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Setting the global health agenda: The influence of advocates and ideas on political priority for maternal and newborn survival

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ABSTRACT

This study investigates a puzzle concerning global health priorities—why do comparable issues receive differential levels of attention and resources? It considers maternal and neonatal mortality, two high-burden issues that pertain to groups at risk at birth and whose lives could be saved with effective intrapartum care. Why did maternal survival gain status as a global health priority earlier and to a greater degree than newborn survival? Higher mortality and morbidity burdens among newborns and the cost-effectiveness of interventions would seem to predict that issue's earlier and higher prioritization. Yet maternal survival emerged as a priority two decades earlier and had attracted considerably more attention and resources by the close of the Millennium Development Goals era. This study uses replicative process-tracing case studies to examine the emergence and growth of political priority for these two issues, probing reasons for unexpected variance. The study finds that maternal survival's grounding as a social justice issue spurred growth of a strong and diverse advocacy network and aligned the issue with powerful international norms (e.g. expectations to advance women's rights and the Millennium Development Goals), drawing attention and resources to the issue over three decades. Newborn survival's disadvantage stems from its long status as an issue falling under the umbrellas of maternal and child survival but not fully adopted by these networks, and with limited appeal as a public health issue advanced by a small and technically focused network; network expansion and alignment with child survival norms have improved the issue's status in the past few years.

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Maternal and neonatal mortality reduction appear prominently among the freshly minted United Nations Sustainable Development Goals (SDGs; Fig. 1) for health, but the issues have not always been on the international health or development policy agendas. Many factors understood to facilitate the ascendance of issues on policy agendas apply to maternal and newborn survival, concerned respectively with reducing preventable deaths to pregnant women and newborn babies. Their global mortality and morbidity burdens are high; an estimated 2.7 million neonates and 303,000 women die annually, while neonatal conditions comprise 202 million and maternal conditions 16 million disability-adjusted life-years (DALYs) (Murray et al., 2012; UNICEF et al., 2015; World Health Organization et al., 2015). And, both issues pertain to groups at risk at birth and whose lives could be saved with effective intrapartum care.

This study seeks to explain how maternal and newborn survival gained status as international health and development priorities, and why they did so in an order and to a magnitude not readily predicted by existing theory. Several factors understood to facilitate issue ascendance—including certain characteristics of the issues, the existence of policy entrepreneurs and concerned actor networks, resonating issue frames and favorable international norms (Fukuda-Parr and Hulme, 2011; Keck and Sikkink, 1998; Kingdon, 1994; McInnes et al., 2012; Price, 1998; Shiffman and Smith, 2007; Shiffman et al., 2016; Snow et al., 1986)—are present in both cases. All other things equal, higher mortality and morbidity burdens among newborns and the cost-effectiveness of interventions would seem to predict that issue's earlier and higher degree of prioritization; however, the opposite has occurred.

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Millennium Development Goal 4.A Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	Millennium Development Goal 5.A Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
Sustainable Development Goal 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	Sustainable Development Goal 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

Fig. 1. International development goals. Sources: Millennium Development Goals (http://www.un.org/millenniumgoals/); Sustainable Development Goals (http://www.un.org/sustainabledevelopment/health/).

Maternal survival began to emerge as a priority some two decades in advance of newborn survival (the mid-1980s compared to the mid-2000s), and at the close of the United Nations Millennium Development Goals (MDG) era had attracted considerably more attention and resources (Fig. 2; Arregoces et al., 2015).

Issues that are unsuccessful or 'lag' in gaining status on organizational and political agendas are rarely examined, but their study in relationship to successful cases promises to help refine existing theory (Carpenter, 2007). We conducted replicative process-tracing case studies examining the emergence and growth of political priority for maternal and newborn survival, probing reasons for unexpected variance between the cases (Yin, 2014). We find that maternal survival's relative advantage stems from its grounding as an issue of social justice for women, which closely aligned the issue with powerful international normative forces and spurred development of a strong and diverse concerned actor network. Newborn survival's disadvantage stems from its long status as a hidden issue falling under the umbrellas of maternal and child survival but not fully adopted by either of these networks, its limited appeal as a public health issue advanced by a small and technically oriented network, and its late alignment with international normative forces.

In the sections that follow we review explanations for variation in agenda setting outcomes, drawing on theory that considers the role of ideational factors. We then present historical case studies tracing the emergence and growth of policy attention and resource allocations to maternal and newborn survival through to the launch of the Sustainable Development Goals in September 2015. In the discussion, we delineate findings and consider their implications for global health and international development priority-setting processes.

1. Agenda setting for global health issues

Social constructivists contend that actors are motivated not just by a logic of consequences (rational and self-interested calculations concerning the likely effects of a presumed course of action), but also a logic of appropriateness (what they perceive is right to do) (Olsen and March, 1989). They posit that principled ideas in the form of norms—shared expectations for the behavior of actors with a given identity (Katzenstein, 1996)—influence the behavior of nation-states and other international actors (Finnemore and Sikkink, 1998). Norms vary in strength. Finnemore and Sikkink (1998) elaborate a life cycle model concerning how norms advance through the international system, gaining strength as they do. In the first stage, entrepreneurs comparable to those described by Kingdon (1994) propose new standards and expectations for behavior by states and other international actors. A critical mass may accept these standards, facilitating a norm cascade across the international system. Finally, norms may become internalized—taken for granted and no longer debated. The MDG framework represents a set of strong international development norms that progressed through this life cycle, with significant implications for the policy agenda status of included issues (Fukuda-Parr and Hulme, 2011; Rushton, 2010; Smith and Rodriguez, 2016).

Alignment with strong and favorable norms—what Price (1998) terms grafting—increases an issue's chances of acquiring agenda status (Rushton, 2010; Cortell and Davis, 1996). Alignment is achieved through framing. Actors employ issue frames (ideational lenses through which problems are understood and portrayed) as political strategy, to shift understandings, attract attention and guide future action (Finnemore and Sikkink, 1998; McInnes et al., 2012; Reubi, 2012; Snow et al., 1986). Issues are more likely to

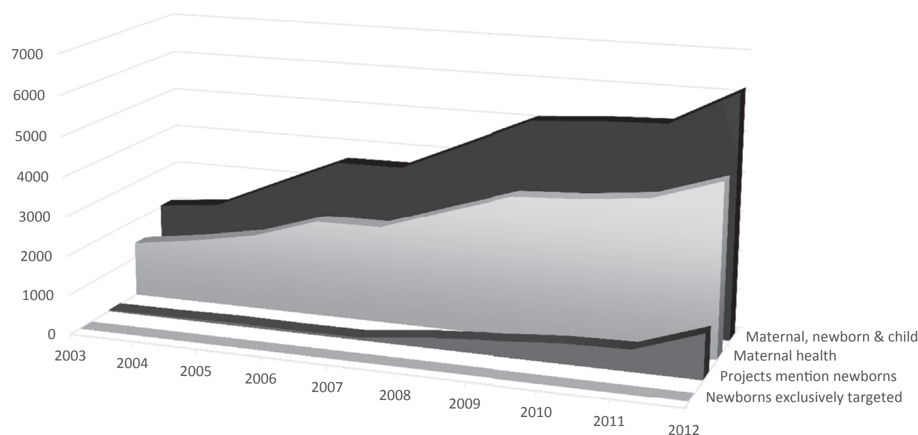

Fig. 2. ODA for maternal, newborn and child health, 2003–2012. Note: In constant 2012 US$ (millions). Source: Arregoces et al., 2015.

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