

Agenda setting for maternal survival: the power of global health networks and norms

Stephanie L Smith^{1*} and Mariela A Rodriguez²

¹School of Public Administration, University of New Mexico, Social Science Bldg Rm 3008, MSC053100, 1 University of New Mexico, Albuquerque, NM 87131-0001, USA and ²CARE, 151 Ellis Street NE, Atlanta, GA 30303, USA

*Corresponding author. School of Public Administration, University of New Mexico, Social Science Bldg Rm 3008, MSC053100, 1 University of New Mexico, Albuquerque, NM 87131-0001, USA. E-mail: slsmith@unm.edu

Accepted 4 September 2014

Nearly 300 000 women—almost all poor women in low-income countries—died from pregnancy-related complications in 2010. This represents a decline since the 1980s, when an estimated half million women died each year, but is still far higher than the aims set in the United Nations Millennium Development Goals (MDGs) at the turn of the century. The 1970s, 1980s and 1990s witnessed a shift from near complete neglect of the issue to emergence of a network of individuals and organizations with a shared concern for reducing maternal deaths and growth in the number of organizations and governments with maternal health strategies and programmes. Maternal health experienced a marked change in agenda status in the 2000s, attracting significantly higher level attention (e.g. from world leaders) and greater resource commitments (e.g. as one issue addressed by US\$40 billion in pledges to the 2010 *Global Strategy for Women's and Children's Health*) than ever before. Several differences between network and actor features, issue characteristics and the policy environment pre- and post-2000 help to explain the change in agenda status for global maternal mortality reduction. Significantly, a strong poverty reduction norm emerged at the turn of the century; represented by the United Nations MDGs framework, the norm set unusually strong expectations for international development actors to advance included issues. As the norm grew, it drew policy attention to the maternal health goal (MDG 5). Seeking to advance the goals agenda, world leaders launched initiatives addressing maternal and child health. New network governance and framing strategies that closely linked maternal, newborn and child health shaped the initiatives. Diverse network composition—expanding beyond a relatively narrowly focused and technically oriented group to encompass allies and leaders that brought additional resources to bear on the problem—was crucial to maternal health's rise on the agenda in the 2000s.

Keywords Agenda setting, global health policy, maternal health, networks

KEY MESSAGES

- Policy attention for global maternal mortality reduction emerged and has grown in relationship to the evolution of international development norms and a global maternal health network's characteristics and actions.
- Strong high-level political support for the United Nations Millennium Development Goals framework elevated maternal survival to a level of prominence on the international development policy agenda.

- Diverse network composition (encompassing a range of actors that can bring various resources to bear on a problem), strong governance and framing strategies shape network capacity to affect agenda status.

Nearly 300 000 women—almost all poor women in low-income countries—died from pregnancy-related complications in 2010 (World Health Organization *et al.* 2012). This number represents a decline since the 1980s, when an estimated half million women died each year, but is still far higher than the aims set in the United Nations Millennium Development Goals (MDGs). An average annual decline of 5.5% is needed to achieve MDG 5A, reduce the maternal mortality ratio (MMR, the number of maternal deaths per 100 000 live births) by 75% from 1990 levels by 2015 (World Health Organization *et al.* 2012). Globally, the MMR declined by an average of 3.1% annually between 1990 and 2010; the rate of decline accelerated during the 2000s (Figure 1) (World Health Organization *et al.* 2012). Though maternal deaths are largely preventable, only 19 of 99 countries with MMR ≥ 100 in 1990 are on track to meet the goal (World Health Organization *et al.* 2012).

The World Health Organization (WHO) began to study the global maternal mortality problem systematically in the early 1980s, and with the United Nations Population Fund (UNFPA) and the World Bank sponsored the first international conference concerning the issue in 1987. The accompanying launch of the Safe Motherhood Initiative marked emergence of a global health network, a group of individuals and organizations connected by a shared concern for reducing pregnancy-related deaths around the world. The network achieved many aims, including establishing a base of evidence concerning the scope of the problem and potential solutions and attracting a degree of support from international agencies, donors and governments. But the issue only reached a level of prominence on the international development policy agenda during the 2000s; world leaders sponsored significant initiatives and a wide range of actors committed unprecedented resources late in the decade. This study investigates causes of the post-2000 change in agenda status for global maternal mortality reduction. It pays particular attention to the role of a global maternal health network in shaping these outcomes.

This study is guided by the Global Health Advocacy and Policy Project (GHAPP) conceptual framework (see Shiffman *et al.* 2016). The framework focuses on three categories of causal factors in the policy process and the interactions between them: (1) global health networks, (2) characteristics of issues and (3) features of the policy environment. We investigate the influence of such factors on policy agenda status as indicated by attention and resources directed towards problem alleviation. We used a process-tracing methodology, drawing upon interviews with 24 actors with close knowledge of the policy issue and more than 250 documents to inform the analysis.

Policy agenda status for global maternal mortality reduction varies pre- and post-2000, shifting from near complete issue neglect to network emergence, expanded problem recognition and growth in the number of organizations and governments with maternal health strategies and programmes in the 1980s and 1990s to significantly higher level attention and resource commitments in the 2000s (Table 1). Features of the global health network, issue characteristics and the policy environment also vary and shape differences in agenda status.

Crucially, the target-oriented MDGs agenda (representing a strong poverty reduction norm) emerged at the turn of the century featuring a goal (MDG 5) to improve maternal health. The increase in agenda status for maternal health in the 2000s is linked to the burgeoning norm and the leaders seeking to advance it. Network governance and framing strategies that closely linked maternal, newborn and child health shaped significant initiatives. In addition, increasingly diverse network composition—expanding beyond a relatively narrowly focused and technically oriented group to encompass allies and leaders that brought additional resources to bear on the problem—was crucial to maternal health's rise on the agenda.

Conceptual framework

This study is part of the GHAPP, a research initiative examining networks that have mobilized to address six global health problems: tuberculosis, pneumonia, tobacco use, alcohol harm neonatal mortality and maternal mortality. Its aim is to understand why networks crystallize surrounding some issues but not others, and why some are better able to influence policy and public health outcomes. GHAPP studies draw on a common conceptual framework grounded in theory on collective action from political science, sociology and economics (Snow *et al.* 1986; Stone 1989; Powell 1990; Kingdon 1994; Finnemore and Sikkink 1998; Keck and Sikkink 1998; Marsh and Smith 2000; McAdam *et al.* 2001; Kahler 2009). The introductory paper to this supplement presents the framework in detail (see Shiffman *et al.* 2016).

The GHAPP studies examine network outputs, policy consequences and impact. Outputs are the immediate products of network activity, such as guidance on intervention strategy, research and international meetings. Policy consequences pertain to the global policy process, including international resolutions, funding, national policy adoption and the scale-up of interventions. Impact refers to the ultimate objective of improvement in population health.

The framework consists of three categories of factors (Shiffman *et al.* 2016). One category, network and actor features, concerns factors internal to the network involving strategy and structure, and attributes of the actors that constitute the network or are involved in creating it. This category pertains to how networks and the individuals and organizations that create and comprise them exercise agency. A second category, the policy environment, concerns factors external to the network that shape both its nature and the effects the network hopes to produce. The third category, issue characteristics, concerns features of the problem the network seeks to address. The idea is that issues vary on a number of dimensions that make them more or less difficult to tackle. GHAPP studies begin with the presumption that no single category of factors is determinative: rather factors in each of the three interact with one another to shape policy and public health effects.

In each category there are several factors that may be particularly influential. Among network and actor features, the

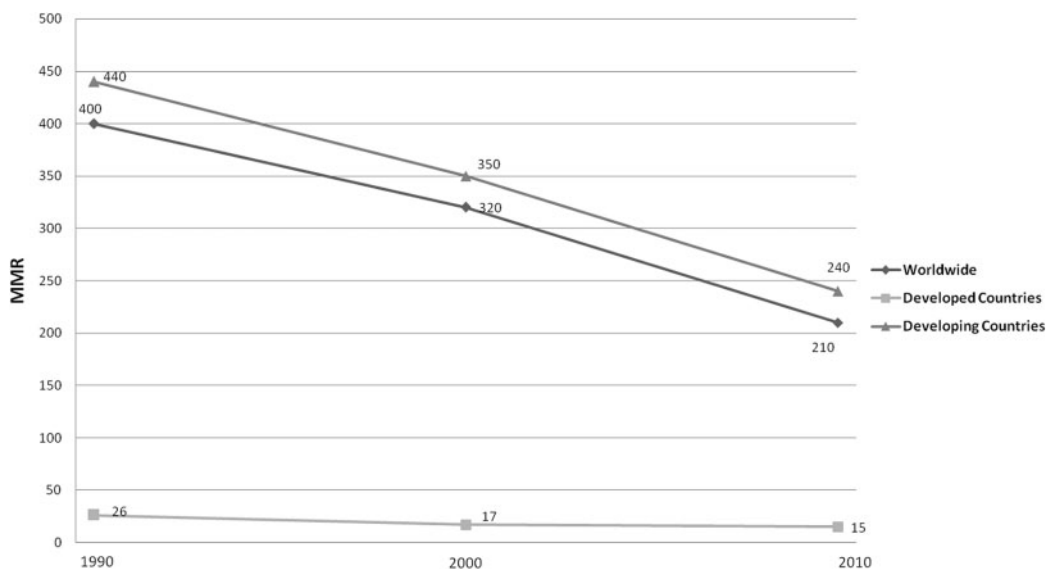


Figure 1 MMR in 1990, 2000 and 2010. Source: World Health Organization, United Nations Children's Fund, United Nations Population Fund, World Bank. 2012. *Trends in Maternal Mortality: 1990–2010*. Geneva: World Health Organization. Note: MMR is calculated as the number of maternal deaths per 100 000 live births.

existence of effective 'leaders' (factor 1) may be one reason networks crystallize in the first place, and why, once they appear, they are able to achieve their objectives. The quality of 'governance' (factor 2) may also matter: the effectiveness of the institutions network members set up to steer themselves towards collective goals (Buse and Walt 2000). A third factor is 'composition' (factor 3). Diverse networks that link scientists, advocates, policy makers and others from both high- and low-income countries may achieve better outcomes than uniform ones because diversity improves collective understanding and problem solving, among other benefits (Hong and Page 2004; Page 2007). On the other hand, heterogeneity may hamper cohesion and increase the likelihood that networks disagree on objectives. The fourth factor is 'framing strategy' (factor 4) (Snow *et al.* 1986; McInnes and Lee 2012): how network actors publicly position an issue to attract attention and resources. Networks may differ in their capacities to discover frames that work.

Several factors in the policy environment may be particularly influential. Among these are 'potential allies and opponents' (factor 5). If there are many groups whose interests align with a network's goals, that network is more likely to expand and be effective than one that faces a dearth of potential allies. Opponents, such as the tobacco industry, may both hinder and facilitate network outcomes: they may seek to discredit the network, but may also inspire mobilization. Substantial 'funding' (factor 6) may enable a network to flourish; however, a network set up at the behest of donors may be perceived as less legitimate than those that emerge from grassroots activism. 'Norms' (factor 7)—standards of appropriate behaviour for a particular group of actors—may also be influential (Katzenstein 1996; Finnemore and Sikkink 1998). The starkest examples of influential norms in global health are those that the health-related MDGs advance (Fukuda-Parr and Hulme 2011). These goals have raised expectations that states, international organizations and other global actors act to reduce burden from that subset of global health problems selected for inclusion.

Among issue characteristics, 'severity' (factor 8), 'tractability' (factor 9) and the nature of 'affected groups' (factor 10) may be particularly influential. Robust networks may be more likely to emerge when problems lead to high mortality and morbidity or social disruption—or are perceived to do so. Also, individuals and organizations may be more likely to act on problems perceived to be soluble (Stone 1989). In addition, affected populations that inspire sympathy, such as children, may be more likely to inspire network mobilization (Stone 1989; Schneider and Ingram 1993) than those that do not. Also, positive network results may be more likely if affected populations are able to mobilize on their own behalf, as people living with HIV/AIDS have done.

Among the framework factors, this study pays particular attention to norms (factor 7). Some of the most influential international development norms in recent decades—norms promoting women's rights and poverty reduction (as represented by the MDGs framework)—have affected maternal health's agenda status. We draw heavily on the norm life cycle model used by Finnemore and Sikkink (1998) to describe and explain growth in agreement surrounding international norms; growing agreement influences actor behaviour. In the model, leadership features centrally in advancing norms through three life cycle stages: (1) norm entrepreneurs facilitate emergence of new standards and expectations for behaviour, (2) norm leaders help to promulgate them towards a tipping point leading to broad acceptance (a norm cascade) and (3) norms are internalized (taken for granted and no longer debated, such as women's suffrage). Institutionalization in international organizations and rules increases the likelihood that norms will progress through the full cycle; not all norms do (Finnemore and Sikkink 1998).

Methodology

We used a process-tracing methodology involving in-depth examination of social and political processes to uncover causal

mechanisms that led to the policy and public health outcomes being investigated (Yin 2003; Bennett 2010). The aim was to trace in detail the role of networks, environments, issue characteristics and other factors in shaping agenda-setting, policy formulation, policy implementation and mortality and morbidity change. GHAPP researchers used the same methodology, began with the same basic set of questions and were in frequent communication to share insights as the studies unfolded. This study was granted exempt status by the Institutional Review Boards of the University of New Mexico and American University due to its public policy orientation and minimal risk to study participants.

To minimize bias, the study drew on multiple sources of information. Documents comprised one source. Documents consulted and analysed include more than 250 reports, strategies, plans, white papers, policy statements, media reports, scholarly journal articles, editorials and comments, meeting and background documents, reports to funders, press releases and public statements (such as consensus statements). Most are published or publicly available through such sources as government, donor and other organizational websites. Some are unpublished documents provided by interviewees. Documents were selected for their relevance to informing the research questions.

Key informant interviews comprised another source. We conducted in-depth semi-structured interviews with a purposive sample of 24 individuals with close knowledge of the following: key actors concerned with maternal health; issue characteristics; political, knowledge, normative and funding environments; and maternal health agenda status, cross-national policy adoption and implementation scale-up. Interviews were conducted with actors representing United Nations agencies, bilateral and multilateral donors, private foundations, non-governmental organizations, research and academic institutions and professional organizations (see Box 1). The interview sample consisted primarily of individuals engaged in maternal health research, programming and/or advocacy to provide deep insights to this network. Document analysis and interviews with a range of actors representing varying individual and organizational perspectives were used to check potential sources of bias. Interviews were conducted between June 2011 and April 2012, lasted an average of 1 h and were recorded and transcribed. We analysed interview transcripts to identify causal

factors and relationships, using the conceptual framework described earlier to guide the coding process.

Data were coded and analysed by hand into a thematic outline guided by the GHAPP conceptual framework (see Yin 2003 on case study databases). Key informants reviewed a draft of this study to check for accuracy in factual content and analysis.

Results

Two strong international development norms have shaped the trajectory of policy attention to global maternal mortality reduction over the past few decades—first a burgeoning women's rights norm and, in the 2000s, the global poverty reduction norm represented by the target-oriented MDGs. The MDG supernorm evolved rapidly with support from a strong network of world leaders and international organizations. Maternal health had received some attention in earlier decades via the women's rights norm and efforts of an emergent global health network, but MDG status fueled its rise to a level of prominence on the international development policy agenda. We trace the history of policy attention to global maternal mortality reduction from emergence in the 1970s to peak in the early 21st century (Table 1). We draw upon our analytical framework to highlight interactions between the policy environment, network and issue characteristics as they changed over time and functioned as facilitating or obstructive factors.

Policy attention to global maternal mortality reduction emerges and grows: 1976–99

In the 1970s and early 1980s, maternal and child health programmes were focused almost exclusively on children (Rosenfield and Maine 1985; Family Care International 2007). An emergent women's rights norm began to shape international health and development agendas during this period. Norm entrepreneurs and international forums advancing women's health and rights, including the Alma-Ata Declaration on Primary Health Care (1978), the Convention on the Elimination of All Forms of Discrimination against Women (1979) and the UN Decade for Women (1976–85), framed maternal mortality as a neglected issue that disproportionately affected a vulnerable group and required redress by governments and donors. Growing international interest in women's health issues, including maternal health, formed bases for United Nations agencies to study the problem in greater depth and begin to co-ordinate a response (WHO 1990).

WHO thus held its first interregional meeting on maternal mortality reduction in 1985, announcing that a half million women died annually of pregnancy-related complications and unveiling new evidence WHO and UNFPA collected in the early 1980s concerning the scope and nature of the problem (WHO 1990). The burgeoning women's rights norm and new evidence opened a window of opportunity to draw national and international attention to the neglected issue (AbouZahr 2001); WHO, World Bank and UNFPA took advantage, sponsoring the first international Safe Motherhood Conference (launching the Safe Motherhood Initiative) in Nairobi, Kenya, 2 years later (Family Care International 2007). The three conference sponsors joined with United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), the International Planned

Box 1 Organizational affiliations of key informants

American University, Averting Maternal Death and Disability (AMDD) at Columbia University, CARE, the United Kingdom's DFID, Family Care International, Gynuity Health Projects, International Federation of Gynecologists and Obstetricians (FIGO), the MacArthur Foundation, Maternal Health Task Force, NORAD, Partnership for Maternal, Newborn and Child Health, Population Council, The Bill and Melinda Gates Foundation, IMMPACT Programme at the University of Aberdeen, UNFPA, USAID, University of San Francisco, White Ribbon Alliance, Women Deliver, World Bank and World Health Organization.

Table 1 Policy attention to global maternal mortality reduction: 1976–2010

Emergence and growth 1976–99	Rise to prominence 2000–10
1970s and 1980s: Maternal and child health programmes focused almost exclusively on children	2000–01: 189 signatories to the United Nations Millennium Declaration commit to significantly reduce maternal mortality by 2015 (MDG5); the UN Secretary-General issues annual implementation reports showing relatively slow progress on reducing maternal mortality
1976–85: The UN Decade for Women, Alma-Ata Declaration on Primary Health Care, and Convention on the Elimination of All Forms of Discrimination Against Women identify maternal health as an issue requiring redress	2004: The UK becomes the first bilateral donor to publish a maternal health strategy
1985: WHO holds its first interregional meeting on maternal mortality reduction and announces half a million women die annually	2004–05: WHO, World Bank and UNFPA begin to support 33 nations in Africa to develop road maps to accelerate progress on the maternal and child health MDGs; India hosts an international conference where 'The Delhi Declaration on Maternal, Newborn and Child Health' is issued; a joint secretariat replacing the Inter-Agency Group for Safe Motherhood, The Partnership for Maternal, Newborn and Child Health, forms
1987: WHO, World Bank and UNFPA sponsor the first international Safe Motherhood Conference; the Inter-Agency Group for Safe Motherhood forms and launches a global initiative	2005: A host of reports and events focused on jumpstarting the MDGs agenda launch, including: the UN Millennium Project report; WHO, UNICEF, UNFPA and UNDP's flagship annual reports; the G8 summit and the United Nations World Summit
1987–92: More than 80 countries participate in regional and national safe motherhood conferences sponsored by the Inter-Agency Group for Safe Motherhood	2006–07: Prime Ministers Stoltenberg and Brown launch initiatives to accelerate progress on the health-related MDGs, engaging other national leaders and funding partners; <i>The Lancet</i> publishes a maternal survival series and special issue for Women Deliver; the first Women Deliver conference is held in London in October 2007
1990s: Research concerning the issue grows significantly and informs programming; the number of organizations, agencies and governments with maternal health programmes and strategies increases substantially	2008: Brown and World Bank President Robert Zoellick launch the High-level Task Force on Innovative International Financing for Health Systems
1994: The ICPD Programme of Action set maternal mortality reduction goals; the issue received attention in other significant international development forums during the decade	2009–11: The UN Secretary-General works with partners to develop and launch <i>The Global Strategy for Women's and Children's Health</i> with US\$40 billion in commitments from 127 stakeholders; the G8 and UNAIDS launch significant initiatives to improve maternal and child health
1997: The Inter-Agency Group for Safe Motherhood sponsored a technical consultation attended by representatives of 65 countries marking the 10th anniversary of the Safe Motherhood Initiative	2012–13: Maternal health receives attention in planning efforts for the successor to the MDGs
1998: WHO sponsored a World Health Day Call to Action for maternal health	

Parenthood Federation and the Population Council to form the Inter-Agency Group for Safe Motherhood to advocate for maternal mortality reduction globally in the same year. Family Care International, founded in 1986 by Jill Sheffield and Ann Starrs (two prominent entrepreneurial actors), served as secretariat. Formation of the Inter-Agency Group marked emergence of a network focused on reducing maternal mortality globally; network emergence and growth (changing network composition; see Box 2) over time enabled concerned actors to bring their collective resources to bear on the problem.

Prior to the launch of the Safe Motherhood Initiative, knowledge of the global maternal mortality problem was limited and few organizations, agencies or governments had programmes focusing specifically on maternal health (Rosenfield and Maine 1985; Otsea 1992; Family Care International 2007). Bolstered by the Initiative and relatively supportive policy environment, concerned actors ramped up research, programme and advocacy efforts in the late-1980s and 1990s. The number of international organizations and agencies with programmes focusing on maternal health increased from six pre-initiative to 26 by 1992 (Otsea 1992; Family Care International 2007). The Nairobi conference and a series of regional and national conferences sponsored by Inter-Agency Group members and others facilitated development of national safe motherhood committees and early plans and strategies addressing the issue; more than 80 countries participated in conferences by 1992 (Otsea 1992; Starrs 1998; Family Care International 2007).

Concerned actors undertook significant new research endeavours in the late-1980s and 1990s. For example, Columbia University's Regional Prevention of Maternal Mortality Network launched in 1987 and US Agency for International Development (USAID) initiated its then optional module to track maternal health indicators in Demographic and Health Surveys in 1988 (Stanton *et al.* 2000). Inter-Agency Group members, university-based researchers (such as those at Columbia and Aberdeen), foundations (such as Ford, MacArthur, Rockefeller and Gates) and bilateral donors [such as Norwegian Agency for Development Cooperation [NORAD], Swedish International Development Cooperation Agency [SIDA] and USAID], among others sponsored a growing number of research initiatives to address knowledge gaps concerning barriers to care and effective interventions in the 1990s (Otsea 1992; UNFPA 2004). These informed policy solutions and led to some improvements in availability and quality of care (see Otsea 1992 and UNFPA 2004 for examples), but evidence of intervention efficacy was limited in scope—too limited to support strong and widely applicable recommendations (Graham and Campbell 1992; Graham 2002; Miller *et al.* 2003). Relatively weak evidence concerning intervention efficacy, uncertain and unwieldy maternal mortality estimates and disagreements among network actors made the issue difficult to sell to policy makers who needed to show returns on investments; this limited attention and resource allocations that were needed to address programme and measurement gaps (AbouZahr 2001; Graham 2002; Starrs 2006; i19; i20; Shiffman and Smith 2007).

Box 2 Composition of the maternal health network, 1987–2013

Comprised of representatives of WHO, World Bank, UNDP, UNFPA, UNICEF, International Planned Parenthood Federation and the Population Council, a maternal health network emerged with formation of the Inter-Agency Group for Safe Motherhood in 1987. The Inter-Agency Group expanded in 2000 when the International Confederation of Midwives, FIGO, the Regional Prevention of Maternal Mortality Network (Africa) and the Safe Motherhood Network of Nepal joined. Family Care International served as secretariat for the formal network until early 2004 when the Partnership for Safe Motherhood and Newborn Health formed and replaced the Inter-Agency Group. Several other organizations and individuals contribute to an expanded informal network connected by a shared concern for reducing pregnancy-related deaths globally (some are also connected through formal/contractual relationships); some of the more visible long-term network actors include individuals representing Columbia University's Prevention of Maternal Mortality Programme, the University of Aberdeen, the London School of Hygiene and Tropical Medicine, the MacArthur Foundation, the Bill & Melinda Gates Foundation, the US Agency for International Development, the United Kingdom's DFID, the University of California San Francisco and the White Ribbon Alliance. Other prominent actors emerging during the 2000s include the Maternal Health Task Force, the Norwegian Agency for Development Cooperation and Women Deliver. The Partnership for Maternal, Newborn and Child Health has formally represented the networks of actors concerned with these three closely linked issues since 2005, forming an alliance of more than 500 members in 2013 (<http://www.who.int/pmnch/about/en/>). Network boundaries are not easy to define; hundreds of actors (including those affiliated with the Partnership for Maternal, Newborn and Child Health and those world leaders championing the health-related MDGs more broadly) identify with and work on behalf of the issue. The network of concerned actors has grown significantly since 2000; collective resources and agenda status have grown in relation.

In spite of these challenges, the women's rights norm that had drawn early attention to the global maternal mortality problem cascaded in the 1990s, setting an expectation that women's health issues would be on the agenda in significant international development forums. The 1990 World Summit for Children, 1994 International Conference on Population and Development (ICPD) in Cairo, 1995 Copenhagen World Summit for Social Development, 1995 Fourth World Conference on Women in Beijing, 1996 Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee's international development goals statement, *Shaping the 21st Century: The Contribution of Development Co-operation* and 1998 World Health Day all issued calls to improve maternal health. Maternal health network actors played a direct role in securing a place for global maternal mortality reduction

on the ICPD and World Health Day agendas (Family Care International 2007; Safe Motherhood 2010); the former drew commitments from 179 ICPD Programme of Action signatories to reduce maternal mortality by half globally from 1990 levels by 2000 and a further half by 2015 and the latter drew support from several United Nations agency heads and then US first lady Hillary Rodham Clinton (United Nations 1995; Safe Motherhood 2010).

Agenda status for maternal health grew significantly following the launch of the Safe Motherhood Initiative as international organizations and governments developed plans, strategies and research endeavours; however, resources to address the problem remained relatively limited through the 1990s (World Bank 1999; Borghi 2001; Graham 2002). Over the course of the next decade, the poverty reduction supernorm represented by the MDGs would take the issue to an as yet unachieved level of prominence on the international development policy agenda.

Global maternal mortality reduction's rise to prominence on the international development policy agenda: 2000–10

The MDGs era changed the equation for maternal survival, markedly increasing its status on the international development policy agenda. Then United Nations Secretary-General Kofi Annan (a norm entrepreneur) engaged in high-level political negotiations to advance an emergent global poverty reduction norm represented by the United Nations Millennium Declaration and Goals framework at the turn of the century. The Goals represent a 'supernorm'; strong support from heads of state lent the MDGs, 'a vehicle to communicate and promote the objective of ending global poverty', an unusual degree of agenda-setting influence (Fukuda-Parr and Hulme 2011, p. 18). Annan wanted consensus on the goals; the maternal health goal (MDG 5)¹ came about due to precedent (allies and network actors had secured attention for the issue in international development forums over the preceding decades) and political feasibility (uncontroversial, maternal health lacked opponents while sexual and reproductive health, specifically abortion, was politically divisive) (Crossette 2004; Hulme 2009, i24). The goals framework reached a tipping point with its publication and implementation commencing in late-2001 (Fukuda-Parr and Hulme 2011); maternal health was thus caught up in the momentum of a powerful norm cascade.

Annan, United Nations agencies, international donors and others, including maternal health network actors—norm entrepreneurs—worked to secure integration of the goals into organizational, national and high-level political agendas and activities; this furthered the norm cascade and moved the norm towards internalization over the course of the next decade. Priority for maternal health grew in tandem with the evolving norm. The Secretary-General employed a framing strategy that exerted pressure on nations to conform; his early Millennium Declaration implementation reports portrayed the maternal mortality reduction picture as 'dreadful' (United Nations General Assembly 2002, p. 9), progress as insufficient (United Nations General Assembly 2003) and rates as 'appalling' (United Nations General Assembly 2004, p. 15). WHO, World Bank and UNFPA worked to accelerate progress on the

maternal and child health goals; they led provision of technical and financial support for 33 countries in Africa to develop road maps for maternal and newborn health (de Bernis and Wolman 2009). The United Kingdom's Department for International Development (DFID, 2004) was a leader among bilateral donors, becoming the first to publish a maternal health strategy in 2004; the strategy cites an obligation to accelerate relatively slow progress on the maternal health goal compared with those for child survival and communicable diseases.

Norm leaders organized a series of high-profile reports and events in 2005—one-third of the way to 2015 (the target date for achieving the goals)—to attract attention to the goals and motivate action on their behalf. These included: the UN Millennium Project report; WHO, UNICEF, UNFPA and UNDP's flagship annual reports (*World Health Report*, *The State of the World's Children*, *State of World Population* and *Human Development Report*, respectively); the UK-hosted G8 summit at Gleneagles; preparatory and high-level meetings of the UN Economic and Social Council and the United Nations World Summit where leaders reaffirmed their commitments to the MDGs (United Nations 2005), among others. The events engaged world leaders in considering how they could advance the MDG agenda, with the health goals receiving particular attention (UN Economic and Social Council 2005; WHO 2005; United Nations, UN Millennium Project 2006; Stoltenberg 2007).

Norm leaders reframed maternal health as linked to newborn and child survival during this period; they also pressed for a new governance structure to facilitate collective action on the three closely related issues. In the *World Health Report 2005: Make Every Mother and Child Count*, WHO laid out a new framework for understanding and addressing MDGs 4 and 5; maternal, newborn and child health were intricately intertwined issues requiring joint address. Participants in an international meeting hosted by the Government of India and leaders of the maternal, newborn and child survival networks² endorsed the framework and called for commitments to address the maternal and child survival goals jointly in conjunction with the report's release. At the behest of donors, the Partnership for Maternal, Newborn and Child Health was formed a few months later, aligning the three separate initiatives under one secretariat housed at WHO (Department for International Development 2005, i1; i5; i20; i22).³ The integrative governance structure (the Partnership), new framing and increasingly influential MDG supernorm shaped subsequent high-level initiatives—Norwegian Prime Minister Jens Stoltenberg's Global Campaign for the Health MDGs and United Nations Secretary-General Ban Ki-moon's *Global Strategy for Women's and Children's Health* most prominently.

Stoltenberg launched an initiative on behalf of the child survival MDG in 2006; consultations with key stakeholders, notably the new Partnership for Maternal, Newborn and Child Health, brought maternal health into the fold (PMNCH 2007; Stoltenberg 2007, i5; i19; i20; i24). The *World Health Report 2005* and the prominent medical journal *The Lancet's* 2006 maternal survival series (featuring articles concerning the severity, tractability and worthiness of the issue authored by several notable maternal health network actors) also informed the initiative (Godal 2007). Stoltenberg recalled being motivated to

act by the 2005 United Nations World Summit as he introduced his plan to advance the maternal and child survival goals at a World Health Assembly meeting in May 2007. He recruited a Network of Global (norm) Leaders, including UK Prime Minister Gordon Brown (who was developing the International Health Partnership, an initiative to advance co-operation and aid effectiveness for the health MDGs, in parallel), Bill and Melinda Gates and the presidents of Indonesia, Mozambique and Tanzania, to support the effort. Stoltenberg launched the Global Campaign for the Health MDGs at the Clinton Global Initiative meeting in September, pledging \$1 billion on Norway's behalf over the next decade (Office of the Prime Minister of Norway 2007).

Maternal health network actors and other norm leaders organized several reports and events that helped to keep policy attention on maternal health between 2006 and 2009; each would come to shape the 2010 *Global Strategy for Women's and Children's Health* (Ban 2010b). Jill Sheffield launched Women Deliver from within Family Care International to advocate for maternal and reproductive health in 2007, attracting support from prominent leaders, including Gordon Brown, several delegates from Norway and the directors of UNFPA, UNAIDS and WHO; Ban launched the *Global Strategy* from the Women Deliver 2010 conference platform. Brown and World Bank President Robert Zoellick (with strong support from Stoltenberg) launched the Task Force on Innovative International Financing for Health Systems in 2008 amidst pressing concerns about slow progress on the health-related MDGs and declining support for maternal and child health during the global financial crisis (Task Force on Innovative International Financing for Health Systems 2009); in 2009, Task Force co-chairs Brown and Zoellick announced the Partnership for Maternal, Newborn and Child Health-brokered global Consensus for Maternal, Newborn and Child Health along with their report and a set of financing measures worth US\$5.3 billion—both informed the *Global Strategy* (International Health Partnership 2009; PMNCH 2009; WHO 2009; Ban 2010b; Fryatt and Mills 2010). Cost effectiveness evidence and framing of women as central actors in efforts to alleviate poverty provided by another 2009 report, *Adding it up: the costs and benefits of investing in family planning and maternal and newborn health* (Singh *et al.* 2009), also proved influential; the Guttmacher Institute and UNFPA-sponsored report came to inform the *Global Strategy*, as well as DFID and the World Bank's frameworks and justifications for investing in reproductive (encompassing maternal) health through 2015 (Ban 2010b; DFID 2010; World Bank 2010).

Ban Ki-moon's attention was drawn to relatively slow progress on MDG 5 and he believed greater investment was needed to address the issue (2009, 2010a). In late 2009, he and Gates Foundation leaders came up with the idea for a global strategy to galvanize resources for and progress on maternal and child health; it was assembled quickly (Jenkins 2010; i5). The Office of the United Nations Secretary-General oversaw its development while the Partnership for Maternal, Newborn and Child Health advocated for solid technical content and secured buy-in and resource commitments from a wide range of allied stakeholders (Ban 2010b, i5; United Nations Office of the Secretary General 2010). Ban used the opening plenary at

Women Deliver 2010 to announce the Joint Action Plan that would become the *Global Strategy for Women's and Children's Health*, calling upon leaders convening at upcoming meetings of the G8 and G20, the African Union and UNAIDS to invest in women's and children's health. The G8 subsequently committed US\$5 billion through the Stephen Harper-led and network-facilitated Muskoka Initiative for Maternal, Newborn and Child Health (PMNCH 2011a, i12; Prime Minister of Canada 2011) and UNAIDS (2011) developed a *Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*.

Official development assistance for maternal, newborn and child health in 74 countries with the highest mortality rates increased between 2003 and 2009, from US\$2.6 billion in 2003 to US\$6.51 billion in 2009, declining for the first time in 8 years in 2010 to US\$6.48 billion (Hsu *et al.* 2012). At its launch in 2010, the *Global Strategy* had leveraged an estimated US\$40 billion in pledges through 2015—an average of US\$8 billion per year—from 127 allied stakeholders, including governments (significantly, 39 low-income countries pledged a combined US\$10 billion), non-governmental organizations (such as World Vision and Save the Children), private foundations (such as the Gates, MacArthur and Packard Foundations) and private sector entities (such as Merck and Johnson & Johnson) (Global Health Visions 2011; PMNCH 2011b). The commitments were significant (though only about half new) and promised to go some way towards closing an estimated funding gap of US\$88 billion for maternal, newborn and child health between 2011 and 2015 (PMNCH 2011b, 2012; Expert Review Group 2012).

There are indicators (based upon self-reporting) that *Global Strategy* stakeholders are supporting intervention scale up (PMNCH 2012, 2013), but the independent Expert Review Group (2012, 2013) charged with tracking progress has reported inequities and slow or no movement on at least half of the indicators they monitor. The global MMR declined at an increasing rate during the MDG era (Figure 1), but only 19 of 99 countries with MMR ≥ 100 in 1990 are on track to meet the maternal health goal (World Health Organization *et al.* 2012). The independent Expert Review Group (2012, 2013) has been unable to draw conclusions about whether the *Global Strategy* and related resource commitments have had independent effects on the status of women's and children's health in the 75 countries where most maternal and child deaths take place.

Discussion

Policy attention for global maternal mortality reduction emerged and grew for some two decades before rising to a prominent position on the international development policy agenda in the 2000s (Table 1). The earlier period is characterized by a shift from near complete issue neglect to network emergence, expanded problem recognition and growth in the number of organizations and governments with maternal health strategies and programmes. The latter period is characterized by significantly higher level attention and increasing resource commitments to improve maternal health globally. Differences between periods of emergence and early growth in issue attention contrast with more prominent agenda

status in recent years, offering insights to the ways in which networks, issue characteristics and policy environments interact to shape each other and policy consequences (our focus on agenda status) over time.

To begin, 'network and actor features' changed between the two periods. Several individuals representing a host of international organizations advocated on behalf of global maternal mortality reduction in the earlier period; they organized conferences, led studies and programmes, wrote and publicized reports, acquired resources and helped to bring about national safe motherhood committees, plans and strategies. Leadership (factor 1) for the issue took place at a higher level and outside the core network that was active in the 1980s and 1990s in the later period—capable, connected and widely respected, Ban, Brown and Stoltenberg provided leadership that drew policy attention at the highest levels of government and resulted in significantly expanded resource commitments to maternal alongside other closely linked health issues. It is unlikely commitments on the scale of the *Global Strategy* could have been achieved by 2010 without them. Factors in the 'policy environment', especially the MDG supernorm (factor 7: norms), helped to bring these leaders on board and to attract policy commitments.

Nonetheless, other network features contributed to the change in agenda status. Network governance structure (factor 2) and framing strategy (factor 4) changed mid-decade; the maternal, newborn and child survival networks joined to bring separate initiatives for three interdependent issues together under a joint secretariat. The new structure and framing helped to draw attention to maternal alongside child survival, shaping emergent leadership initiatives and commitments related to the health MDGs. Priority for maternal survival grew as the issue came to be embraced by a wider range of actors—by high-level political leaders and other allies alongside the relatively narrowly focused and technically oriented group that had historically been at the network's core; diverse network composition (factor 3) was crucial to maternal health's rise on the agenda.

In the 'policy environment', two strong international development norms (factor 7; women's rights and global poverty reduction as represented by the MDGs) identified maternal mortality as a problem requiring redress; priority for maternal health developed in relationship to the life cycles of these norms, suggesting Finnemore and Sikkink's (1998) framework adds a layer of analysis to our conceptual framework that is useful for understanding how agenda status changes over time. A cascading women's rights norm and norm leaders facilitated issue attention during the 1980s and 1990s as governments and international organizations put women's health on their agendas and moved to internalize the norm; maternal health was relatively uncontroversial, helping to secure its place on the consensus-driven MDG agenda at the turn of the century. The power of the MDG supernorm, its rapid cascade and movement to internalize the framework led to major initiatives that advanced attention and resources to improve maternal health.

Norm life cycles and the actors that work to advance them play key roles in issue promotion, but they do not advance all issues under a given norm's umbrella equally—norms are not monolithic. Not all women's health issues have risen to

maternal health's agenda status; for instance, universal access to reproductive health was only added as a target under MDG 5 in 2007. The maternal health case suggests that politically feasible issues are more likely to rise on policy agendas than those rooted in controversy. In addition, maternal health appears to have attracted attention from leaders at least in part because it was clearly and specifically identified as a goal (MDG 5 to reduce maternal mortality by three quarters from 1990 levels by 2015). Maternal health contrasts with issues such as pneumonia that account for a large proportion of under-five child mortality but are unnamed under the child survival goal and receive relatively little political attention (see Berlan 2016). This is consistent with Finnemore and Sikkink's (1998) suggestion that 'Norms that are clear and specific, rather than ambiguous or complex... are more likely to be effective' (pp. 906–7); Fukuda-Parr and Hulme (2011) point out that the MDGs 'were specifically designed to meet such conditions' (p. 23). Such propositions should be tested across issues as findings could have significant implications for agenda setting in global health.

Finally, 'issue characteristics' play facilitating and hindering roles in this case. Evidence gathered concerning the severity (factor 8), causes and potential solutions to the problem (factor 9: tractability) helped to spur network formation and draw attention to the issue in the mid-1980s. Network actors helped to grow the evidence base in the years that followed, but data limitations hampered development and promotion of widely agreed upon recommendations (factor 4: framing) in the earlier period; network actors and allies issued several consensus statements concerning intervention strategy in the second period (PMNCH 2005, 2009; Starrs 2006, 2007; Freedman *et al.* 2007)—the contents of leadership initiatives in the late 2000s reflect these consensus statements. Strong evidence and agreement on intervention strategy help to position issues in ways that resonate with policy makers, facilitating priority generation for issues. Finally, affected groups (factor 10), poor women in low-income countries, have not been positioned to advocate for themselves; however, they have been viewed sympathetically and as central actors in efforts to alleviate poverty (aligning with the MDG supernorm) (Singh *et al.* 2009; Ban 2010b; DFID 2010; World Bank 2010). Policymaker perceptions of women's agency may influence the status of women's health issues on the international development agenda; unanimous support for the ICPD Programme of Action and United Nations Millennium Declaration appear to support this proposition, but it should be investigated further across issues, groups and countries.

Conclusion

Our framework of analysis sets up several questions pointing to factors that shaped the trajectory of policy attention for global maternal mortality reduction pre- and post-2000. How strong is the evidence and agreement concerning the severity of the problem and policy solutions? Is there an operative norm and what life cycle stage is it in? How strong are leadership, governance and network composition for the issue? How sympathetic and involved are affected groups and what are policymaker perceptions of their agency? The answers to these

questions differ for the two periods; varying qualities of network and actor features, issue characteristics and the policy environment shaped differences. But the maternal health case particularly highlights roles of norms in shaping agenda status. A new international development agenda will succeed the MDGs in 2015; its evolution and strength will shape the trajectory of more and less clearly identified goals—likely with significant implications for global health and the as yet unfinished MDG agenda.

Supplementary Data

Supplementary data are available at *HEAPOL* online.

Funding

This study was supported by the Bill and Melinda Gates Foundation (OPPGH4831).

Acknowledgements

We are grateful to the Bill and Melinda Gates Foundation for supporting this study and to all the individuals who agreed to be interviewed for this study. We also express appreciation to Carol Medlin, who provided valuable input on the design of the project.

Conflict of interest statement. None declared.

Endnotes

- ¹ Universal access to reproductive health was added as MDG 5B and maternal mortality reduction became MDG 5A in 2007.
- ² Conference co-sponsors included the Partnership for Safe Motherhood and Newborn Health (successor to the Inter-Agency Group, bringing newborns into the maternal health fold in 2004), the Healthy Newborn Partnership and the Child Survival Partnership. Ministers and delegations from several countries (such as Bangladesh, Bolivia, Cambodia, Ethiopia, India, Mali, Mozambique, Nepal, Pakistan, Tanzania and Uganda), UN agencies, international nongovernmental organisations (NGOs), foundations, professional bodies, academia and civil society representatives signed 'The Delhi Declaration on Maternal, Newborn and Child Health' (PMNCH 2005; WHO 2005).
- ³ Founding Partnership members are listed at: <http://www.who.int/mediacentre/news/releases/2005/pr41/en/index.html> (accessed 31 October 2013).

References

- AbouZahr C. 2001. Cautious champions: international agency efforts to get safe motherhood onto the agenda. *Studies in Health Services Organization & Policy* **17**: 387–414.
- Ban K. 2009. *Resilience and Solidarity: Our Best Response to Crisis*. [press release] 19 May 2009. http://www.who.int/mediacentre/events/2009/wha62/secretary_general_speech_20090519/en/index.html, accessed 29 January 2012.
- Ban K. 2010a. *Women Deliver 2010: Opening Plenary/Celebrate Progress*. [video online] http://www.livestream.com/womendeliver/video?clipId=pla_3af249cb-7656-4c3f-a88c-a1bbdafdf08f&utm_source=lslibrary&utm_medium=ui-thumb, accessed 29 January 2012.

- Ban K. 2010b. *Global Strategy for Women's and Children's Health*. [pdf] Geneva: World Health Organization. http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf, accessed 19 April 2012.
- Bennett A. 2010. Process tracing and causal inference. In: Brady EE, Collier D (eds). *Rethinking Social Inquiry: Diverse Tools, Shared Standards*. Lanham, MD: Rowman & Littlefield Publishers.
- Berlan D. (2016) Pneumonia's second wind? A case study of the global health network for childhood pneumonia. *Health Policy and Planning* **31**(Suppl. 1): 33–47.
- Borghji J. 2001. What is the cost of maternal health care and how can it be financed? *Studies in Health Services Organization & Policy* **17**: 247–96.
- Buse K, Walt G. 2000. Role conflict? The World Bank and the world's health. *Social Science and Medicine* **50**: 177–9.
- Crossette B. 2004. *Reproductive Health and the Millennium Development Goals: The Missing Link*. Menlo Park, CA: Population Program/William and Flora Hewlett Foundation.
- de Bernis L, Wolman Y. 2009. *UNFPA Maternal and Newborn Health National Plans (Road Map) Assessment: African MNH Road Maps Assessment Report*. New York: UNFPA.
- Department for International Development. 2004. *Reducing Maternal Deaths: Evidence and Action, a Strategy for DFID*. [pdf] London: DFID. <http://www.eldis.org/vfile/upload/1/document/0708/DOC17246.pdf>, accessed 19 April 2012.
- Department for International Development. 2005. *DFID's Maternal Health Strategy Reducing Maternal Deaths: Evidence and Action*. First Progress Report. London: DFID.
- Department for International Development. 2010. *Choices for Women: Planned Pregnancies, Safe Births and Healthy Newborns: The UK's Framework for Results for Improving Reproductive, Maternal and Newborn Health in the Developing World*. [pdf] London: DFID. <http://www.dfid.gov.uk/documents/prd/rmnh-framework-for-results.pdf>, accessed 6 November 2011.
- Expert Review Group. 2012. *Every Woman, Every Child: From Commitments to Action. The First Report of the Independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health*. Geneva: World Health Organization. http://www.who.int/woman_child_accountability/iERG/reports/2012/en/, accessed 26 November 2012.
- Expert Review Group. 2013. *Every Woman, Every Child: Strengthening Equity and Dignity Through Health. The Second Report of the Independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health*. Geneva: World Health Organization. http://www.who.int/woman_child_accountability/iERG/reports/2013/en/, accessed 30 October 2013.
- Family Care International. 2007. *Safe Motherhood a Review: The Safe Motherhood Initiative 1987-2005*. New York: Family Care International.
- Finnemore M, Sikkink K. 1998. International norm dynamics and political change. *International Organization* **52**: 887–917.
- Freedman LP, Graham WJ, Brazier E *et al.* 2007. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. *Lancet* **370**: 1383–91.
- Fryatt R, Mills A. 2010. Taskforce on Innovative International Financing for Health Systems: showing the way forward. *Bulletin of the World Health Organization* **88**: 476–77.
- Fukuda-Parr S, Hulme D. 2011. International norm dynamics and the "End of Poverty": understanding the Millennium Development Goals. *Global Governance* **17**: 17–36.
- Global Health Visions. 2011. *U.S. Maternal Health Donors: A Landscape Analysis*. [pdf] Brooklyn, NY: Global Health Visions. http://maternalhealthtaskforce.org/component/docman/cat_view/83-global-health-visions?Itemid=220, accessed 1 September 2012.
- Godal T. 2007. *Concept Paper in Relation to the Development of the Global Business Plan to Accelerate Progress Towards MDG 4 and 5*. [pdf] Geneva: World Health Organization. <http://www.who.int/pmnch/events/2007/gbpconceptpaper.pdf>, accessed 20 September 2013.
- Graham WJ. 2002. Now or never: the case for measuring maternal mortality. *Lancet* **359**: 701–4.
- Graham WJ, Campbell OMR. 1992. Maternal health and the measurement trap. *Social Science & Medicine* **35**: 967–77.
- Hong L, Page SE. 2004. Groups of diverse problem solvers can outperform groups of high-ability problem solvers. *Proceedings of the National Academy of Sciences of the United States of America* **101**: 16385–9.
- Hsu J, Pitt C, Greco G, Berman P, Mills A. 2012. Countdown to 2015: changes in official development assistance to maternal, newborn, and child health in 2009–10, and assessment of progress since 2003. *Lancet* **380**: 1157–68.
- Hulme D. 2009. *Reproductive Health and the Millennium Development Goals: Politics, Ethics, Evidence and an 'Unholy Alliance'*. Working Paper. [pdf] Manchester: The University of Manchester Brooks World Poverty Institute. http://www.eadi.org/fileadmin/MDG_2015_Publications/fukuda-parr_and_hulme_2009_international_norm_dynamics.pdf, accessed 12 September 2011.
- International Health Partnership. 2009. *Leaders Commit New Finance to Tackle Women's and Children's Health in the Developing World*. [press release]. <http://www.internationalhealthpartnership.net/en/taskforce>, accessed 29 January 2012.
- Jenkins K. 2010. *Acting Together for Maternal and Newborn Health*. Middlesex, UK: World Vision International. <http://www.wvi.org/vi/wviweb.nsf/updates/D97F267F7BD60AFC8825776C00720500?opendocument>, accessed 19 April 2012.
- Kahler M. 2009. Networked politics: agency, power, and governance. In: Kahler M (ed). *Networked Politics: Agency, Power, and Governance*. Ithaca, NY: Cornell University Press, pp. 1–22.
- Katzenstein PJ (ed.). 1996. *Alternative perspectives on national security. The Culture of National Security: Norms and Identity in World Politics*. New York: Columbia University Press. Introduction.
- Keck ME, Sikkink K. 1998. *Activists Beyond Borders: Advocacy Networks in International Politics*. Ithaca, NY: Cornell University Press.
- Kingdon JW. 1994. *Agendas, Alternatives, and Public Policies*. Boston, MA: Longman.
- Marsh D, Smith M. 2000. Understanding policy networks: towards a dialectical approach. *Political Studies* **48**: 4–21.
- McAdam D, Tarrow S, Tilly C. 2001. *Dynamics of Contention*. Cambridge: Cambridge University Press.
- McInnes C, Lee K. 2012. Framing and global health governance: key findings. *Global Public Health* **7**(Suppl. 2): S191–8.
- Miller S, Sloan NL, Winikoff B *et al.* 2003. Where is the "E" in MCH? The need for an evidence-based approach in safe motherhood. *Journal of Midwifery & Women's Health* **48**: 10–8.
- Office of the Prime Minister of Norway. 2007. *Stoltenberg Launches Campaign to Reduce Maternal and Child Deaths*. [press release] 26 September 2007. <http://www.regjeringen.no/en/dep/smk/Press-Center/Press-releases/2007/Stoltenberg-launches-Campaign-to-Reduce-.html?id=481751>, accessed 23 January 2012.
- Otsea K. 1992. *Progress and Prospects: The Safe Motherhood Initiative 1987-1992. Background Document for Meeting of Partners for Safe Motherhood*. Washington, DC, March 1992. Washington, DC: The World Bank.
- Page SE. 2007. Princeton University Press. *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools, and Societies*. Princeton, NJ: Princeton University Press.
- PMNCH (Partnership for Maternal, Newborn & Child Health). 2005. *Lives in the Balance: The Partnership Meeting for Maternal, Newborn and*

- Child Health: The Delhi Declaration*. [pdf] Geneva: World Health Organization. http://www.who.int/pmnch/resources/delhi_declaration_english.pdf, accessed 23 January 2012.
- PMNCH (Partnership for Maternal, Newborn and Child Health). 2007. *The Global Business Plan for Millennium Development Goals 4 and 5*. [pdf] Geneva: World Health Organization. <http://www.who.int/pmnch/activities/globalbusinessplan/en/index.html>, accessed 23 January 2012.
- PMNCH (Partnership for Maternal, Newborn and Child Health). 2009. *New Global Consensus on Maternal, Newborn and Child Health*. [press release] 23 September 2009. http://www.who.int/pmnch/media/press/2009/20090923_mnchconsensuspr/en/index.html, accessed 29 September 2013.
- PMNCH (Partnership for Maternal, Newborn and Child Health). 2011a. *Deauville G8 Accountability Report: G8 Commitments on Health and Food Security: State of Delivery and Results*. Geneva: World Health Organization. http://www.who.int/pmnch/media/membernews/2011/20110526_g8swatch_2011/en/index.html, accessed 29 January 2012.
- PMNCH (Partnership for Maternal, Newborn and Child Health). 2011b. *The PMNCH 2011 Report: Analysing Commitments to Advance the Global Strategy for Women's and Children's Health*. Geneva: World Health Organization. http://www.who.int/pmnch/topics/part_publications/2011_pmnch_report/en/index.html, accessed 9 February 2012.
- PMNCH (Partnership for Maternal, Newborn and Child Health). 2012. *The PMNCH 2012 Report: Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health*. Geneva: World Health Organization. http://www.who.int/pmnch/topics/part_publications/2012_pmnch_report/en/index.html, accessed 18 October 2012.
- PMNCH (Partnership for Maternal, Newborn and Child Health). 2013. *The PMNCH 2013 Report: Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health*. [pdf] Geneva: World Health Organization. http://www.who.int/pmnch/knowledge/publications/pmnch_report13.pdf, accessed 25 October 2013.
- Powell WW. 1990. Neither market nor hierarchy: networks forms of organization. *Research in Organizational Behavior* **12**: 295–336.
- Prime Minister of Canada. 2011. *PM Announces New Maternal, Newborn and Child Health Initiatives*. [press release] 27 May 2011. <http://www.pm.gc.ca/eng/media.asp?category=1&featureId=6&pageId=26&id=4133>, accessed 25 May 2012.
- Rosenfield A, Maine D. 1985. Maternal mortality—a neglected tragedy. Where is the M in MCH? *Lancet* **2**: 83–5.
- Safe Motherhood. 2010. *Safe Motherhood at 10*. [online]. <http://www.safemotherhood.org/priorities/safe-motherhood-at-10.html>, accessed 10 October 2012.
- Schneider A, Ingram H. 1993. Social construction of target populations: implications for politics and policy. *American Political Science Review* **87**: 334–47.
- Shiffman J, Quissell K, Schmitz HP *et al*. 2016. A framework on the emergence and effectiveness of global health networks. *Health Policy and Planning* **31**(Suppl. 1): 3–16.
- Shiffman J, Smith S. 2007. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet* **370**: 1370–9.
- Singh S, Darroch J, Ashford L, Vlassoff M. 2009. *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. New York: Guttmacher Institute and UNFPA.
- Snow A, Burke Rochford E, Worden S, Benford R. 1986. Frame alignment processes, micromobilization and movement participation. *American Sociological Review* **51**: 464–81.
- Stanton C, Abderrahim N, Hill K. 2000. An assessment of DHS maternal mortality indicators. *Studies in Family Planning* **31**: 111–23.
- Starrs AM. 1998. *The Safe Motherhood Action Agenda: Priorities for the Next Decade. Report on the Safe Motherhood Technical Consultation*. Colombo, Sri Lanka, 18–23 October 1997. New York: Family Care International.
- Starrs AM. 2006. Safe motherhood initiative: 20 years and counting. *Lancet* **368**: 1130–2.
- Starrs AM. 2007. Delivering for women. *Lancet* **370**: 1285–7.
- Stoltenberg J. 2007. *Address by Jens Stoltenberg, The Prime Minister of Norway at the 60th World Health Assembly*. Geneva, 18 May 2007. [pdf] Geneva: World Health Organization. http://apps.who.int/iris/bitstream/10665/22636/1/A60_DIV6-en.pdf, accessed 19 April 2012.
- Stone DA. 1989. Causal stories and the formation of policy agendas. *Political Science Quarterly* **104**: 281–300.
- Task Force on Innovative International Financing for Health Systems. 2009. *More Money for Health, and More Health for the Money*. [pdf] Task Force on Innovative International Financing for Health Systems. http://aid.dfat.gov.au/publications/Documents/more_money_for_health.pdf, accessed 19 April 2012.
- United Nations. 1995. *Report of the International Conference on Population and Development*. Cairo, 5–13 September 1994. New York: United Nations.
- United Nations. 2005. *The 2005 World Summit High-Level Plenary Meeting of the 60th Session of the General Assembly Documents*. New York: United Nations. <http://daccess-ddsny.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement>.
- United Nations General Assembly. 2002. *Millennium Declaration Implementation Report*. New York: United Nations. <http://www.un.org/millenniumgoals/sgreport2002.pdf?OpenElement>, accessed 19 April 2012.
- United Nations General Assembly. 2003. *Millennium Declaration Implementation Report*. New York: United Nations. <http://www.un.org/millenniumgoals/sgreport2003.pdf?OpenElement>, accessed 19 April 2012.
- United Nations General Assembly. 2004. *Millennium Declaration Implementation Report*. New York: United Nations. <http://www.un.org/millenniumgoals/sgreport2004.pdf?OpenElement>, accessed 19 April 2012.
- United Nations Office of the Secretary General. 2010. *Secretary-General's Forum: A Global Effort on Women and Children's Health*. New York: United Nations. <http://www.un.org/sg/hf/summary.shtml>, accessed 19 April 2012.
- United Nations, UN Millennium Project. 2006. *Statements of Support for 'Investing in Development: A Practical Plan to Achieve the Millennium Development Goals'*. [press release]. <http://www.unmillenniumproject.org/press/endors01.htm>, accessed 1 October 2013.
- UNAIDS. 2011. *Countdown to Zero: Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive*. 2011–2015. Geneva: UNAIDS.
- UN Economic and Social Council. 2005. *Preparatory Event for ECOSOC 2005 High-level Segment on Millennium Development Goals and Follow Up to Conferences*. New York. 16–17 March 2005. New York: United Nations. http://www.un.org/en/ecosoc/meetings/2005/16-17_March_2005.html.
- UNFPA. 2004. *State of World Population 2004. The Cairo Consensus at ten: Population, Reproductive Health and the Global Effort to End Poverty*. New York: UNFPA.
- World Bank. 1999. *Lessons from 10 Years of Experience. Safe Motherhood and The World Bank*. Washington DC: The World Bank, Human Development Network.
- World Bank. 2010. *The World Bank's Reproductive Health Action Plan 2010–2015*. [pdf] Washington, DC: World Bank. <http://siteresources>.

- worldbank.org/INTPRH/Resources/376374-1261312056980/RHActionPlanFinalMay112010.pdf, accessed 9 February 2012.
- World Health Organization. 1990. *Maternal Health and Safe Motherhood Programme Progress Report, 1987–1990*. Geneva: World Health Organization.
- World Health Organization. 2005. *The World Health Report 2005: Make Every Mother and Child Count*. [pdf] Geneva: World Health Organization. http://www.who.int/whr/2005/whr2005_en.pdf.
- World Health Organization. 2009. *New Global Consensus on Maternal, Newborn and Child Health to Save over 10 Million Lives: World Leaders Commit to Innovative Funding for Women's and Children's Health*. [press release]. 22 September 2009. http://www.who.int/pmnch/media/press/2009/20090922_worldleadersconsensus/en/, accessed 1 October 2013.
- World Health Organization, United Nations Children's Fund, United Nations Population Fund, World Bank. 2012. *Trends in Maternal Mortality: 1990-2010*. Geneva: World Health Organization.
- Yin R. 2003. *Case Study Research: Design and Methods*. 3rd edn. Thousand Oaks, CA: Sage Publications, Inc.