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Public Policy as Dividends of Democracy: An Appraisal of the 'Abiye' Safe Motherhood Programme in Ondo State, Nigeria.

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Abstract
Public policy is a well thought-out statement and coordinated plan of action by government to address and solve identified problems facing members of the public. Its 'publicness' derives from its ability to comprehend the supra-value of the public interest and over-arching desire to meet the needs and aspirations of the people in a manner that conforms to their expectations. In Africa, as in some other parts of the world, however, implementation appears to be the graveyard of public policy. Experience reveals that many so-called public policies are driven by private, individual or group interests that affect their delivery capacities. Where this is not the case, policy implementation encounters so many problems, including that of continuity that they fail to achieve the expected good for members of the public on a sustainable, long term basis. In light of the above, this paper assesses the 'Abiye' Safe Motherhood Programme of the Ondo State Government in South-West Nigeria, which was designed to address the challenge of high maternal mortality in order to meet one of the Millennium Development Goals (MDGs). To achieve these, the author examines the groundwork for the programme, its structure, implementation, reach and impacts on the lives of the people by combining the social survey method of interview with content analysis of available literature. Our findings show that although the programme succeeded in reducing maternal mortality rate significantly within the state, like other public policies and programmes in many unstable democracies of the Third World, it nevertheless faced several challenges related to implementation. The paper addresses these and its lessons in order to improve the delivery capacities, outcomes and the sustainability of key public policies in developing countries.
Key words: Public policy, Dividends of Democracy, Safe Motherhood Programme.

1. Introduction

Whatever their ideology or manner in which they secure power, all governments have the responsibility not only to spell out the law, enforce it, and secure the state (or polity) against external aggression and internal insurrection. Also, governments have to provide for the general welfare of the citizens. However, the ability of a government to achieve the above, and how it gets them done, depends on how it secures power and how it exercises such. The source of power of a government and how it uses such marks the qualitative differences between autocratic, totalitarian and liberal democratic systems (Olaoye, 2003:53-55).

Of all forms of government, liberal-democracies appear most attractive not only in terms of principles, structures and processes, but also in terms of what they can achieve on the long run, for and with the people. This is because in democracies, power derives from the people, to which government is also responsible. Also, democracies have mechanisms for the control of government. For this reason, democratic governments endeavour to justify their hold onto power by instituting and implementing people-oriented policies and programmes. For the masses of poor peoples in Third World countries for whom healthcare is a major challenge, this fact is very crucial for survival. Public policy is a major means by which governments meet the needs of citizens, and in democracies, they are often deliberative in nature. For this reason, Dryzek (2000) as well as Innes and Booher (2000) argue, such policies can achieve more, lasting results.

The constitution stipulates the structure and processes of government. It also defines the limits of government power, the rights, privileges and obligations of citizens. But it is the people-factor that legitimizes government and its actions in democracies. First, it is the people who vote governments into power; second, through consultation, they make inputs into what governments should do and how to do these in order to achieve results that people will have reasons to value and cherish because they meet their desires and expectations.

Government actions are goal-directed and the major goal of government is to solve identified problems facing members of the public. Most governments seek to do so by designing specific courses of action to deal with

specific public problems. This is what Bressler, Friedrich, Karlesky, Stephenson (Jr.) and Turner (2002:399) called a 'policy strategy'.

Scholars have defined public policy from various perspectives. While Dye (2001:2) defines public policy as "whatever governments choose to do or not to do", Parsons (1995) view policy as an attempt to define and structure a rational basis for action or inaction. For him, it is an expression of political rationality, because to have a policy is:

> …to have rational reasons or argument which contain both a claim to an understanding of a problem, an a solution. It puts forward what is, and what ought to be done. A policy offers a kind of theory upon which a claim for legitimacy is made… A politician is, expected to have 'policies' as a shop is expected to have goods to sell.
>
> (Parsons, 1995:15)

If Parsons conceive public policy as intension, other scholars regard it as a course of action in response to social problems. This is clearly the case for Anderson (1976:1-6), as well as for Vig and Kraft (2000:4), who view public policy as a purposive action followed by an actor or set of actors in dealing with a problem or matter of concern. Their definitions take cognizance of what is actually done rather than what is proposed or intended, and indicate that a policy is much more than a decision, which is simply a choice among alternatives. In essence, public policies are developed or made by governments, its agencies, officials or representatives in a political system, in order to provide solutions to problems or address issues that affect citizens either as individuals or groups.

From the foregoing, we can discern the following characteristics of public policy: one, public policies are not just intentions but the actions of government; two, they are goal-specific, directed towards solving particular public problems; three, they are deliberate rather than chance, accidental or random occurrences. This also presumes that several alternative courses of action must have been considered before the choice was made.

Furthermore, public policies are usually not once-for-all events but series of interconnected decisions, actions and events which may span time and space that are directed at addressing the particular issue or problem in focus. Five, public policies usually have targets against which performance can be measured; and finally, public policy decisions are usually undertaken by a few people (in government) on behalf of the majority. However, implementing public policies will often require more people, both as individuals and as groups.

In constitutional democracies, Vig and Kraft (2000:4) note, public policies are enacted through constitutional processes; they require the force of law; and are binding on all members of society. In this sense, public policy is almost an expression of political sagacity, a means of carrying on politics. Thus, public policies constitute an avenue to fulfill election campaign promises by addressing issues that affect the lives of the citizenry which electoral candidates see ahead and build into their campaign manifestoes.

2. Frameworks or Models for Public Policy Making in Democracies

There are many frameworks, perspectives or models that attempt to explain public policy making (and implementation) in general. These include the systems and demographic frameworks (Anderson, 2000; Sharkansky, 1969; Alt and Chrystal, 1983); Dye, 1966; and Hofferbert, 1974). Also, there is incrementalism (Hyde, 1992; Wildavsky, 1986, 1984, and 1972; Wanat, 1974; Bay brooke and Lindblom, 1963); rational-comprehensive decision-making (Thompson, 1967; March and Simon, 1958; Lindblom, 1965; Simon, 1957); elitism (Mills, 2000); and Pluralism (Dahl, 1961). Others include the bureaucratic, Marxist, free market capitalist and the garbage can model (Trow, 1984; Clark, 1983 as well as Cohen, March and Olsen: 1972).

While the demographic and systems frameworks emphasize the importance of environmental factors and characteristics in policy making and implementation, incrementalism argues that decision-making in the public realm is determined by time and that present policies are, to a large extent, determined by past policies and vary only marginally from them. The rational comprehensive model urges policy makers to identify the problems they want to solve, analyze different alternative solutions, assess the costs and benefits of each and select that alternative that promises the highest benefits and least costs. This is called the mini-max criterion. Elitism and pluralism are the opposite sides of the same coin. While elitism portrays public policy decision making as the exclusive preserve of the elite in the interest of elites, pluralism suggests that public policy decisions are results

of the power interface amongst various groups contesting for the political space and represent different interests among the citizenry.

The Marxist model presupposes that public policy in non-Marxist Societies is a weapon through which members of the ruling economic class oppress the working class. But the market capitalist framework prescribes a minimalist role for government, arguing that the invisible forces of demand and supply determine public policy in most cases. The bureaucratic model argues that, owing to their expertise and commitment, bureaucracies are very important to policy making. Finally, the garbage-can model which was developed to apply the rational-comprehensive model more appropriately to government-type organizational behavior, argues that public policy making is often characterized by ambiguity, uncertainty and political symbolism or ritualism.

Deciding what frameworks or models would be appropriate for policy analysis in democracies is not an easy task, since a lot depends on the evaluation criteria employed and the ability of models to integrate knowledge between propositions, creating networks and the types of situations to which they are applied.

As Lane (2000:73) argues:

> Various models of the policy cycle may perform differently according to the evaluation criteria employed…Instead of rejecting or accepting one public policy model, we may point out the type of situations where a model performs well and the situations where it is inadequate…The functions of public policy models are to explain, understand, interpret and organize data concerning the making of decisions by public bodies – government. Just as data without models are blind, so models without data are empty.

From the foregoing, one can advance the argument that models of public policy making and implementation that would comprehend the dynamics of policy making in a democracy must be able to accommodate the aggregation of inputs from various stakeholders. Thus, they must be able to appreciate the values of consultation, the bottom–up process and the need for social diffusion and aggregation, rather than social differentiation and segregation. Above all, such models must encourage gravitation towards the ideas of the public interest, which are inclusive of consensus, effectiveness, efficiency and service delivery.

3. Objectives of the 'Abiye' Safe Motherhood Programme

'Health is wealth, a popular adage says. The development of a country depends on the prosperity of its people, which in turn depends on their productivity, which is directly related to how healthy the people are. The Nigerian healthcare delivery system is so poor that it ranked a distant 197 in a 200-country healthcare delivery survey that was carried out by the World Health Organization (WHO) recently (News monitored on Press TV, February 21, 2013). This is not surprising, given that Nigeria allocates less than 5% of its annual budgets to health, instead of the 15% that is recommended by the World Health Organization (News monitored on Press TV, February 21, 2013). The Abiye Safe Motherhood programme is aimed at reducing the high maternal mortality rate in Nigeria, Ondo State inclusive. High maternal mortality is one of the major contributors to high death rates in Africa, Nigeria inclusive. For instance, it is on record that:

> (Although) Nigeria has only two percent of the global population, it contributes 10% to the global maternal mortality burden. Annually, an estimated 52,900 Nigerian women die from pregnancy-related causes out of a global total of 529,000. A Nigerian woman's lifetime chance of dying from pregnancy-related causes is one in 13.
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> (Health Reform Foundation of Nigeria (HERFON), 2008:195).

According to the Nigeria Demographic and Health Survey 2003 (National Population Commission, Nigeria and ORC Macro, 2004), with an annual estimated one million deaths of children who are below five years old, Nigeria contributes 10% of the global child mortality figures, which is the second largest from any single country globally. Infant Mortality Rate (IMR) stood at 100 per 1000 live births while under-five mortality rate (U5MR) was 201 per 1000 live births. Although a 1999 Multiple Cluster Indicator Survey attributed a lower zonal maternal mortality rate to the South West Zone compared to other zones in Nigeria (Federal Office of Statistics and UNICEF, 2000), a 2008 National Demographic and Health Survey ranked Ondo State as the worst in South West Nigeria in terms of maternal and child health.

The Abiye Safe Motherhood Programme in Ondo State is aimed specifically at addressing this health challenge to the people of Ondo State. It is also in pursuit of two (i.e numbers 4 and 5) of the Millennium Development Goals (MDGs) that were adopted by the United Nations in 2000 and launched by 147 Heads of State and Government present at the September 2001 United Nations Millennium Summit, who pledged to pursue eight specific goals that were meant to boost individuals' rights to development, peace, security, eradication of poverty in its different dimensions and to promote sustainable development by the year 2015 (WHO, 2005). As evaluation criteria, the Abiye Safe Motherhood Programme aims by 2015, to achieve one of the two MDG goals related to women's health. The first is to reduce child mortality rate by to thirty three percent (33%) and to reduce maternal mortality rate through improvements in maternal health by seventy-five percent (75%) from 1990 levels. The second women's health-related MDG goal which the 'Abiye' programme seeks to meet indirectly, is to enhance access to sexual and reproductive rights, and this is implicit in MDG goal six, namely to combat HIV/AIDs, malaria and other diseases.

These evaluation criteria are in line with the health indicators that were established for Millennium Development Goals number 4 and 5 as shown in Table 1 below.

4. Philosophy, Aims, Structure and Implementation of the 'Abiye' Safe Motherhood Programme

4.1 Philosophy

The philosophy behind the 'Abiye' Safe Motherhood project is the belief of the state government in grooming healthy people as the major engine of productivity and development. Developed by a mass (i.e labour) oriented political party that seeks to grant unto citizens the rewards, popularly called 'dividends' of democracy, 'Abiye' is a timely intervention that is aimed at addressing high child and maternal mortality rates that have become sources of worry even to the World Health Organization in certain regions of the world, Africa and Nigeria inclusive. Through the programme, the mass- oriented government believes that pregnancy should no longer be interpreted to mean a death sentence for women.

4.2 Aims

The 'Abiye' Safe Motherhood project aims at combating high child and maternal mortality rates in Ondo State by addressing the following four major factors that predispose pregnant women to death:

(i) Delays in seeking care when complications arise;
(ii) Delays in reaching care when eventually, decisions are taken to seek care;
(iii) Delays in accessing care on arrival at a healthcare facility; and
(iv) Problems with the referral system when the need arises to refer patients to other health facilities for better care (Ogundipe, 2011).

4.3 Structure

The programme has a tripartite structure which includes the following:

(i) The beneficiaries, who constitute the target group. These are pregnant mothers and young children up to age 5;

(ii) Health centres or clinics near beneficiaries or target group. These include the Mother and Child Hospital (MCH) initiative, as part of the means of addressing delays caused by distance to healthcare facilities in accessing healthcare by pregnant mothers when decisions are taken to do so. To further remove delays, each registered pregnant mother is empowered to communicate directly with community health extension workers and Health Rangers at no cost to callers, through the provision of toll-free call-handsets for mothers at the point of registration. The facility also includes free drugs and free-of-charge delivery services. All these costs are borne by the state government. In these ways, the 'Abiye' programme has succeeded in removing many physical and economic barriers to accessing healthcare and safe delivery by pregnant mothers drastically.

(iii) Three, is the provision of physical infrastructure, training, expertise and other inputs such as means transportation even from the residences of patients to the nearest healthcare facilities. These infrastructure included the upgrading of existing health centres and clinics, building of specially dedicated Mother and Child Hospitals, training and posting of professional midwives, birth attendants and community health extension workers called Health Rangers to communities; as well as provision of tricycle ambulances that are fitted with necessary gadgets, both to facilitate easy movement of pregnant mothers to healthcare facilities when the need arises, and if necessary, to take birth before reaching the nearest health facility (Ogundipe, 2011:2).

4.4 Implementation

Implementation of the programme began with a pilot scheme that was domiciled at Ifedore Local Government Council headquarters, Igbara-Oke, and a Mother and Child Hospital that was domiciled at Akure, the state

capital. With the success of the pilot scheme, the state government began to replicate the project in the remaining seventeen (17) local government areas of the state, including the riverine areas.

5. Appraisal the Impact of the 'Abiye' Safe Motherhood Programme

It is necessary to commence an appraisal of the impact of the Abiye Safe Motherhood Programme on maternal and child mortality with a comparative assessment of relevant available data on child and maternal mortality before and after the commencement of the programme. Also, the appraisal may benefit from an analysis of earlier programmes targeted at addressing the problems of child and maternal mortality in Nigeria that encountered problems and an examination of the causes and nature of such problems.

According to Mahmood Fathallah, founder of Safe Motherhood Initiative, "more women have died in childbirth (globally) than men have died in battle" (Roeder, 2013). Available survey results on the causes of maternal mortality found that 20% are due to delays in taking decision about taking the woman to hospital in case of delivery complications. Also, such delays are proved to be related to ignorance about sources of appropriate care, poverty, cultural practices that are harmful to health and male dominance in decision-making. Another 40% of mortalities are attributed to delays in transporting patients to a health facility as a result of transportation problems while the last 40% of maternal mortalities are caused by delays in receiving appropriate care on arrival at a health facility (Wekki, 2008).

In spite of these global realities, however, it has been noted that interventions to address delays resulting from decision making and transportation did not receive the required attention in safe motherhood programming in Nigeria (HERFON, 2008:205). This fact was amply demonstrated in the implementation of the under-listed safe motherhood policy interventions in Nigeria's history:

(a) National Reproductive Health Policy and Strategy of 2001;

(b) Training in Life Saving Skills (LSS) for nurses and the Modified Life Saving Skills (MLSS) for community health extension workers that was organized to promote availability and accessibility of pregnant mothers to skilled attendants in twelve states of Nigeria by the United Nations Fund for Population Activities (UNFPA), and by the World Health Organization (WHO) in six states; and

(c) The UNICEF-supported Women and Children Friendly Initiative of 2004, that was aimed at actualizing VISION 2010 in order to reduce maternal and neonatal mortalities by 50% and morbidities by 30%, respectively, by the year 2010; and

(d) The Integrated Maternal, Newborn and Child Health (IMNCH) strategy that was adopted in 2007 in recognition of the natural linkage between mother and newborn child. It was aimed at addressing the fragmented way in which safe motherhood programmes were planned and delivered. It was meant to provide a continuum of care, address over 90% of causes of maternal and child mortality, build synergy, accelerate coverage and maximize impact in attaining MDG goals 4 and 5. (HERFON, 2008:203-204).

In spite of the aforementioned efforts, however, maternal and child mortalities remain high in Nigeria. A UNICEF-sponsored study to assess the impact of maternal care in some northern states and Abuja, where programmes had been hoisted to reduce maternal mortality found a maximum of 18% coverage in the Federal Capital Territory (FCT), Abuja, and as low as 0% in Kalgo Council Area of Sokoto State (HERFON, 2008:204).

Apart from delays in decision-making, transportation and in receiving attention and care on arrival at healthcare facilities, other challenges that affected the implementation of these earlier programmes were related to inadequate financing, non-availability of materials, equipment and shortfalls in human resources (HERFON, 2008:204).

The 'Abiye' Safe Motherhood Programme was designed to address several of the challenges that plagued these earlier efforts. These include delays at various various points from decision to seek care, transportation and the giving of attention by medical personnel. Other crisis points that the 'Abiye' programme was designed to address included manpower resources, finance, logistics support, and physical and economic access, as noted under our discussion of the structure and implementation of 'Abiye' above.

A qualitative difference between 'Abiye' and these other programmes has to do with programme orientation. While many of the former safe motherhood programmes were vertical in orientation, being donor-driven by international institutions and lacking in local content and inputs, 'Abiye' is horizontal in design and implementation, totally planned and implemented by the Ondo state government in consultation with the people.

Policies succeed more when they are domesticated and have local inputs from beneficiaries who are often proud to 'own' such programmes.

Another difference between them is that while the former programmes did not significantly remove financial barriers on utilization of healthcare delivery services, the 'Abiye' programme is entirely free to beneficiaries, from the point of registration to communication, transportation, as well as drug and other medical supplies. In addition, the 'Abiye' programme gave free post-natal care to beneficiaries for two months after delivery.

Finally, there is no discrimination between indigenes and non-indigenes as pregnant women come from neighbouring states to access the programme (*personal interview with beneficiaries*). As a result, the programme has made positive impacts on maternal and child mortality in Ondo state. Some achievements of the programme are as follows:

a) The programme has facilitated access to quality healthcare unrestricted by financial constraints by pregnant mothers and children. This is significant in a country where a substantial proportion of the citizens are poor, yet a higher proportion of expenditure on health is born 'out-of-pocket' by patients. Finance was a major reason for the failure of many of the older programmes on safe motherhoold in the country;

b) Establishment of wide-spread contact with beneficiaries in their natural places of abode, for the purposes of safety and convenience. About twenty-six thousand, one hundred and fifty (26,150) women had been reached as at June 12, 2011 (Ogundipe: 2011:12); and

c) The programme recorded a huge success in terms of live births. According to Ogundipe (2011:12), "a comparison of maternal mortality rates with major medical facilities in four different states indicated that the 'Abiye' programme had the lowest maternal mortality ratio during its first year of operation". The programme reduced maternal death by 15% and child death by 26% within three years, having safely deliverred "almost 11,000 babies … out of which more than 1, 500 were by caesarian section". (*African Examiner,* April 22, 2012).

Due to these and other achievements of the programme, several national, inter-continental and international bodies like the Society of Gynaecology and Obstetrics of Nigeria (SOGON), World Health Organization (WHO), and health-funding bodies like the World Bank have commended the programme, recommending it for adoption towards mitigating the rise in maternal and child mortality in Africa (*African Examiner,* April 22, 2012).

6. Challenges to the 'Abiye' Safe Motherhood Programme

In spite of its achievements, the 'Abiye' Safe Motherhood Programme is faced with several challenges. The first of these is the question of sustainability after the tenure of the government that initiated it. In a country that is riddled with abandoned projects, in many cases as a result of changes in government and, or political party in power, this threat is very real. This is because the understanding of 'continuity' by Nigerian politicians ends with an extra tenure of office, and not with on-going projects. Every political chief-executive either believes or is persuaded to think that he or she must initiate new projects to demonstrate that he/she has ideas to move the society forward. In this way, many lofty ideas and projects initiated by past governments get jettisoned and left unfulfilled. It can be safely said that next to implementation, change of government is the graveyard of public policy in Nigeria. This is true in this situation, given the fact that 'Abiye' is the brainchild of the Labour Party, which has never ruled any state in Nigeria apart from Ondo state.

Another challenge to the programme is the ability and determination of the government to spread the programme to other parts of the state, apart from Ifedore Local Government Council where the pilot scheme is located, Akure, the state capital and Ondo Local Government Council, where Mother and Child Hospitals have already been built. These challenges revolve around the need for greater financing, training of more Health Rangers and Community Health Officers. Also, there is the challenge posed by the different topographies in the state, particularly the riverine areas, and how to cope in such a way that delivery will not be adversely affected.

A third group of challenges are related to the need for responsiveness in line with current realities and best practices worldwide. The private sector is a major player in healthcare delivery in Nigeria, and the Federal Government is encouraging public-private partnerships in the economy, such as public infrastructure and service delivery in many sectors of the economy, including telecommunications, the power sector and road development, among others. Against this background, the need to evolve public-private partnerships in the health sector cannot be over-emphasized.

There are many avenues, areas and reasons in the Nigerian health sector where and why public-private partnerships are desirable. Due to the growing gap between need and budgetary allocations to the health sector in Nigeria, the growing list of health needs that the public sector alone cannot meet, the under-utilization in the public sector of certain resources like buildings, equipment and other inputs which are lacking in the private sector, and the need for public-private collaborative health research to deliver better health services to Nigerians, the time has come to engage in such partnerships.

Unfortunately, Nigeria does not have robust experience in working out such arrangements. Nevertheless, it is a necessity that circumstances are imposing on players in the Nigerian health sector if the goals of health-for-all must be achieved. Therefore, being a trailblazer in safe motherhood in Nigeria and Africa, the 'Abiye' Safe Motherhood Programme is expected to blaze yet another trail in the area of public-private partnership for better healthcare delivery in the country and the African continent.

However, there is a need for the Ondo State Government to be steadfast and vigilant towards ensuring that obtrusive politicking does not erode the gains already made by 'Abiye'. This is because the Federal Ministry of Health thinks that disparities in health programmes between the federal and state governments is a cog in the wheel of progress in healthcare delivery in Nigeria (News monitored on Radio Nigeria Network News @ 7.00am, Tuesday, March 26, 2013). Since the Minister only fell short of calling for the harmonization of all healthcare programmes by all state governments in Nigeria irrespective of the political party in power that is floating such programmes, the Minister might have been thinking of replicating the 'Abiye' Safe Motherhood Programme nationwide. This is the recommendation by many national, regional and international stakeholders in global health, including the Society of Gynaecology and Obstetrics of Nigeria (SOGON), World Health Organization (WHO), and health-funding bodies such as the World Bank.

7. Conclusion

This paper has examined the impact of democracy and democratic processes on the effectiveness of public policies, in terms of policy adoption, planning and implementation, using the 'Abiye' Safe Motherhood Programme of the Olusegun Mimiko-led Labour Party administration of Ondo State in Nigeria's Fourth Republic as case study. Among other things, we found that robust consultation and consensus-building through the bottom-up process of decision-making allows government to design policies that people will have reasons to value, support and desire to 'own'.

The research also demonstrates that democratization of people-oriented programmes and policies in democracies provide a template for remarkable achievement of policy goals and objectives, even in hostile environments where policy failure is most expected. The paper also suggests that negative politicking and inefficient resource allocation can constitute potential pitfalls of public policies and programmes, no matter how 'popular' such may be amongst the population.

Finally, the paper re-iterates the need for programme designers and implementers in the developing world to be dynamic and remain sensitive to prevailing circumstances so as to be able to take advantage of possibilities and opportunities provided by the environment, not only to sustain, but also to improve on the achievements of public policies and programmes. This is because the design and implementation of public policies and programmes that would achieve results in Third World countries may not necessarily follow examples from the developed world.

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Table 1: Goals of the 'Abiye' Safe Motherhood Programme in relation to the United Nations MDGs

Goal	Health Targets	Health Indicators
Goal 4	Reduce Child Mortality	13. Under five mortality rates
Target 5	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	14. Infant mortality rate of one-year 15. Proportion of one-year old children immunized against measles.
Goal 5	Improve Maternal Health	16. Maternal mortality ratio
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	17. Proportion of births attended by skilled health personnel
Goal 8 Target 18	In co-operation with the private sector, make available the benefits of new technologies, especially information and communications.	

Sources: Abstracted from "Implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/57/270/31 July 2002), first annual report based on the "Road map towards the implementation of the United Nations Millennium, Declaration", Report of the Secretary-General, A/56/326 (6 September 2001); United Nations Statistics Division, Millennium Indicators Database, verified in July 2004; World Health Organization, Department of MDGs, Health and Development Policy (HDP).