

Generation of political priority for global health initiatives: a framework and case study of maternal mortality

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Why do some global health initiatives receive priority from international and national political leaders whereas others receive little attention? To analyse this question we propose a framework consisting of four categories: the strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself. We apply this framework to the case of a global initiative to reduce maternal mortality, which was launched in 1987. We undertook archival research and interviewed people connected with the initiative, using a process-tracing method that is commonly employed in qualitative research. We report that despite two decades of effort the initiative remains in an early phase of development, hampered by difficulties in all these categories. However, the initiative's 20th year, 2007, presents opportunities to build political momentum. To generate political priority, advocates will need to address several challenges, including the creation of effective institutions to guide the initiative and the development of a public positioning of the issue to convince political leaders to act. We use the framework and case study to suggest areas for future research on the determinants of political priority for global health initiatives, which is a subject that has attracted much speculation but little scholarship.

Introduction

Global health initiatives vary in the amount of political priority they receive from international and national leaders. Child immunisation, family planning, and HIV/AIDS, for instance, at some points have attracted great resources, whereas malnutrition and pneumonia have received little attention despite also addressing high-burden disorders. We know little about the sources of variance in priority levels afforded to global health initiatives, since there is an absence of systematic research into this subject.

We propose an initial framework for analysing the determinants of political priority for global health initiatives, and we hope future researchers will modify and improve this framework. It consists of four categories: the power of actors involved, the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself. We apply this framework to the global safe motherhood initiative, which was launched in 1987 to reduce levels of maternal mortality. This initiative reached its 20th anniversary in 2007, but despite determined efforts by advocates, it has yet to attract the level of political attention its founders hoped it would receive. A recent study on political priority for maternal mortality reduction took the country as the unit of analysis and developed a framework that sought to explain variance in levels of national priority for safe motherhood in Guatemala, Honduras, India, Indonesia, and Nigeria.¹ Our study asks a similar question about variance in political priority levels, but the unit of analysis is the global health initiative. It deepens and expands the first framework by grounding it in the extensive research on collective action.

A global initiative is an organised effort linking people and organisations across national borders to address an issue of international concern, such as climate change or

human rights. Global political priority is the degree to which international and national political leaders actively give attention to an issue, and back up that attention with the provision of financial, technical, and human resources that are commensurate with the severity of the issue. We know that global political priority is present when: (1) international and national political leaders publicly and privately express sustained concern for the issue; (2) the organisations and political systems they lead enact policies to address the problem; and (3) these organisations and political systems provide levels of resources to the problem that are commensurate with its severity. These three factors include not only international but also national components, since global initiatives rarely aim to generate priority only among international organisations—they also seek political support from national political systems.

Global political priority alone is not sufficient to address an international problem successfully. Effective policies, technology, and implementation systems, among other elements, are also crucial. However, global political priority aids success, and therefore is essential to investigate.

In this paper we present the framework, examine determinants of global political priority for safe motherhood with reference to this framework, point to challenges that the initiative might face in gaining priority over the coming decade, and identify questions for future research into sources of political priority for global health initiatives.

Framework for determinants of political priority for global initiatives

Researchers have sought to understand why initiatives pursuing social and political change succeed or fail in attracting political support. They have investigated several types of collective action efforts, including international networks for issues such as climate change,^{2–6} social movements for causes such as civil rights,^{7–10} and policy

communities that aim to place particular issues on national agendas.^{11–13} A central concern in collective action research is the role of power: the power of actors connected with the issue; the power of the ideas used to define and describe the issue; the power of political contexts to inhibit or enhance political support; and the power of some characteristics of the issue, such as the number of deaths a particular disease causes, to inspire action.^{2–13}

These four elements form the foundation of our framework for the determinants of political priority for global initiatives (table). Initiatives are more likely to attract political support if they share specific features in all categories.

The first element is the power of the actors involved in the initiative. Initiatives differ in the strength of those who participate in them, in the quality of linkages between these actors, and in their collective capacity to confront opponents.^{14–16} Among those who influence initiative acquisition of political support are policy communities (factor 1)—the network of individuals and organisations who operate globally and who are linked by a central concern for the issue. These communities include prominent leaders of non-governmental organisations, government officials, bilateral donors, members of UN agencies, other international organisations, and academics. Policy communities that agree on basic issues such as how the problem should be solved are more likely to acquire political support than are those that are divided by such issues, since politicians will be more likely to listen to those in agreement as authoritative sources of knowledge.

The emergence of respected leaders who are embraced by the community (factor 2) helps with coalescence and

provides direction to the initiative. For example, the former director of the UN Children's Fund (UNICEF), James Grant, is often cited as an example of such a leader. Strong guiding institutions (factor 3)—ie, organisations or coordinating mechanisms with a mandate to lead the initiative—are also crucial. Initiatives might start through informal associations or as projects inside formal organisations, but they must build their own enduring institutions if they are to survive.⁷ Continual competition among concerned organisations to control the issue could hamper the creation of these structures. The Task Force for Child Survival and Development (formerly led by Grant) has been noted as a guiding institution that is particularly effective for the cause of child health. Finally, initiatives are more likely to generate political support if they link with grassroots organisations in civil society that are pushing for global attention to the issue (factor 4), rather than remaining confined to select members of a global policy community. Pressure from grassroots AIDS activists on national governments and international organisations, for instance, has helped to increase donor aid to address the disease in developing countries.¹⁷

Ideas also shape political support for initiatives. The role of ideas in politics has inspired much research,^{4,18} which is grounded in recognition that material influences alone cannot explain all political behaviour and that people interpret the world around them very differently. The central ideational variable in collective action research is the frame—ie, the way in which an issue is understood and portrayed publicly.¹⁰ Any issue can be framed in several ways. For example, HIV/AIDS has been framed as a public-health problem, a development issue, a humanitarian crisis, and a threat to security.^{17,19} Some frames resonate more than others, and

	Description	Factors shaping political priority
Actor power	The strength of the individuals and organisations concerned with the issue	<ol style="list-style-type: none"> 1 Policy community cohesion: the degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the global level 2 Leadership: the presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause 3 Guiding institutions: the effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative 4 Civil society mobilisation: the extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level
Ideas	The ways in which those involved with the issue understand and portray it	<ol style="list-style-type: none"> 5 Internal frame: the degree to which the policy community agrees on the definition of, causes of, and solutions to the problem 6 External frame: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environments in which actors operate	<ol style="list-style-type: none"> 7 Policy windows: political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decisionmakers 8 Global governance structure: the degree to which norms and institutions operating in a sector provide a platform for effective collective action
Issue characteristics	Features of the problem	<ol style="list-style-type: none"> 9 Credible indicators: clear measures that show the severity of the problem and that can be used to monitor progress 10 Severity: the size of the burden relative to other problems, as indicated by objective measures such as mortality levels 11 Effective interventions: the extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive

Table: The four categories for the framework on determinants of political priority for global initiatives

different frames appeal to different audiences. Finance ministers, for instance, might be more likely to respond to frames that emphasise the economic costs of a health problem than are health ministers, who might pay more attention to frames that focus on public-health benefits and losses. Frames that resonate internally (factor 5) unify policy communities by providing a common understanding of the definition of, causes of, and solutions to the problem. Frames that resonate externally (factor 6) move essential individuals and organisations to action, especially the political leaders who control the resources that initiatives need.

The political contexts in which actors operate also exert substantial influence over political support levels.^{20–23} Those involved in the initiative might have little control over these contextual factors, but they should take them into account if they wish to develop effective strategies. Many elements of political context matter, but two are essential. First are policy windows (factor 7), which are moments in time when worldwide conditions align favourably for an issue, presenting advocates with especially strong opportunities to reach international and national political leaders.¹² Policy windows often open after major disasters (such as a tsunami), discoveries (a new vaccine), or forums (global UN conferences). For example, the Millennium Development Goals (MDGs) have helped with the opening of policy windows for some of the causes included. A second crucial element of context is the global governance structure for the sector (factor 8)—ie, the set of norms (shared beliefs on appropriate behaviour) and the institutions that negotiate and enforce these norms. International treaties, laws, and declarations exist for many sectors, including trade, the environment, and health, usually with an international organisation or set of organisations in charge of their enforcement. In some sectors, these structures work well; in others, they are dysfunctional. Several studies have expressed concern about the increasingly fragmented structure of global governance for health, with many organisations competing for power, constantly shifting priorities, and no one organisation or set of organisations with the power to coordinate.^{24–25}

Finally, the nature of the issue itself shapes political priority. Some issues are intrinsically easier to promote than others.^{2,26} Problems that are easily measured are more likely to gain political support than are those that are not, since policymakers and advocates will have information to confirm the severity and monitor progress (factor 9). For instance, studies providing credible evidence of high population growth and fertility rates interacted with other factors in the 1970s and 1980s to convince political leaders in many developing countries that they had population problems that needed attention. Problems that cause substantial harm, as indicated by objective measures such as numbers of deaths, are more likely to attract resources than are those that do not, since

policymakers will perceive harmful problems as more serious (factor 10). Problems with fairly simple, inexpensive, evidence-based solutions will be easier to promote than will those without these features, since policymakers prefer to devote resources to issues that they think they can address effectively and cheaply (factor 11). Cheap and effective vaccines, for example, have helped to generate political attention for child immunisation policies.

No one factor is necessary or sufficient for political support: some initiatives that have not attracted political priority possess several of these characteristics and some initiatives that have received political attention are without several. For example, HIV/AIDS presently attracts great political support despite extensive contention within its global policy community, and polio eradication continues to receive substantial resources despite the disease's small global burden compared with many other disorders. Conversely, chronic diseases such as cardiovascular disorders, cancer and diabetes, some communicable diseases such as pneumonia, and a number of risk factors such as malnutrition attract few worldwide resources despite causing high morbidity and mortality. These cases suggest the need for continual research into the determinants of political priority for global health initiatives, including assessment of the relative causal weights of the factors, their interactive effects, and whether different combinations of factors could raise the issue in global health.

However, existing research into collective action provides evidence that, other things being equal, every factor enhances the likelihood that an initiative will receive priority. A global policy community is more likely to generate political support for its concern if it is cohesive, well-led, guided by strong institutions, and backed by mobilised civil societies; if it agrees on solutions to the problem and has developed frames for the issue that resonate with political leaders; if it takes advantage of policy windows and is situated in a sector with a strong global governance structure; and if it addresses an issue that is easily measured, is high in severity, and has effective interventions available. In such a situation, the power of those involved with the initiative, ideas, political contexts, and issue characteristics all work in favour of the initiative.

Methods used to apply framework

To examine the global safe motherhood initiative we used process-tracing, which is a method that is commonly used in qualitative social science inquiry and involves analysis of several sources of information to uncover social processes and assess causality.²⁷ In 2005–07, we conducted 23 interviews, lasting on average 1.5 h, with individuals centrally involved in the development of the global initiative, including most of its founders. All individuals had worked on safe motherhood with a UN agency, multilateral financial

institution, university, or international non-governmental organisation. We also analysed data from a complementary study on political priority for maternal mortality reduction in five developing countries, which included interviews with bilateral donors, national political officials, and national non-governmental organisation leaders.¹ Additionally, we undertook archival research on the history of the initiative, collecting and reviewing more than 70 documents from coordinating organisations for the initiative, donors, UN agencies, non-governmental organisations, and other actors. Furthermore, we consulted published work on maternal mortality and the safe motherhood initiative. Once we had collected the information, we reviewed the interview transcripts, documents, and published work to analyse factors that shaped political priority for the initiative. One of our aims was to capture the perspectives of global safe motherhood actors themselves on the state of political priority for the initiative. We therefore draw heavily on excerpts from the interviews in presentation of our data. We provided a draft of the paper to many of the interviewees, and incorporated feedback that they provided. We also distributed and presented the paper at a consultation organised by the MacArthur Foundation in May, 2007, on global safe motherhood strategy, which was attended by 24 individuals connected to initiative. We revised the draft on the basis of feedback from several participants who attended the meeting.

We do not take a position on the technical debates surrounding appropriate intervention and measurement strategies that have emerged in the initiative.^{28–30} Instead, our aim was to examine the content of these debates and how they were understood by the participants themselves to assess the effect the debates had on political support for the initiative. Our focus is on the initiative's global level rather than national or grassroots level actors and debates, except in instances when national and grassroots organisations have affected or been affected by the global safe motherhood initiative. National and community experiences, and the perspectives and voices of actors from developing countries, are crucial to the history of safe motherhood and deserve research attention.^{31–36} This case study, however, limits itself to examining developments surrounding the global safe motherhood initiative.

A limitation of the method of our case study was the difficulty in controlling for confounding variables of influence, and in assessment of the relative causal weight of factors that we identified as shaping political priority. As we note above, this study should be taken as an initial exploration of the complex question of issue ascendance and neglect in global health. Substantially more research, ideally comparing global health initiatives varying in political support levels, will be necessary to establish which factors are most and least influential in shaping political priority.

The case of safe motherhood

In 1987, the World Bank, WHO, and the UN Population Fund (UNFPA) sponsored a conference in Nairobi, Kenya, which launched the Global Safe Motherhood Initiative.³⁷ Its aims were to raise awareness of the roughly half a million yearly maternal deaths worldwide, nearly all of which occurred in developing countries, to spark efforts to address this problem, and to reduce maternal mortality levels by half by the year 2000. After the conference, an Inter-Agency Group for Safe Motherhood (IAG) formed to focus global attention on the issue, bringing together several international agencies and non-governmental organisations associated with the launch. Since this conference two decades ago, safe motherhood advocates have engaged in a sustained effort to convince international organisations and national political leaders to prioritise maternal mortality reduction.

Nearly all respondents perceive the initiative's results in terms of production of political support to have been disappointing. Many published accounts on the initiative also reached this same conclusion.^{29,38,39} However, several respondents believe that the 20th anniversary year of the initiative will offer an opportunity to generate political momentum for safe motherhood.

Actor power

Since the start of the initiative, the policy community has been divided over intervention strategy, which has affected its credibility with international and national political leaders (interview [I] 3 [May, 2006]; I9 [June, 2006]; I15 [June, 2006]). Throughout the 1970–80s antenatal risk screening and the training of traditional birth attendants formed the core strategies for maternal survival.²⁸ An influential article in *The Lancet* in 1985⁴⁰ expressed concern about these strategies, arguing that most maternal deaths could not be prevented and that women needed access to emergency obstetric care in the event of complications at childbirth. Although they do not deny the need for emergency obstetric care, other advocates emphasised that its importance had been exaggerated (I2 [June, 2005]) and that community-level and preventative activities had crucial roles in the prevention of maternal deaths. Some advocates supported what has been termed the skilled attendance approach. Its core message, expressed at safe motherhood's tenth anniversary conference in 1997, in Sri Lanka, was to ensure skilled attendance at delivery, defined as "having a health worker with midwifery skills present at childbirth, backed up by transport in case emergency referral is required".⁴¹

Participants in the debates suggest that the disagreements were more than technical; they took on a personal quality. One respondent commented:

"[People became] extremely defensive about their ideas... If you didn't agree with the idea you were bad and wrong...It was kind of like President Bush. If you are against this idea then you are a traitor"
I2 [June, 2005]

Another participant described the whole history of the initiative to be “one of competing camps” (I3 [May, 2006]). A third participant believed that positions became deeply entrenched and nearly immutable:

“We always know the answer. First traditional birth attendants and antenatal care, then that doesn’t work so skilled attendants and emergency obstetric care... There is view bias. [You must] take the company line”
I6 [May, 2006]

A 2006 *Lancet* series on maternal survival called for deliveries to be attended by midwives in health centres, with other medical professionals present and higher levels of care available if needed.⁴² The series indicated a consensus that had been building gradually among some members of the policy community about the need to have both skilled attendants at birth and emergency obstetric care if needed. Many respondents noted a substantial decrease in tension in the policy community, partly because of this emerging consensus (I4 [May, 2006]; I5 [May, 2006]; I6 [May, 2006]; I7 [June, 2006]; I8 [June, 2006]; I15 [June, 2006]). However, this agreement did not encompass all members of the policy community. Some expressed strong concern about what to do in the interim, before such facilities could be established, in view of resource scarcity and the difficulty that poor countries faced in expanding care.⁴³

Weak guiding institutions hindered the acquisition of political support. The IAG grouped effective individual advocates for safe motherhood and well-respected researchers. However, it included technical officials in the represented agencies rather than their senior leaders, hampering its ability to develop global political support for maternal mortality reduction.³⁹ Furthermore, controversy surrounded membership—IAG members made a deliberate decision initially to remain small. One founding member explained the rationale for this:

“A lot of groups wanted to be in and the IAG was not perfect but worked well together...The group felt strongly that smaller was better. It was easier when dealing with difficult issues [such as] abortion”
I21 [August, 2006]

Another initial IAG member commented that this decision created difficulties, noting that, “we were accused, rightly so, of being a small inside group” (I23 [September, 2006]). A non-member articulated one of the consequences of this decision:

“The IAG was not and never was perceived as a strong mouthpiece for safe motherhood until much later”
I9 [June, 2006]

Another issue for guiding institutions, one that the IAG was not able to resolve, concerned relations between UN agencies. For other health issues such as child survival, family planning, and technical advice, a clear UN agency took the lead (UNICEF, UNFPA, and

WHO, respectively). However, such agency leadership in the UN system never developed for safe motherhood.³⁰ UNICEF, UNFPA, WHO, and the UN Development Program (UNDP) all developed safe motherhood activities, which were often run independently of one another. At some points, the agencies were antagonistic, differing on intervention approach and competing for scarce safe motherhood resources (I7 [June, 2006]; I10 [June, 2006]; I11 [June, 2006]; I17 [July, 2006]). One respondent from the UN involved in safe motherhood believed that the core problem was an absence of UN agency ownership:

“UNICEF was involved but children are its bread and butter...UNFPA was neither here nor there...It had advocacy and policy but not programs. The WHO balances between norms and standards and implementation—back and forth—it deals with many things. So safe motherhood doesn’t have a home in the United Nations and that’s a big problem”
I10 [June, 2006]

Between 2002 and 2005, pressured by donors who did not want to fund separate efforts (I7 [June, 2006]), the Safe Motherhood Initiative and the IAG gradually merged with other initiatives to become a broader partnership for maternal, newborn, and child health. The idea of continuum of care was intuitively appealing to some organisations and actors involved, since it sought to ensure that the health of newborns, children, and mothers would be promoted in a synergistic way (I18 [July, 2006]; I23 [September, 2006]). The idea and birth of the partnership were contentious, however; its leaders have had to manage tensions between its members since its launch (I3 [May, 2006]; I5 [May, 2006]; I7 [June, 2006]; I9 [June, 2006]; I15 [June, 2006]; I18 [July, 2006]; I23 [September, 2006]). The alliance between safe motherhood and newborn survival has been uneasy, and that between safe motherhood and child survival even more so. One point of contention concerns different perspectives on facility versus community or home-based delivery. Additionally, many advocates of child survival have been wary of politically contentious discussions surrounding unsafe abortion, which is a leading cause of maternal mortality. Underlying these tensions has been a concern over the division and control of scarce resources. Commenting on the place of safe motherhood amidst these partnership tensions, one respondent said:

“There are three siblings. Child survival is older, richer, more resourceful. The newborn is weak, small, but got a new grant from Gates for US\$60 million. It is the small child in the family that everyone looks to. Safe motherhood is the middle child; it doesn’t know exactly where to be. We need a good parent to take care of the three equally, or unequally—safe motherhood needs more vigorous opportunities”
I10 [June 2006]

Supporters of the partnership argue that the cause of maternal survival rightly belongs under its fold, integrated

with child and newborn health (I23 [September, 2006]). However, several safe motherhood advocates are suspicious, wondering whether the partnership ultimately will serve the cause of maternal survival (I3 [May, 2006]; I9 [June, 2006]; I16 [June, 2006]; I17 [July, 2006]). One advocate notes that with the emergence of the partnership, many members of the safe motherhood community are no longer sure if an initiative for safe motherhood still exists.

Weak mobilisation of civil society organisations has also hindered the acquisition of political support. In 1999, the White Ribbon Alliance formed with the aim of promoting cross-national advocacy for safe motherhood, linking civil society institutions with donor and other organisations. However, few grassroots organisations concerned with the global dimensions of the issue have emerged. One reason could be the absence of access to the political process on the part of those most directly affected by this issue—ie, poor women with little education, who face substantial gender discrimination in many poor countries. Several respondents note also the initiative's detachment from grassroots activities that do exist (I9 [June, 2006]; I10 [June, 2006]; I15 [June, 2006]). One respondent, commenting on how far removed policy community debates were from local realities, said:

"There's a huge disjuncture. 35 000 feet discussions. And I'm worried the gap is getting bigger. International discussions are devoid of reality on the ground"
I15 [June 2006]

A widely embraced leader could have helped surmount historical difficulties of policy community fragmentation, weak guiding institutions, and little civil society mobilisation. However, no such figure emerged (I5 [May, 2006]; I15 [June, 2006]). Several individuals associated with the initiative at particular junctures were perceived potentially to have this capacity, but they did not take up the opportunity. Referring to child survival's best-known leader, one respondent surmised:

"Safe motherhood doesn't have a Jim Grant. Where's the ambassador?"
I15 [June, 2006]

Ideas

Finding a resonating set of ideas—ie, positioning the issue publicly in ways that attract political support—has been a persistent challenge for the initiative. Since the initiative's launch, several political leaders in developing countries have come to perceive maternal mortality as an issue that is deserving of attention and resources.^{33,36,44} However, few leaders have prioritised maternal mortality, especially compared with the many national leaders that have prioritised issues such as child survival and HIV/AIDS.

Safe motherhood advocates have made concerted efforts to develop frames for the issue that might resonate. They have emphasised the severity of the issue, made rights-based arguments, connected the issue to economic outcomes, and noted the effects on

children.^{45,46} Despite these efforts, no frame has convinced many political leaders, which is a situation that continues to puzzle several members of the policy community. As one respondent states:

"Why is it like this? Why have we not seen the flow of resources to do something about it? The issue has all the emotional appeal on so many different levels. The case can be made economically, in terms of household productivity, the next generation of children. What more do you need to capture the imagination? I don't understand it"
I15 [June, 2006]

The initiative's initial positioning could have contributed to difficulties in attracting political support from one group that might otherwise have lent powerful backing to the cause: the women's movement. When World Bank officials first came up with the idea for an international conference for maternal mortality in 1985, they were conscious of the unwillingness of the US administration to support family planning internationally. Sensitive to the US administration's conservatism regarding reproductive issues, Bank officials wanted to find, in the words of one of the organisers, "a concept that is politically unassailable, a name that brings in money, that makes a lot of people heroes, something the American administration cannot oppose" (I22 [August, 2006]). From these deliberations, the term safe motherhood was borne. The organisers coalesced surrounding the term, partly because they thought that it was unlikely to incite active opposition from the administration. However, as one respondent put it:

"The feminists didn't like the term 'safe motherhood' so [the issue] was never picked up by women's groups"
I17 [June, 2006]

The same respondent notes that many men, too, may have been reluctant to engage the issue, but for a different reason, arguing:

"The neglect of women's issues...does reflect some level of unconscious bias against women at every level, from the community to high-level decisionmakers...While we may ignore it, maternal health does involve sex and sexuality; it is bloody and messy; and I think many men (not all, of course) have a visceral antipathy for dealing with it"

The framing of the issue inside the policy community also has posed difficulties. Fundamentally, the community has united with a shared belief that maternal mortality is a neglected tragedy that demands redress. This idea was the source for an article that helped bring international attention to the issue. The 1985 piece in *The Lancet* by Allan Rosenfield, regarded by many to be the cause's most effective champion, and Deborah Maine,⁴⁰ emphasised the neglect of maternal survival in favour of child health. However, beyond this core point of agreement, the policy community until recently has had difficulty identifying common ideas. An internally resonating frame would need clear answers to several

issues, none of which the policy community has yet to resolve in full. These issues include whether maternal mortality or maternal health more broadly is the focal concern; how progress should be measured; whether the continuum of care idea is embraced as the core positioning of the issue; the precise strategies to address the problem; and the relation of the initiative to other health concerns, including family planning, the broader reproductive health agenda, and health systems development.

Political contexts

Advocates have sought to build a favourable global political environment for safe motherhood by organising international meetings and events for maternal mortality reduction, seeking inclusion of the issue in other global meetings, and aiming to take advantage of policy windows such as those associated with the MDGs (I7 [June, 2006]; I18 [July, 2006]; I19 [August, 2006]; I21 [August, 2006]; I22 [August, 2006]; I23 [September, 2006]). The effect of their efforts is uncertain. AbouZahr has argued in a review of the history of the initiative that “these efforts have lacked conviction”, noting that, “safe motherhood meetings tend not to attract the most senior decisionmakers.”³⁹

The first efforts to promote maternal mortality reduction took place in 1985, before the launch of the initiative, at the end of the UN Decade for Women, when advocates for women’s rights identified maternal mortality reduction as one of several issues that might sustain the women’s agenda (I21 [August, 2006]). The 1987 Nairobi conference was the first major international event for safe motherhood. Safe motherhood also made the agenda of the Third International Conference on Population and Development in Cairo in 1994, and the Fourth World Conference on Women in Beijing in 1995.⁴⁷ In 1997, a conference in Colombo, Sri Lanka, marked the tenth anniversary of the initiative, and in 1999, new initiatives and programmes formed for maternal mortality reduction, including Columbia University’s Averting Maternal Death and Disability Program. This programme received US\$50 million from the Gates Foundation, which is the largest grant so far for safe motherhood.

A policy window—ie, a favourable confluence of events providing an opportunity for advocates to press political leaders—opened for safe motherhood in 2000. In that year, UN member states announced the MDGs, a set of poverty alleviation objectives for the year 2015. Maternal health was one of a select group of health goals to make the MDGs, with goal number five being the reduction of the global maternal mortality ratio by 75% over 1990 levels by the year 2015.

Whether the maternal health MDG, efforts by advocates to take advantage of the MDG, and continual efforts by global safe motherhood advocates have had substantial effect on political support and resources is uncertain. A weak global governance structure for health (including absence of leadership on the issue of safe motherhood

within the UN system) has hampered the capacity of the initiative to create and take advantage of opportunities. On the positive side, the UK Department for International Development (DFID), influenced by the MDGs, has increased maternal and newborn health funding from GB£0.9 million in 2001–02 to £16.2 million in 2005–06.⁴⁸ Other donors also increased funding for maternal survival during this time.⁴⁸ Furthermore, the MDG commitment stood behind several substantial global calls for action, including a declaration in 2005 in New Delhi, India, from UN agency heads and many developing country governments calling for global progress on maternal, newborn, and child health.⁴⁹ Additionally, the leaders of the countries that rank number one and two in terms of numbers of maternal death, India’s Prime Minister Manmohan Singh and Nigeria’s former President Olusegun Obasanjo, commented publicly on the maternal health MDG. They expressed concern about their countries’ high levels of maternal death, and demanded that their governments act to address the issue.^{35–36}

Conversely, several studies show continuing large gaps in global resources for maternal health.^{50–52} One study estimated that an additional US\$1 billion was needed to meet maternal and newborn health needs in 2006,⁵³ and another identified a need for a minimum yearly average increase of \$3.9 billion over 10 years to meet combined maternal and newborn health needs.⁵² Furthermore, only a few developing countries have made maternal mortality reduction a political priority since the initiative’s launch.¹

The initiative’s 20th anniversary year, 2007, could present new opportunities for generation of political priority for safe motherhood. In February, 2007, IMPACT (a maternal mortality research initiative) disseminated results from several years of studies on measurement strategies and programme assessment. In September, 2007, an initiative led by the Norwegian government to accelerate progress towards the achievement of the child and maternal survival MDGs was launched. The culminating event is the Women Deliver conference, which will be held in October, 2007. Heads of state, ministers of planning and finance, and other senior political officials have made commitments to attend this event, creating the potential for the meeting to bring about the high-level political support for the issue which has previously been lacking.

Issue characteristics

Three characteristics of the issue itself have made attracting political support for maternal mortality difficult. First, maternal deaths are not as common as are those caused by several other high-burden disorders (eg, HIV/AIDS, malaria); second, accurate measurement of maternal mortality is technically difficult; and third, the interventions to avert maternal death are not as simple as are those for some other disorders (such as several children’s diseases that are preventable by vaccine).

The most recent estimate of the number of annual maternal deaths globally is 529 000 for the year 2000.⁵⁴ Although this figure is high, it is much lower than the annual number of deaths from HIV/AIDS (2·9 million), tuberculosis (1·6 million), and malaria (1 million), as well as the number of deaths to children younger than 5 years (10·6 million), and neonates (4 million).^{55–59} Many advocates for safe motherhood are acutely aware of these figures (I5 [May, 2006]; I15 [June, 2006]) and have debated whether maternal health advocacy should instead emphasise other indicators of severity, such as morbidity, lifetime risk of death, or combined maternal and newborn deaths (which total 4·5 million).

Additionally, maternal mortality is more difficult to measure than are other health outcomes such as infant mortality, child mortality, and fertility.⁶⁰ The fairly low numbers of maternal deaths in any specific geographic locality mean that confidence intervals for estimates from most survey methodologies are large, making actual levels difficult to ascertain and whether change occurred across time difficult to establish. These challenges have led some researchers and programmers to turn to process indicators to assess effect and measure progress. Other researchers, although not denying the need for such indicators, emphasise the importance of continuing to find better ways to measure maternal mortality itself.⁶¹

Another difficulty is that the interventions necessary to prevent maternal death are not as simple as are those for other disorders, such as specific diseases that are preventable by vaccine. Few of the leading maternal health epidemiologists believe that a simple solution is available, and most argue that functioning health systems are crucial.^{62,63} Disagreement exists about the actual degree of complexity of the necessary interventions, the strength of the evidence base for these interventions, and their cost (I2 [June, 2005]; I3 [May, 2006]; I6 [May, 2006]; I7 [June, 2006]; I12 [June, 2006]; I15 [June, 2006]).^{63,64}

Several respondents suggest that the sometimes contentious public discussions surrounding measurement and evidence have had adverse effects on the initiative's ability to acquire political support and resources, and have contributed to policy community fragmentation:

“We hang out our dirty washing. Other people are more discreet”
I15 [June, 2006]

“We don't know what's effective. We can't measure outcomes very well”
I3 [May, 2006]

“We focus on uncertainties. That is the truth but it will not convince the Minister of Finance”
I15 [June, 2006]

“I would go with my ideas [to a donor] and [X] would go with hers and who was to say who was correct”
I9 [June, 2006]

These problems notwithstanding, safe motherhood advocates have used estimates, however imprecise, to generate attention for the cause. For example, in the mid-1980s, Robert Cook from WHO sponsored studies that produced the first estimate of global maternal mortality levels: half a million maternal deaths annually.⁶⁵ This figure drew the attention of international agency heads and others key to the initiative's inception.^{30,39} Revised estimates from UN agencies in the mid-1990s provoked discussion between national leaders and UN agencies surrounding the issue, which might have increased maternal mortality's profile with donor institutions.³⁹

Conclusions

Factors shaping global political priority for safe motherhood

If we consider all the four categories of factors that affect the acquisition of global political support, we see that the safe motherhood initiative has had many difficulties. With respect to actors, the global policy community has been fragmented, no powerful institutions have emerged to guide the initiative, and organisational rivalries have persisted throughout its history. Additionally, although the initiative included highly capable individuals, it never found a recognised leader. Furthermore, the primary victims of maternal mortality (poor women in the developing world) have little political power and are disadvantaged by gender inequalities, and civil society mobilisation to make this cause a global priority has been weak.

With regard to ideas, the global policy community has not yet established an internally resonating frame, and still struggles to find external frames that will move political leaders to action. With respect to political context, global policy windows have opened, but how well the policy community has taken advantage of these opportunities is unclear. The fragmented global structure of governance for health has made an institutional home for safe motherhood difficult to find. With respect to issue characteristics, the severity of the problem is low compared with other conditions if indicated by mortality levels, hampering resource acquisition and mobilisation efforts. Measurement is a continuing problem, and no widely accepted and simple way to monitor progress has emerged. Interventions are not simple, the evidence base for these interventions is weaker than it is for some other issues, and the policy community has had trouble developing consensus on which interventions should be prioritised. Because of these difficulties caused by both the nature of the issue and the decisions of actors, the safe motherhood initiative remains in a state of infancy even after 20 years.

Building global political priority for safe motherhood

2007 could present a window of opportunity to generate political support for the cause. Cohesion is building in

the policy community as proponents of skilled attendance and emergency obstetric care bridge their differences. A major policy window has opened, prompted by the MDGs and the 20th anniversary of the initiative. Additionally, the Partnership for Maternal, Newborn and Child Health could provide a new coordinating mechanism for global leadership on the issue.

Creation of political momentum will need four connected political challenges to be addressed, in addition to continuing technical challenges surrounding intervention and measurement. First is building on the growing cohesion in the policy community so that it can speak with authority and unity to international and national political leaders. Second is the creation of enduring guiding institutions to sustain the initiative. The partnership might provide a platform, but in view of its recent creation and tensions in the policy communities that compose it, assessment cannot yet be made. Third is finding external frames that resonate and will convince political leaders that they should be concerned about the issue. Policy community members have offered several ideas on framing, but none has taken hold widely. Fourth is building stronger links with national initiatives and mobilising country-level civil society organisations. The weakness of such links and minimal social mobilisation for the cause in countries with high maternal mortality has hampered the acquisition of global political support.

Future research on political priority for global health initiatives

The main question is why do some global health initiatives attract political priority whereas others remain neglected? Our investigation, grounded in a synthesis of research on collective action and one case study, represents only a start in examination of this complex issue. Further study and refinement of the framework is needed, ideally through comparisons across global health initiatives that vary in levels of political support. Such studies would have great value both for theory development and for practice. Empirically-grounded explanations on issue ascendance and neglect would advance our knowledge of dynamics for agenda setting in global health. Equally importantly, they would offer guidance to struggling global health initiatives such as safe motherhood on how to generate much needed political support.

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