled attendants to ensure they are adequate; assessment of whether the health care system provides the necessary support to trained personnel; and support for regulations or legislation detailing the roles of skilled attendants and rules of practice.

What is clear is that the task of getting the resources in place implies multiple expenditures at different levels of government. Given this, does budget analysis offer a new tool for taking on the resource challenge, and if so how?

A Budget Approach to the Resource Challenge

Joel Friedman of the International Budget Project addressed the challenges of analyzing budget allocations for the key human and infrastructure resources needed to provide skilled care. He focused on a more traditional approach to budget analysis, using the budget as the entry point for examining maternal health programs and priorities. Other forms of budget work, such as tracking maternal health expenditures or examining the quality of health services, can also be used to bolster the efforts of safe motherhood advocacy. But, in many cases, it is appropriate to begin with an examination of maternal health programs by identifying resources for these activities in the budget, and assessing whether these programs have been adequately funded and whether the funds are being used efficiently and effectively.

Budget Basics

Many of the items that are essential components of a maternal health program–health professionals and their training, medical equipment and supplies, health infrastructure, transportation infrastructure, statistics to measure progress, and outreach services–will be funded in the executive's budget. For advocates interested in undertaking budget analysis, an important first step is to understand how these items might be presented.

All budgets are organized by ministries or departments, the so-called "administrative unit." While the health ministry is probably most important for this area of work, it may also be necessary to look at other ministries such as Public Works for questions of infrastructure, or statistical agencies for data collection. Within a ministry, budgets are usually broken down by bureaus or subgroups of the agency, and then by programs. Generally, it is the program-level that is most important for identifying key activities.

Budgets are also organized by "functional" and "economic" classifications. Function means the expenditures are classified according to the purpose for which they are to be used. Most maternal health spending will be in the health function, but some relevant spending is likely to be found

elsewhere. Economic classifications distinguish between funds that are used, for instance, to pay wages or to construct a clinic.

The budget can also contain non-financial information, such as number of beneficiaries served, or information related to performance indicators and performance targets for the programs. This information can help establish a link between a policy commitment and actual expenditures and make the intended (and actual) impact of programs more understandable.

Levels of Spending

An analysis of a country's maternal health programs will often require examining more than one budget, as well as addressing questions about which actors are shaping maternal health policy and which ones are delivering the services. An analysis that focuses only on funding in the national budget, for instance, may miss crucial implementation issues at the local level affecting the effectiveness of the spending. Looking only at the lower level of government where the service is delivered, on the other hand, may miss important funding issues in the national budget.

International donor funds, whether project-specific or general budget support, are also important to consider. In many countries, the health system relies heavily on these external funds. The problem is that donor funds don't always flow through the budget, particularly in the case of project-specific activities, making this funding stream complicated to monitor.

It may also be important to understand the role of private contributions, including out-of-pocket expenditures by the patients or expenditures by private sector entities (insurance plans, religious groups, etc.) These amounts may be reflected in the budget in the form of fees collected or assumed in the level of funding for a particular activity. Capturing the impact of private contributions on the provision of health care is often difficult, but the fact that low-income populations can be very sensitive to out-of-pocket expenses may make it an important factor.

Assessing the Allocations

Once the relevant activities in the relevant budget have been identified, the next steps are likely to focus on whether the programs are designed in a way to provide the desired outcomes and whether the activities are adequately funded. Using their knowledge of the policies and programs needed to address the problems of maternal mortality, advocates may decide to assess whether the activities funded in the budget are well-designed and whether the various activities work well together. Such analyses can be particularly important in the maternal health field where the coordination of multiple activities or objectives is critical.

These analyses should ultimately come together in an overall assessment of the government's policies and the extent to which they are adequately funded in the budget. At a basic level, such analysis seeks to determine the full cost of implementing desired programs and use these funding levels as a benchmark for assessing government budgets. Civil society groups can provide useful information for assessing budget allocations and clarifying the type of trade-offs involved with different funding levels.

Understanding the Big Picture

One of the important benefits of budget work in this area is that it creates the potential for maternal health advocacy to engage in the annual budget debate. To engage in these debates effectively, however, advocates must understand not only the set of questions directly related to maternal health, but also the broader context in which the budget is being made and policies are being developed. Advocates should keep an eye on the range of political and economic factors affecting the health budget because they can have a significant impact on the funding available for safe motherhood programs. Given the diversity and complexity of maternal health issues, it may also be important to keep track of key factors influencing the budgets of other relevant ministries.

A well-developed budget analysis program must also be mindful of the broader macroeconomic and fiscal trends that affect all areas of the budget. While the issue of how much government earns through taxes may seem far removed from maternal health, for instance, these revenues ultimately affect funding levels. Even high-priority areas cannot remain immune from overall budget trends for long.

Having a general understanding of budget trends can help shape advocacy strategies, making them more appropriate to the fiscal circumstances. In cases where funding is limited, strategies that stress value for the money, by making existing programs more efficient, may be more effective than those that press for more funds to be allocated.

Ensuring Equity in Access to Services - A View from Ecuador

David Acurio described how Ecuador has taken on the challenge of ensuring equity in access to maternal health services. Economic disparities and social inequity are significant problems in Ecuador. The country's income gap more than doubled from 1988 to 2000, with the wealthiest quintile now earning nearly 28 times the income of the poorest quintile. At the same time, and despite the reality of growing inequality, public expenditures for health and education were gradually reduced while other areas such as defense, infrastructure and public works have risen. These reductions in the health budget served to exacerbate an already difficult situation for the country's poor in terms of access to health services.

In 1994, the Free Maternity Law was passed in order to guarantee universal free access to health services to women and children under the age of five. The measure, which passed with a modest budget allocation, was an important starting point for correcting the problem of access to services.

At the operational level, the program is run by the Ministry of Health, which passes funds to the municipalities for distribution to providers as reimbursement for services provided during the month. The program features a series of innovative accountability mechanisms. The resource distribution process, for example, is controlled by an inter-institutional committee comprised of representatives of the Health Ministry and the municipalities as well as women's organizations and urban and rural sector organizations. Local level user committees are also formed to monitor the quality of services.

Maternal health advocacy groups in Ecuador, generally supportive of the program, have more recently begun to express concern that Ecuador's maternal mortality ratio continues to be one of the highest in Latin America. Poverty and social exclusion are clearly at the heart of the problem, as is demonstrated by the fact that maternal mortality is highest among populations that are most economically disadvantaged. Studies also confirm that the principal medical causes of these deaths are those related to obstetric emergencies, something that could be mitigated by ensuring universal access to timely and good quality emergency obstetric care (EmOC).

These two facts point to an important limitation of the Free Maternity Law, which is that it has not guaranteed access to EmOC as a critical feature of providing universal access to health services. The reason is partially a structural one: the program is located in the Ministry of Health despite the fact that poor women access health care through a separate social security system, while EmOC is only provided at the hospital level. Furthermore, where services do exist, the quality is often poor.

Many advocates agree the Free Maternity program has improved equity in access simply by providing maternal health services to poor women who would not otherwise seek or have access to such services. The case shows, however, that even if more women utilize maternal health services, this alone will not automatically lead to a reduction in maternal mortality. In order to reduce maternal mortality, it is necessary that EmOC be a part of the public health system at all levels.

Approaching Equity through Budget Analysis — The Mexico Case

Helena Hofbauer described how Fundar used budget analysis to better understand challenges of equity in access to health services. As in Ecuador, economic and social disparities are dramatic in Mexico, both at the individual level and between states. These disparities are directly reflected in the incidence of maternal mortality. In 2001, five Mexican women died each day due to complications from pregnancy or birth. Of these women, 65 percent were not protected by the social security network, meaning they had limited access to maternal health services.

With these challenges in mind, the organization began to study the question of equity in access to health services in Mexico, focusing on four issues:

- Does Mexico's legal framework provide for equity?
- What is the distribution of the general health budget between different groups of the population?
- What sorts of health care programs exist for the most disadvantaged?
- How do decentralized funds impact the situation of equity in Mexico?

Equity in the Law — Mexico's legal framework clearly establishes a commitment to ensuring equity in access to health services, both through recognition of the International Covenant on Economic, Social and Cultural Rights and in the National Health Policy. The former establishes general obligations for all rights, including non-discrimination, progressive achievement, and the use of maximum available resources. The latter reinforces these commitments by establishing that services will be provided with preference to the poorest sectors, that people will pay to the extent that they are able, and that universal health care is guaranteed.

Equity in Distribution — Looking more closely at the health budget, researchers found that total health spending is distributed through various public institutions, each serving different segments of the population. The IMSS and ISSSTE are social security institutions that offer health services to persons employed in the formal sector (private sector or government), about half of the population. The Health Ministry (SSA) offers health services to unemployed and informally-employed persons, roughly the other half of the population. A relevant part of the Health Ministry's budget has been decentralized to sub-national governments through a mechanism called FASSA.

The research illustrated that persons employed in the formal sector received 65 percent of the health budget, while those who were unemployed or working in the informal sector benefited from only 35 percent, despite being the same size and in a more vulnerable situation. On a per capita basis, each person from the first group counted on 165 dollars per year, while someone from the second group had only 92 dollars allocated to cover her needs. These findings confirm that vulnerable groups are not being given preference as established by law. Instead, they are receiving fewer resources.

Programs to Improve Equity — The Mexican government does make an attempt to provide services to the most marginalized sectors of the population through a series of specific programs operated by state or national-level health ministries. All of these programs offer a basic health care package, including care for pregnant women. However, the ongoing effort to encompass more people in order to achieve universal health coverage–without proportionate increases in financial allocations–has meant that the level of service per capita has diminished over time. The researchers looked further at how these programs distribute their spending and found that states with higher levels of marginalization actually receive less spending per capita, thereby perpetuating the underlying inequity.

Decentralization and the Poor — FASSA, a mechanism to decentralize health funds to offer services for the population with no social security, also contributes to rather than corrects the problem of inequity. The population covered by FASSA is heavily concentrated in the poorer states of South and Southeast Mexico. But the amount of money available per capita in those states is lower, despite being the areas where need is highest. The researchers looked at availability of doctors and number of hospital beds and found the same inverse relationship with levels of marginalization. The reason for these incongruities is quite simply that the formula for allocation between states gives higher consideration to existing infrastructure and personnel than to unfulfilled needs. As a result, and despite a number of programs designed to provide health services to poor and marginalized populations, the distribution of those funds actually undermines commitments to ensuring equal access to health services.

Effective and Efficient Service Delivery - A View from India

A written presentation prepared by Dileep Mavalankar of the Indian Institute of Management in Ahmedabad described some of the policy, management and resource barriers to effective and effi-

cient care delivery in India. As is the case elsewhere, attempts to measure maternal mortality in India are not highly accurate and often mask dramatic variations from one state to another. What is known, however, is that 100,000 women die each year in India, a number that is significant despite the variations. And while national policymakers and international donors have made the reduction of maternal mortality in India a priority, the country's maternal mortality ratio has not declined much over the past two decades, providing a clear indication that something is not working.

State governments in India are responsible for providing health services and are thus the source of approximately three-quarters of total public expenditure for health. Public expenditures only represent 20 percent of total health expenditures, however, compared to 80 percent private contributions, mainly in the form of out-of-pocket payments. For a country of more than one billion people, 80 percent of whom live on less than two dollars per day, it isn't difficult to envision the difficulties of making effective and efficient health services universally available.

At an infrastructure level, the distribution of government health facilities is fairly equitable as a result of centralized planning since the 1950s. This means that buildings are in place even though they may not be in optimal condition. Planners tried to ensure access to health services through a widely spread network of facilities in rural areas and, as a result, the norms for health facilities per population are somewhat better in tribal and desert areas where population density is low. Numerically, the size of India's public health infrastructure is impressive: 600 district hospitals; 3000 rural hospitals; 22,000 primary health care centers; and 130,000 sub-primary health centers.

The problems related to service delivery begin to appear when you look at the distribution of human resources and access to emergency obstetric care. Of an estimated 22,000 specialist obstetricians available in the country, only about 780 work in state health facilities in rural areas. Those 780 people serve a population of 750 million. The others work in private practice and medical colleges, mainly in urban areas. Each rural district of about two million people has only two to three government obstetricians, usually in one district hospital. An estimated 3,043 government ObGyns are needed to fulfill the requirement of rural areas, four times the number of doctors currently available.

The figures related to anesthesiologists are even more dramatic, showing one to three doctors for a district of two million people. When anesthesiologists are posted to priority areas, they are often put in places where they can't work because there is no surgeon, or they are assigned another job outside their specialization. A deficit in the availability of regular blood supply presents still another impediment to providing quality care. It is estimated that blood supplies meet only about 10 percent of estimated need in rural areas.

These dramatic disparities are symptoms of policy and management issues that serve as barriers to effective care delivery in India. For example, the fact that life-saving functions such as cesarean sections are not delegated to basic doctors instead of specialists means these services remain unavailable to large parts of the population. An alternative would be to provide training, currently nonexistent, to basic doctors to perform procedures like cesarean sections and basic anesthesia. Another response would be to provide additional posts for anesthesiologists and obstetricians in rural sub-district hospitals. Without such policy changes, rural EmOC services will continue to be unreliable and insufficient.

On the management side, a range of problems have been discovered related to the accountability of staff in rural areas. Because many health professionals do not live in the village where they are posted, their availability is often limited to three or four hours a day. Rural health centers tend to have very high absence rates without valid reasons, and supervision is often inadequate. In some areas, the lack of supervision means that demands for bribes or illegal payments are common, further hampering access by people unable to pay. Inadequate policies for posting and transferring staff further contribute to the problem of neglect of rural area facilities.

Similar problems affect the distribution of necessary supplies and equipment, or the availability of water, electricity and fuel, presenting impediments for even basic care. Few rural hospitals or health centers have access to telephone or wireless communication, and ambulances, where they exist, are often non-functional. These transportation and communications deficiencies further restrict access of rural populations to quality care.

Together, these challenges show that strategies to ensure effective and efficient service delivery must look beyond infrastructure and personnel to the policy and management choices being made within the larger health system.

Budget Analysis to Improve Accountability — The Case of Uganda

Zie Gariyo of the Uganda Debt Network described how community-level budget analysis was used to address problems related to service delivery in Uganda. Uganda was one of the first countries to qualify for debt relief under the Highly Indebted Poor Countries (HIPC) initiative. As part of the agreement, the government must channel resources no longer going toward debt servicing into a Poverty Action Fund (PAF) to finance programs in primary education, primary health care, water and sanitation, rural roads, agriculture extension, micro-finance, and HIV/AIDS. The PAF represents a major source of financing for Uganda's national budget, and the vast majority of the country's resources for health and education.

The PAF is an important focal point for organizations like the Uganda Debt Network (UDN) that are interested in monitoring the utilization of public resources and ensuring that social spending is reaching the people who most need it. In 2002, the UDN developed a Community Based Monitoring and Evaluation System (CBMES) to engage poor people in monitoring and evaluating programs for poverty reduction in their own communities with the goal of improving the quality and delivery of social services.

An important aim of the CBMES is to empower communities by helping citizens develop the skills needed to ask the right questions and follow through to get the answers. The program provides people with information about poverty alleviation strategies and policies and teaches them to do local budget analysis. As part of the CBMES, volunteer monitors work directly with service providers to evaluate service delivery and discuss the results. The findings are also presented to local government officials by the community monitors, who use their knowledge to request further information and negotiate solutions.

Almost from the beginning, the program began to document significant obstacles to service delivery. In one district, for example, a first report issued by the community monitors raised concern about deficiencies in management, procurement, and control systems of a local health unit. It called attention to the fact that up to 75 percent of critical supplies were disappearing shortly after arriving in the clinic. This information was presented to district officials, forming the basis for a subsequent negotiation of measures to correct the problems. In other areas community monitors documented problems with bribery and corruption, poor management of health facilities, and other practices that undermine the quality and delivery of services.

The program has created an important new space for dialogue between government and communities, enabling poor people to participate in the discussion of public priorities and ultimately improve the services available to them. It has empowered people to challenge their leaders on issues of transparency and accountability in service delivery, and given communities a sense of ownership of government projects. An evaluation of the CBMES pilot phase in four districts also showed an improvement in health and education services and a reduction in substandard work as a result of the program.

The Community-Based Monitoring and Evaluation System (CBMES) has demonstrated how local-level community participation in monitoring and evaluation can contribute to making service delivery more effective.

VI. New Strategies and New Perspectives

Maternal mortality is a problem we can solve, but it is not a problem for which there are easy solutions. For this very reason, civil society advocates and experts around the world have a critical role to play in producing and sharing knowledge about strategies that work, and in assessing whether governments are making real progress toward their goals.

Participants at the meeting agreed that the year 2005 presents a unique opportunity to come together around the goal of reducing maternal mortality with the launching of the World Health Report in April, the Millennium Summit in September, and other high-level international meetings. In this context, budget analysis offers a new approach for showing how governments are taking on the maternal mortality challenge and what components they are or are not addressing. It places researchers and advocates in a position to shed light on where public resources are going and how these goals are being approached.

During the dialogue, it became clear that the prospect of uniting applied budget analysis with advocacy to reduce maternal mortality offers numerous advantages for both fields. For budget analysts, the clarity of purpose shared by maternal health advocates working at the international, national and sub-national levels can add depth to their work. One of the risks of budget work is that it can become more focused on the numbers than the issues and policies that drive the numbers. According to Zie Gariyo, "It is exciting to see budget work move to another level where we pose as many questions as we answer." Vinod Vyasulu of India agreed, saying budget groups tend to look at health issues as a percentage, whereas this link can help them to do a much finer tracking of numbers. The maternal health field is one where there is a relatively clear set of problems, policies and proposals on which to focus.

For maternal health advocates, budget analysis promises to strengthen and complement existing strategies for reducing maternal mortality by presenting new analytical tools, new allies, and a powerful new language for dialoging with policymakers. Budget work offers interventions both at the policy level to ensure that good policies are adequately reflected in the budget, and at the level where services are delivered by providing crucial monitoring and assessment. Budget work can also help increase transparency and accountability around government efforts to reduce maternal mortality by generating new information, and by demanding more information. Increased transparency and accountability will in turn benefit other maternal health advocacy strategies by opening up the policy environment. Finally, budget work offers maternal health advocates the skills to engage more directly in crucial funding debates. According to Ann Starrs of Family Care International, budget analysis has the potential to strengthen local and national advocacy initiatives by making them more specific, rather than just telling government that it isn't doing enough.

Challenges Ahead

While the possible advantages of joint work are clear, the group struggled with a series of challenges or difficulties that lie ahead.

Complexity and Scale — As many of the cases showed, the need for comprehensive strategies to effectively reduce maternal mortality implies multiple expenditures that cut across areas and levels of government. This means that budget work in this area will need to be similarly broad in scope, therefore requiring more time, more people and more resources–things that few organizations have available.

Skills Deficit — Many civil society groups dedicated to maternal health and safe motherhood do not have the sort of skills needed to do rigorous budget analysis in house. To develop these skills requires significant training, or creating new positions for analysts, both of which, again, require funding. As an alternative, organizations can build alliances and shared objectives with existing budget groups as a way to incorporate the needed skills.

Measuring Success and Demonstrating the Link — Like many development indicators, maternal mortality ratios are used for measuring long-term trends rather than short-term changes. In the context of budget analysis, this means MMR cannot be used to track changes from one budget cycle to the next. This fact led some participants to question whether it would be possible to establish a clear link between budget analysis strategies and a decline in maternal mortality. Others explained that such a link is not necessary. Instead, the role of budget analysis is to demonstrate that resources must be allocated in order to make progress toward established maternal health goals. Budget work can help ensure that good policies are being adequately funded, and that those resources are reaching the populations and programs for which they are targeted.

The False Appeal of Simplicity — The reality that reducing maternal mortality requires a multifaceted approach is itself a problem because, as one person stated, "...this complexity leads governments to do small things that don't really add up to much." Elected officials often respond more favorably to short term objectives that can be achieved while they are in office. Narrowly focused proposals are similarly more attractive than comprehensive programs because they are more easily communicated to the public. And, with budgets inevitably limited, reducing a solution to one or two key actions is often more appealing than recognizing that an effective approach is inherently complex, linking a variety of policy and structural problems. In short, policymakers work in a reality that doesn't favor comprehensive, long-term strategies. Lynn Freedman wondered whether budget analysis can help show that short term, easy solutions don't usually work.

Absence of Accountability Mechanisms — Martha Murdock of Family Care International expressed concern that even in countries where good policies are already in place, there are often no accountability mechanisms to facilitate efforts to monitor progress toward the stated goals. A similar difficulty is found when explicit targets are defined but the strategy for getting to those goals is not, once again making it difficult to monitor or hold governments accountable for their progress. Can budget work be effective in the absence of such accountability mechanisms?

These challenges and others will be confronted in different ways by advocates as they move forward in building new strategies. The solutions they find will help inform others about how strong and effective initiatives are built.

Where to Begin

The possibilities for linking budget work with strategies to reduce maternal mortality around the world are numerous, a fact that may provoke as much confusion as enthusiasm for advocates interested in making this link. The first step, according to David Acurio, is to "begin with what we want to achieve, and then how." Advocates should start by considering various levels or potential entry points to help define their focus.

Good Policies with Committed Funding — The first level of work is where policies are designed and structured, and where money is allocated. At this level the role of advocates is to ensure that good, comprehensive policies are in place, with all the essential components (such as skilled care and EmOC) included, and to verify that those policies are translated into specific budget commitments.

Assessing the Allocations — A second level would take a closer look at the budgets to observe how funds are being allocated across departments, levels of government, regions, and programs. That is to say, are adequate amounts of money being allocated to the appropriate areas for the correct purposes? And, are those funds going to the regions and populations that most need them?

Following the Funds — The third level of analysis is the implementation level, with a focus on one or more of the numerous programs that can help reduce maternal mortality if done well. Such programs might focus on training skilled attendants, improving infrastructure, improving the quality of care, ensuring transportation, etc. At this level,

success depends partly on having the right budget allocations, but also on whether the funds are ultimately getting to the people and purposes for which they are targeted, and whether those programs or services are making a difference.

Strategy Choices

Once project objectives have been defined, advocates must consider a series of strategic alternatives related to the scope, scale and design of their initiative.

• Impact the Debate versus Building the Case

Several participants considered it important to seize the opportunity presented by various international meetings in 2005 by putting something on the table that has impact in the global debate about how to reach maternal mortality goals. Is it possible, they asked, to identify in the budget a couple of key issues or indicators that can be measured to show progress toward maternal health goals? The basic question is what governments should be investing in as a priority with regard to maternal health. If advocates can agree on those priorities, then they can work together to try to measure those commitments in the budget and inform governments about their progress toward these goals. The emphasis, however, must be on using solid analysis to get to a few crucial numbers that illustrate the situation and redefine the debate.

Other participants emphasized the need to generate more systematic evidence about the potential impact of budget work on safe motherhood and maternal mortality. Ana Langer of the Population Council suggested a longer-term approach in which budget analysis is tested at the community level as a tool to reduce maternal mortality. By analyzing the maternal health situation and relevant budget issues throughout the life of the project, the intervention would provide evidence about what needs to be done. This information could then be used to inform government, NGOs, media and the general public, providing lessons that can be shared internationally or used as case studies for moving forward.

• Comparative versus Country–specific

Many participants found the idea of a multi-country comparative project attractive because of the potential for learning about what sorts of policy and advocacy strategies are most effective. A project of this sort would argue again for the identification of a few meaningful indicators that could be measured across countries. Some questioned whether this implies a risk that the analysis will inadvertently reduce the problem–and thus the attention of policymakers–to a handful of issues. Daniela Diaz of Fundar explained that cross-country comparisons can be valuable and done well if the methodological framework is flexible enough to use in different country settings, focused on cross-cutting issues, and allows for context-specific analysis where needed. In all cases, however, researchers or advocates should avoid generalizations or forcing comparisons across very different contexts and situations.

• Defining the Scope

Keeping in mind that funding for maternal health is usually spread across many departments, public institutions, and levels of government, each advocacy effort must also define the level of budget analysis to be undertaken and consider the tradeoffs of the strategy being too focused or too comprehensive. As Joel Friedman said, "...budget work is most effective when it strives to understand the big picture. If an analysis is too narrowly focused, it is likely that key factors affecting the success of the program or activity will be ignored." The most effective strategies will combine a focus on individual programs and activities with an understanding of the larger budget and policy context.

• Finding the Allies

Using budget work to promote maternal health agendas is a promising new area of work that calls for finding new allies to complement existing partnerships. Whether in civil society, academia, private sector or government, the challenge is to locate people who are committed to this issue and looking for ways to make progress. According to Daniela Diaz of Fundar, an important factor behind the success of the Mexico project was an emphasis from the beginning on building alliances with organizations and networks with significant experience in the field of maternal health and maternal mortality.

Making the Link

In the end, making the link is not about identifying a single project. It is about stimulating ideas and knowledge that open the door for multiple explorations between people who care about the issue of maternal mortality. As Warren Krafchik observed, there are virtually no country or global studies to date documenting the links between public finance and maternal mortality and the impact of those efforts. During a lengthy discussion, participants at the Mexico City meeting offered various ideas about how to begin working together to build understanding, document success, improve policy, and build new skills.

• Information to Improve Understanding

While maternal mortality information is usually available at the country level, participants agreed that more and better information could be useful for any advocacy initiative.

Working within the limits — Some groups may decide to begin working with the limited information available. For example, Cecilia de la Torre explained that the Chiapas project began by analyzing available information to see where the money was going. They compared what was being published by the government with what was actually taking place and then used that information to sensitize communities. Joel Friedman commented that in cases where the budget is not very transparent, just adding one fact to the debate will often get the ball rolling and stimulate attention. By getting government to enter into the debate, even if it is to deny that fact, they have to open up and provide alternative information in order to deny it.

Making existing information more accessible — Another strategy is to organize existing data in a way that is more accessible for researchers and advocates working on the maternal mortality issue. This could take the form of a national or international budget information system that reflects the priorities established by maternal health advocates and tracks those numbers on an ongoing basis. Vinod Vyasulu of the Center for Budget and Policy Studies in Bangalore, India described how his organization developed a service for other nongovernmental groups by organizing and certifying government budget data, thereby making it more accessible to a broader civil society audience.

Pressing for greater transparency — There is much to be gained by convincing governments to provide more and better information. The International Budget Project's Transparency Project has found that many governments already produce for internal use much of the data required for analysis, they simply do not publish it. In cases where the information is not available, the initial challenge is often just to demonstrate that information is lacking and document the implications of that lack of information for society. Others groups may follow the example of the Uganda Debt Network by collecting their own information at the programmatic level to augment that provided by government and donor institutions. In all of these cases, even gains that are slow and incremental can start the ball rolling toward greater transparency.

• Documenting Success

Many agreed it would be very useful to have access to case studies where success has been achieved. These materials could highlight cases where budget analysis enabled advocates to impact maternal health policy or allocations, such as Mexico or Uganda, and the factors that led to success in each case. Other case studies could look at places where maternal mortality ratios were reduced significantly –such as Sri Lanka, Malaysia or the State of Kerala in India– with the objective of trying to understand the context in which progress was made. All of these documents would serve a variety of purposes from improving knowledge about what works to providing models that might be replicated wholly or partially in other areas.

• Analysis to Improve Policy and Allocations

While various analytic endeavors can and will emerge as a result of this dialogue, some participants at the Mexico meeting saw important potential for a collaborative effort to examine the issue of equity in budget allocations. According to Lynn Friedman, people who work on the health equity issue need to find ways to move beyond documenting disparity. She suggested trying to identify formulas by which allocations happen and the logic behind them as a way to reveal the forces that cause inequity to become entrenched.

Another set of ideas emerged around the possibility of establishing minimum standards for evaluating the progress of governments around the world toward reducing maternal mortality. Some were uncomfortable with the idea of minimum standards but agreed that it would be interesting to try to identify a set of common indicators located in the budget that could be tracked across countries.

• Training and Empowerment

Various participants saw exciting potential in budget work for community-level initiatives and as a tool to empower women and civil society groups at that level. Banke Akinrimisi of Nigeria spoke of the need for capacity-building for national organizations to help them get to the point where they can do the sort of country-level analysis necessary, and at the local levels to empower people to ask the right questions. Ninuk Widyantoro described a movement in Indonesia among women working for legal protection. It is focused on the district level with the objectives of strengthening health provider capacity and empowering the community. In her opinion, budget analysis could be an important new "bullet" to empower these women and strengthen their work.

This sort of learning could be advanced by the preparation of a manual that defines strategies available to groups working at various levels and provides methodologies for undertaking this work. In-country training seminars are another alternative for providing guidance to groups starting out in this area, possibly sponsored by national or international organizations in conjunction with the International Budget Project.

• Progressive Strategy

Ann Starrs of Family Care International offered a final approach that combines many of these tactics, moving from an information and knowledge-building exercise to more targeted activities. She highlighted the need for a mapping exercise as a first step, with the objective of identifying technical organizations working on safe motherhood and maternal mortality issues that are interested in making the budget link, and budget organizations with which they might engage. This "map" would facilitate a subsequent effort to raise awareness in both fields about using budget analysis as a tool and why it can be important. Then, as new experiences begin to emerge, opportunities should be created to discuss them with a larger community of budget and maternal health activists as tools for broader learning and reflection.

Concluding Remarks

Making the link between applied budget analysis and strategies to reduce maternal mortality does not offer automatic answers, nor does it promise success in achieving the ultimate goal of saving lives. Rather, it is a common language to join two important movements and communities of people, both of which are committed to advancing social justice and protecting human rights. It is a tool for using information to advance knowledge, and for using knowledge to improve decision-making and public well-being. And, it is a way to promote accountability by knowing whether government promises are being translated into sound policies and appropriate allocations.

The objective of the meeting convened in Mexico City in November 2004 was to explore the potential for making this link and arrive at some concrete ideas about next steps. Participants at that meeting, and the organizations and networks they represent, are already taking those initial steps. In January 2005, the Mexico meeting's convening organizations met again in New York to plan a multi-country research and advocacy initiative with the objective of learning more about the relationship between public finance and maternal mortality while gathering information that could be used to influence budget priorities in each country. The initiative will ultimately provide lessons about successful research and advocacy on these issues that can guide and encourage similar work in other countries.

This report and the joint effort that was set in motion following the meeting ultimately hope to pave the way for others who are committed to reducing maternal mortality to advance the common agenda more effectively, coming closer to the goal of preventing unnecessary maternal deaths.

Putting Maternal Health on the Policy Agenda: A Case Study from Mexico

In 2001, five women died each day in Mexico due to complications during pregnancy or childbirth. In 2002, 67 percent of registered maternal deaths occurred in the southern and southeastern states of the country, where a significant number of inhabitants lack social security, live in conditions of extreme poverty in rural areas, and are indigenous. Despite more than a decade of governmental efforts to reduce maternal deaths, the country's maternal mortality rate remains unchanged. At the heart of the problem is a lack of access by poor women to maternal health services.

In 2002, Fundar, a center for analysis and research working on budget issues in Mexico, began evaluating the extent to which public resources were being allocated to the reduction of maternal mortality. Despite its significant experience in the area of gender budgeting, the organization did not have knowledge about the policies and resources needed to effectively reduce maternal mortality. In order to carry out more meaningful research and produce politically relevant information, the organization decided to form an alliance with civil society organizations and networks with longstanding experience in the field of maternal health.

As a first step, Fundar invited these organizations to provide input in the early stages of research design. The research plan was outlined at a working meeting where basic premises were analyzed, discussed and validated. The maternal health experts described the kind of information that would be useful to their efforts and campaigns. Such exchanges continued throughout the research process with the input helping to sharpen the project design at each stage. At the same time, the organizations began to develop a shared understanding of what was necessary to shed light on the issue of maternal mortality and prioritize resources for addressing it.

The research produced more than a hundred pages of data and analysis. Further meetings were held to discuss the findings and their policy relevance and to build an advocacy strategy around them. At this stage, the advocacy experience of Fundar's partner organizations was crucial for opening up channels of communication and making the research findings politically relevant. Even before governmental discussion and review of the budget began, alliance members were able to convene relevant public officials and disseminate the information in a strategic and deliberate manner. Once the budget proposal for 2003 was tabled, efforts were made to keep a broader audience informed about decisions being made through radio broadcasts and articles in national newspapers.

The results of the campaign in this first stage were impressive. In 2002, additional funds for Arranque Parejo en la Vida, a new program to target maternal health, were earmarked in decentralized health expenditures, amounting to an increase of almost 900 percent. The research had strengthened the agenda of groups with a longstanding commitment to the maternal mortality issue by giving them powerful new information and arguments. It also reinforced the efforts of public officials working on gender, equity and health, who increasingly sought input from Fundar and other alliance members to defend their own policy proposals and budget requests.

The strategic alliance between Fundar and the network of groups dedicated to the reduction of maternal mortality has continued beyond that initial campaign. On the policy side, some of the budgetary advances made in 2002 were subsequently lost as funding for key programs was absorbed into larger budget areas, making continued monitoring difficult. But the dialogue between the advocacy alliance and key policy makers has continued. In April 2005, at a forum convened by Fundar and the national legislature, officials from the Health Ministry announced a decision to designate emergency obstetric care as a priority in all maternal health programs going forward, a critical advance in the struggle to reduce maternal mortality. This decision was influenced by a costing exercise in which Fundar illustrated that providing EmOC is financially viable.

The Mexico case offers a number of important lessons for advocates worldwide. To begin with, the results of the research were more meaningful and ultimately more powerful for advocacy purposes because they responded to issues identified by individuals working on the topic on a daily basis. The project's early emphasis on developing a shared perspective and common understanding helped build a more successful and sustained collaboration. During the advocacy stage, information was presented in a timely fashion, making use of the political opportunities offered by the discussion of the budget. In addition, the advocacy strategy sought to maximize the collective and individual strengths of the organizations comprising the coalition. Finally, the initial effort laid the groundwork for ongoing dialogue with policy makers in the Health Ministry and National Congress, a collaboration that continues to shape the way these policy makers are responding to the challenge of maternal mortality.

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