Generating Political Priority for Neonatal Mortality Reduction in 4 Developing Countries

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Abstract

Each year 3.1 million babies die before reaching one month of life. Over the last four decades, neonatal mortality has declined at a slower pace than child mortality. As a result newborns now constitute more than 40% of deaths to children under five. Achieving Millennium Development Goal number four on child survival will require acceleration in the pace of neonatal mortality decline. One factor that could facilitate acceleration is an increase in the level of political priority national governments give the issue.

This report examines policy attention for newborn survival in four low-income countries - Bangladesh, Bolivia, Malawi and Nepal - as a means of investigating how and why governments come to prioritize the issue. Using a qualitative case study methodology, we conducted 140 interviews with actors involved in newborn survival globally and in these four countries, analyzed more than 400 hundred government, donor and NGO reports and visited implementation sites. Drawing on a policy framework, we examined the extent to which policy attention has emerged in these countries and reasons for differences in levels of attention.

As of 2000 newborn survival received minimal policy attention in these four countries. By 2010 attention had emerged to varying degrees in the four. In Bangladesh and Nepal the issue had emerged as a health priority. In Bolivia attention rose through 2006 but stagnated in the latter half of the decade. In Malawi, despite efforts by advocates, the government has yet to give the issue significant attention. Among the factors that shaped these differences were the presence of national champions promoting the cause; the degree of cohesion among national newborn survival policy communities; the effectiveness of these champions and policy communities in generating and disseminating evidence on the scope of the problem and on solutions; and political transitions that altered national health priorities. The experience of these four countries offers guidance on how political priority can be generated for newborn survival and for other health issues that low-income countries face.

Introduction

In many low-income countries newborn babies face difficult odds in living past the first month of life. About 3.1 million deaths occur every year to babies younger than 28 days – of which more than 99% are in low-income countries (Rajaratnam et al. 2010). Decreasing at 2.1% per year over the period 1970 to 2010, neonatal mortality has been the slowest declining component of deaths to children under five, and now comprises 40.7% of under-five mortality (Rajaratnam et al. 2010). This slow decline presents a significant barrier to achievement of Millennium Development Goal number four, which calls for a two-thirds reduction in child mortality over 1990 levels by 2015.

Before 2000, few organizations or national governments paid much attention to neonatal mortality. Since that year several organizations involved in global health have come to address the problem, as have a number of national governments. This wave of attention is surprising: there was no sudden increase in the number of babies dying or swift spread of a virus that alarmed the governments of wealthy countries. The attention may also be uneven: it may be no more than a handful of global health organizations and governments of low-income countries that have come to prioritize the issue.

Drawing on a public policy framework, this report examines political priority for newborn survival in four countries that have attracted considerable interest from researchers and policy-makers concerned with the issue: Bangladesh, Bolivia, Malawi and Nepal (table 1). Its aim is to investigate why and how countries come to pay attention to the issue. We know priority is present when: (1) national leaders publicly and privately express sustained concern for the issue; (2) the government, through an authoritative decision-making process, enacts policies that offer

widely embraced strategies to address the problem; and (3) the government allocates and releases public budgets commensurate with the problem's gravity. Political priority alone is hardly sufficient for generating neonatal mortality decline: many other factors contribute, including the scale-up of programs that include interventions proven to reduce newborn deaths. Nevertheless, political priority may support these other factors and facilitate scale-up, making it an important subject for investigation.

Table 1: Newborn survival and economic indicators, by country: mid to late 2000s

Indicator	Bolivia	Nepal	Malawi	Bangladesh
Neonatal mortality rate in 2010 (deaths per 1000 live births)[1]	19	25	27	31
Number of newborn deaths in 2008 (deaths to children under 28 days of age)[2]	6,506	22,578	17,193	113,884
Skilled attendance at delivery (percentage)[3]	71	19	73	27
Last birth protected against neonatal tetanus (percentage)[4]	40	63	89	83
GNI per capita in 2009 (US dollars, Atlas method)[5]	1630	440	290	580

Between 2009 and 2011 we prepared individual studies on political priority in each country and globally (Shiffman and Kazembe 2009; Smith and Neupane 2011; Smith and Torrez 2011; Shiffman and Sultana 2011; Shiffman 2010). In this paper we bring together the five studies. In the sections that follow, we explain this study's methodology and the public policy framework we used to analyze the cases. We then present results on levels of and determinants of priority,

[1] Source: Institute for Health Metrics and Evaluation 2010. Accessed May 13, 2011.
[2] Source: Black et. al 2010.
[3] Sources:
For Bangladesh: USAID et al. 2010. Data are for three years preceding survey.
For Bolivia: MSD et al. 2009. Data are for five years preceding the survey.
For Malawi: National Statistical Office and Measure DHS 2011. Data are for five years preceding survey.
For Nepal: Macro International 2007. Data are for five years preceding the survey.
[4] Sources:
For Bangladesh: NIPORT et al. 2009. Data are for three years preceding survey.
For Bolivia: MSD et al. 2009. Data are for five years preceding the survey.
For Malawi: National Statistical Office and Measure DHS 2011. Data are for five years preceding survey.
For Nepal: Macro International 2007. Data are for five years preceding the survey.
[5] Source: World Bank 2011.

organized with reference to this framework. In the discussion and conclusion, we draw out implications for priority generation for newborn survival.

Methods

We used a process-tracing methodology for each of the five studies, a qualitative case study research strategy commonly employed in public policy research with a political science orientation (Yin 1994). Process tracing uses multiple sources of information to minimize bias, establish common patterns of causality, and reveal social and political processes – the major goal of this research. Process tracing in particular and case study methodologies more generally have received increasing attention in political science inquiry in recent years because of their unique capacity to consider political and social phenomena in their real-life context, with particular attention to historical influences (Yin 1994; Brady and Collier 2004). More commonly used methodologies in public health and medical research, including randomized controlled experiments, structured surveys, and statistical analysis of health service utilization, do not normally have these advantages (Yin 1994). A limitation of the case study approach is the difficulty in controlling for confounding influences on the outcomes of interest. As such, inferences about determinants of priority in this study must be understood as propositions that require further research, ideally in comparative context.

In each study we asked the same two questions: to what extent is neonatal mortality reduction on the policy agenda, and what factors have facilitated or obstructed priority for the issue? Two considerations shaped country selection. First, each has been a focal country for the Saving Newborn Lives (SNL) program of Save-the-Children USA – a Gates Foundation-funded initiative begun in 2000 with the aim of reducing neonatal mortality. Second, at the time of case

selection, SNL leaders presented us with evidence that led them to believe policy activity surrounding newborn survival had advanced more in these countries than in others in the same region: Sub-Saharan Africa in the case of Malawi; South Asia in the cases of Bangladesh and Nepal; and Latin America in the case of Bolivia. As such, case selection is likely biased in the direction of positive policy attention. If one were extrapolating from these findings, a reasonable presumption would be that political priority has not proceeded as far in comparable countries.

We used five types of sources to conduct these studies, triangulating among these to minimize bias: key informant interviews; government reports and documents; donor and NGO reports; published research on newborn survival; and observations from visiting sites of newborn survival projects. We cleared the study protocol through the Syracuse and American University Institutional Review Boards, which granted the studies exemption from review, as they focused on public policy and posed minimal risk to informants. From 2008 through 2010 we conducted 140 interviews (33 for the global study; 26 for Bangladesh; 26 for Bolivia; 26 for Malawi; 29 for Nepal). For the country studies, we conducted most of the interviews in person in country. We also conducted several follow-up interviews by telephone. In each of the four countries we collaborated with domestic researchers with expertise in health policy. Most interviews lasted between one and two hours. We interviewed three groups of individuals: those centrally involved in efforts to address newborn survival; those in a position to observe and offer authoritative information about the effectiveness of these efforts; and those critical of the efforts. Of the 140 interviews, 21 were with members of United Nations agencies; 26 were with Ministry of Health ministers, secretaries and officials, or government officials from other ministries; 3 were with parliamentarians; 22 were with officials of donor agencies and their programs; 10

were with researchers; 32 were with international non-governmental organizations including SNL; 16 were with domestic non-governmental and civil society organizations; and 10 were with frontline health workers. Interview (I) numbers are listed in parentheses (I-G refers to an interview for the global study; I-N for Nepal; I-Ba for Bangladesh; I-Bo for Bolivia; and I-M for Malawi). We identified individuals through publicly available documents, commentaries and consultation with individuals working on the issue globally and in each of the countries – a key informant rather than a sampling selection strategy. We informed interviewees they would not be identified in the text. For the global, Nepal and Bolivia studies interviews were recorded and transcribed; for the Bangladesh and Malawi studies - where many informants were reluctant to be recorded - detailed notes were taken. Rather than follow a set of structured questions, we sought through open-ended questions to elicit the unique knowledge that each informant held about efforts to address newborn survival.

Additionally, we carefully read and cross-checked more than 400 documents to develop a history of newborn survival initiatives globally and in each country, in order to evaluate the level of political attention for neonatal mortality reduction and to facilitate analysis of the factors that shaped priority levels. Documents included demographic and health and other surveys; government policy documents, health reports, and technical guidance on newborn survival; documents from bilateral and multilateral donors; national government development plans; reports from foundations and NGOs; and published research on newborn survival. These documents were gathered from government, NGO and donor archives; direct solicitation from interviewees; research libraries in the United States; and web-based searches. In addition, we observed implementation of newborn survival activities in villages, local health centers and

hospitals in Bangladesh, Bolivia, Malawi and Nepal, and attended and observed global conferences where newborn survival was being discussed.

Once all the material had been collected, we reviewed interview notes and documents to check facts across multiple sources to develop a history of newborn survival efforts and policy attention globally and in each country. We inputted some of the information into NVIVO 8 software, a program that facilitates the analysis of qualitative data. The comparison and cross-checking of information from interviews was crucial because respondents often did not remember accurately when particular developments occurred. For each of the five reports, at least four individuals involved in newborn survival efforts reviewed the case study to check for factual accuracy. The Malawi and global reports were presented at meetings of newborn survival actors (in Lilongwe, Malawi and Washington, DC, respectively), where we received and incorporated additional comments.

To analyze the data we drew on two frameworks we had developed from prior studies concerning factors that had shaped political priority globally and in five developing countries for a related issue: maternal survival (Shiffman 2007; Shiffman and Smith 2007). Most of the factors in the two frameworks overlap. We therefore combined them into one framework consisting of eleven factors in three categories: transnational influence, domestic advocacy and national political environment (table 2). We explain the meaning of each factor in the results section, alongside the data corresponding to that particular factor. In conducting the newborn analysis, we grouped together data from each of the five studies corresponding to each factor, and considered whether and the extent to which each factor shaped political priority levels. As

we did so, we went back and forth between the framework and the data, considering the extent to which the framework adequately captured the causal factors at work, and modifying the framework accordingly. As such, these studies cannot be considered to have posed a test on the adequacy of the framework, but rather an opportunity to refine the framework. Future studies will be needed to determine the framework's adequacy and broader applicability.

Table 2: Framework on determinants of political attention for health initiatives (modified from Shiffman 2007 and Shiffman and Smith 2007)

Factor	Category	Description
1. Norm promotion	Transnational influence	Efforts by international agencies to establish a global norm surrounding the issue
2. Resource provision	Transnational Influence	The offer of financial and technical resources by international agencies to address the issue
3. Political entrepreneurship	Domestic advocacy	The presence of respected and capable national political champions promoting the cause
4. Policy community cohesion	Domestic advocacy	The degree of coalescence among the network of individuals and organizations involved with the issue
5. Focusing events	Domestic advocacy	The organization of forums to generate national attention for the issue
6. Credible indicators	Domestic advocacy	The availability and strategic deployment of evidence to demonstrate the presence of a problem
7. Clear policy alternatives	Domestic advocacy	The availability of clear policy alternatives to demonstrate that the problem is surmountable
8. Guiding institutions	Domestic advocacy	The presence and effectiveness of agencies with a mandate to lead the initiative
9. Civil society mobilization	Domestic advocacy	The extent to which grassroots organizations have mobilized to press national political authorities to act
10. Political transitions	National political environment	Political changes, such as regime transitions, that positively or adversely affect prospects for promotion of the issue
11. Existing health priorities	National political environment	Priority for other health problems that may facilitate or divert policy-maker attention to new issues

Results

Levels of priority

As of 2000 the governments of these four countries gave minimal attention to newborn survival (indicated by the three criteria in the introductory section). By 2010, the issue had come to receive some policy attention in each, but the extent differed markedly across the four. In

Bangladesh and Nepal, newborn survival had emerged as a health priority. In Bangladesh, the government had in place a national strategy specifically for newborn survival, enacted in 2010 (Government of Bangladesh 2009b). Child mortality reduction, including neonatal survival, was discussed at cabinet meetings (I-B12). The government's forthcoming health sector development program for 2011-2016 includes newborn care as a key component, and requests $417 million for a maternal, neonatal and child services operational plan, second highest among the 31 such plans in the health sector program (Government of Bangladesh 2010). In 2000 the government had no specific neonatal mortality reduction aims; in this latest plan newborn survival is one of the core priorities, with an objective of reducing neonatal mortality to 21 per 1000 births by year the 2016 (Government of Bangladesh 2010). In addition, in collaboration with government, major donors including the United States Agency for International Development (USAID) and the Australian Agency for International Development (Ausaid) were providing nearly $100 million for programs that included neonatal mortality reduction aims (Shiffman and Sultana 2011).

In Nepal, with the support of the Prime Minister and the country's commitment to achieving the child survival MDG, the issue rose early in the decade from a position of obscurity under the umbrellas of maternal and broader child survival initiatives to one of relative prominence. In 2004, Nepal enacted a national neonatal health strategy (Ministry of Health, His Majesty's Government of Nepal 2004b), the first low-income country to do so. Former first lady, prominent safe motherhood advocate and current member of Nepal's Constituent Assembly Arzu Deuba has used her status to give voice to newborn issues since 2001, including incorporating maternal and newborn health as a priority in her political party's (Nepali Congress Party)

platform (I-N1; I-N9; I-N17). In late-2008 a former State Health and Population Minister was drafting a law to support maternal and newborn health care (I-N17). And, by 2010 the government and development partners were piloting a community-based newborn care package in ten of 75 districts, with plans for nationwide scale-up (I-N2).

Priority levels in both countries should not be over-stated: attention is confined predominantly to the health sector and health organizations have yet to scale-up programs nationally. Nevertheless, Bangladesh and Nepal have become two of the few low-income countries where neonatal survival has come to occupy a prominent place on the health agenda.

In Bolivia and Malawi, the situation by the end of the decade was less certain. In Bolivia neonatal survival received specific policy attention with the initiation of neonatal integrated management of childhood illness (IMCI) programs in 2002 and 2004 (Ministerio de Salud y Deportes 2004a, 2005). Later in the decade, the government developed policy documents including neonatal survival aims, including national strategic plans to improve maternal, perinatal and neonatal health for the periods 2004-8 and 2009-2015 (Ministerio de Salud y Deportes 2004b; Estado Plurinacional de Bolivia 2009). However, since 2006, the government's focus has moved toward a broader social development agenda, shifting the health ministry's focus toward nutrition, and away from more specific vulnerable groups such as the newborn (Tapia 2010; World Bank 2009; I-Bo12).

In Malawi, in 2007 the government enacted a policy document with newborn survival aims, entitled the *Road Map for Accelerating the Reduction of Maternal and Newborn Mortality and*

Morbidity – the first Sub-Saharan African country to adopt such a national program (Ministry of Health, Republic of Malawi 2005). The Road Map itself was integrated into the cornerstone of Malawi national health policy - a Sector Wide Approach (SWAp) - which seeks to harmonize national health development efforts and integrate government and donor work (Republic of Malawi 2008). Newborn survival is included in the SWAp's essential health package, a set of health services intended to address the country's most acute health problems. This being said, as of 2009, with the exception of a small policy community concerned with reproductive health issues and several units in the Ministry of Health, few senior officials in government or the donor community gave the issue much notice (I-M10; I-M22). Moreover, it is unclear just how much difference these national policy documents are making in altering the priorities of a health sector facing severe human resource problems (Mueller et al. 2008; I-M6; I-M17).

Eleven factors, each identified in previous research on public policy agenda setting, shaped the degree to which newborn survival emerged on national policy agendas of these four countries (table 2). These are divided into three categories: transnational influences, domestic advocacy, and the national political environment.

Transnational influences

It was a group of international advocates and organizations that first put newborn survival on the global agenda. They used several mechanisms to influence national political systems to embrace the cause.

Norm promotion. International relations scholars, particularly those who emphasize the role of ideational factors in politics, argue that countries form their policy preferences not simply

through national political processes, but also through participation in the international political arena, which helps shape societal norms and therefore policy preferences (Keck and Sikkink 1998; Finnemore 1996). For instance, the World Bank and other development agencies teach governments to believe that it is appropriate that they should have national AIDS commissions. Ministers of Health meet at World Health Organization-sponsored events and exchange ideas on how best to address communicable disease outbreaks. UN member states collectively agree on development goals and compete with one another to achieve these.

International norms were an influential force in the decisions of countries to address newborn survival. The most powerful mechanism was MDG 4, the child survival millennium development goal. UN member states unanimously agreed to the MDGs in 2000, giving these goals considerable moral authority. MDG 4 contributed to the establishment of a global expectation that states act to ensure that children do not die (Fukuda-Parr and Hulme 2011). As evidence emerged that newborn mortality comprised more than 40% of child mortality, a newborn survival norm emerged – an expectation that state obligations extend to the protection of the lives of newborn babies (Shiffman 2010).

Several pieces of evidence indicate that the four countries were swayed to act on child and newborn mortality in part due to MDG 4. In Bangladesh the government set up a national task force on the child and maternal survival MDGs, chaired by the Secretary of the Ministry of Health and Family Welfare (Saving Newborn Lives 2007); ministers discussed the child survival MDG at weekly inter-ministerial meetings with the Prime Minister (I-Ba12); achieving the health MDGs became one of the pillars of the government's health program for 2003-2011

(Government of Bangladesh 2009a); and its national poverty reduction strategy placed great emphasis on the child survival MDG (Local Consultative Groups Bangladesh 2005). Nepal invoked MDG 4 in its national neonatal health strategy and in its national health plan for 2004 to 2009 (Ministry of Health, His Majesty's Government of Nepal 2004a, 2004b). Nepali politicians have been motivated to act because the country is poised, like Bangladesh, to become one of the few to achieve MDG 4 (I-N7; I-N11). The government of Malawi publicly declared its commitment to the MDGs. The Road Map invokes MDG goals, as do several other child survival initiatives in the country, including an Accelerated Child Survival and Development program and IMCI (Ministry of Health, Community Health Sciences Section 2007; Ministry of Health, National IMCI Unit 2006). The Bolivian government committed to the MDGs in 2000, and this commitment influenced health ministers to support development of neonatal IMCI (I-Bo12). The maternal and child survival MDGs are noted in national plans addressing maternal and newborn health (Ministerio de Salud y Deportes 2004b; Estado Plurinacional de Bolivia 2009). Health officials also connect Bolivia's commitments to the MDGs with the country's health insurance plans and other strategies introduced in the 2000s (Ramos 2005; Tapia 2010).

Another influence on a global newborn survival norm was the formation of the Saving Newborn Lives program of Save the Children USA. The program was the brainchild of Save the Children USA health leaders (I-G3; I-G8). Influenced by data showing high rates and slow decline in global neonatal mortality levels, as well as research by Indian physician Abhay Bang on the effectiveness of home-based neonatal care delivered by village women (Bang et al. 1999), Save the Children officials approached the Gates Foundation in 2000 with an idea for a global newborn survival program (I-G3; I-G8). Foundation officials responded enthusiastically,

attracted by the possibility of rapid declines in mortality through low-cost interventions (I-G8). Within the year the foundation funded Save's six-page proposal for $50 million over five years (I-G3; I-G8). By 2002 SNL had established programs in each of the four countries considered here. Across time, SNL evolved into far more than a program: it was recognized as an agent of diffusion of the idea that the world had a responsibility to save the lives of newborn babies (I-G12; I-G14; I-G18; I-G26).

Of equal importance to global norm-setting for newborn survival was the formation of an informal network of health professionals in the first half of the 2000s, which exercised global leadership on the issue alongside SNL (I-G5; I-G10; I-G15; I-G25; I-G31). The network's core consisted of no more than 15 individuals from international research, donor, NGO and UN agencies. These individuals were well positioned to exercise agenda-setting power in global health: most had established reputations in the specialties of child and maternal survival, and worked at prominent global health organizations, including UN agencies and major research institutions with access to financial and technical resources (I-G10; I-G15; I-G18; I-G31). These individuals had no formal mechanisms for coordination, and did not explicitly refer to themselves as a network. However, they functioned as one, meeting frequently at international gatherings and collaborating on projects. At least one of the core members stood behind nearly all major global initiatives for newborn survival across the decade.

A 2005 neonatal survival series in the medical journal *The Lancet* solidified many of the ties that now exist between these individuals, and also served to advance a global newborn survival norm (I-G18; I-G22; I-G28). The series became a point of reference on the severity, causes, costing

and solutions to the problem of newborn mortality (I-G6; I-G12; I-G18; I-G19;I-G22), and had a substantial influence on national policies. For instance, after its publication, at least 20 African governments approached WHO for technical advice on addressing the issue (Lawn et al. 2006), and the series was a major factor behind UNICEF's decision to engage newborn survival (I-G17; I-G20).

In addition, other actors with norm setting influence stepped up their engagement with newborn health across the decade. In the early 2000s SNL sought to formalize an alliance of organizations with an interest in newborn survival, helping to create and becoming the secretariat for the Healthy Newborn Partnership (I-G5), which lasted until 2005 when it was disbanded in favor of a broader Partnership for Maternal, Newborn and Child Health. The latter partnership grew to link 300 organizations in efforts to address the health problems of these vulnerable groups (Partnership for Maternal, Newborn and Child Health 2011). UNICEF hired neonatal survival specialists at its global headquarters, and country offices initiated programs with a newborn focus (I-G17; I-G20). The World Health Organization's flagship publication, the World Health Report, focused on maternal, newborn and child health in 2005 (World Health Organization 2005), and its 2008-2013 strategic plan includes an explicit objective on newborn survival (World Health Organization 2008).

Resource provision. International relations scholars have identified several other forms of transnational influence on the policy preferences of countries (Stone 1999). One mechanism is compulsion, such as the leverage the International Monetary Fund wields when it threatens to deny loans to countries that face severe financial crises if they do not adopt structural adjustment

programs. Another mechanism is resource provision: the enticement of financial and technical assistance from the International Monetary Fund and other organizations to governments if they agree to adopt particular priorities and policies.

Compulsion does not seem to have been at work with respect to newborn survival. The enticement of financial and technical resources, however, did shape the behavior of these four countries and provided material backing for the norm-promotion efforts of international actors. Globally, from the late 1980s USAID funded several global maternal and child health programs that included improvement in newborn health as a goal, including MotherCare (1989 to 2000), BASICS (1994 to 2009), ACCESS (2004 to 2010), and MCHIP, which integrated and replaced BASICS and ACCESS (2008 to the present) (Maternal and Child Health Integrated Program, undated). The first major donor grant for newborn survival specifically was from the Gates Foundation for the establishment of SNL - $50 million in 2000 to start the program, and an additional $60 million for the period 2006-2011. In addition, the Foundation has offered at least five other grants of over $25 million to other organizations for programs with major neonatal mortality components (Bill and Melinda Gates Foundation 2010). In 2009, a global health financing task force announced $5.3 billion in commitments for maternal, newborn and child health (Taskforce 2009). At their 2010 summit in Canada G8 leaders committed $5 billion over five years for maternal and child health (Kaiser Foundation 2010). In September 2010 the UN Secretary-General announced a global strategy for maternal and child health, backed by $40 billion in commitments, although it is unclear what portion were new pledges and how much will actually be dispersed (United Nations 2010).

Financial and technical resources from global actors made their way to these four countries. In Bangladesh, in 2006 USAID began a $15 million program to promote home and community-

based care in four upazilas in Sylhet district (Riggs-Perla et al. 2008). The focus was on training a cadre of women, each serving approximately 1000 households, in basic maternal and newborn care (ACCESS Bangladesh 2011). In 2007, the domestic NGO BRAC began a maternal, neonatal and child health project covering a population of 8 million in urban slums, with $25 million in funding from the Gates Foundation (BRAC 2009; I-Ba2). Three maternal, newborn and child survival programs, in 15 of Bangladesh's 64 districts, involved UNICEF: a $16.5 million project funded by Ausaid that linked UNICEF and the government; a $24 million program, also funded by Ausaid, carried out by UNICEF, BRAC and the government (Ausaid Bangladesh 2011); and a $31 million project funded by the United Kingdom and European Commission, linking UNICEF with two other UN agencies: the World Health Organization (WHO) and the United Nations Population Fund (UNFPA) (UNICEF Bangladesh 2007).

In Malawi, a newborn health program for 2006-2011, carried out by Save the Children USA, was funded with $2.5 million from USAID and $833,000 from SNL (Save the Children 2007). For fiscal year 2010 alone the Obama administration's global health initiative provided $6 million for maternal, newborn and child health to the country (Michaud and Kates 2011).

In Nepal, USAID is one of the largest health sector donors, (USAID Nepal 2011) with significant support going to maternal, child and newborn health ($7.4 million US in 2008) (USAID 2008, 2010b). Between 2006 and 2009, the USAID-funded initiative entitled Nepal Family Health Program II contributed to an increase in postpartum/newborn visits within three days of birth by 33 percent (USAID 2010a). USAID, UNICEF, Ausaid, the German Agency for Development (GTZ), Save the Children and other partners are currently providing financial and technical assistance to Nepal's government to promote and evaluate Nepal's Community-based Newborn Care Package to reduce child mortality (USAID 2010b; UNICEF undated). Between

2001 and 2010, SNL advocated for and provided technical assistance to the government to develop a national neonatal health strategy and increase attention to newborn health in its maternal and child health programming. Additionally, SNL has supported research on effective interventions, including the Morang Innovative Neonatal Intervention (MINI) project, has helped with curriculum development for health professionals, and has educated policymakers, media representatives and the public on the problem.

USAID has long been a major supporter of maternal and child survival work in Bolivia. In 2008 alone it allocated US$ 6.5 million to support child survival and maternal health in the country (USAID 2008). PAHO/WHO (Pan American Health Organization/World Health Organization) has provided significant technical support to Bolivia, including supervision and monitoring of clinical neonatal IMCI implementation (PAHO 2011b) and training for maternal and newborn health professionals in partnership with USAID (PAHO 2004, 2011a). In addition to providing technical support to the health ministry and bringing together a network of international organizations (including Pan American Health Organization, UNICEF, the World Bank and USAID) to advocate for newborn survival, Saving Newborn Lives Bolivia supported the domestic NGO network PROCOSI with approximately US $1.1 million to plan and coordinate promotion of Essential Newborn Care education, training and research in its first phase (Saving Newborn Lives 2005; PROCOSI 2006) and research into appropriate and cost-effective postnatal care interventions in its second phase. In 2009, PAHO, FCI, USAID, Save the Children, UNICEF, UNFPA and Bolivia's Safe Motherhood and Birth Mesa among others provided technical support to the health ministry to formulate and launch *The National Strategic Plan to Improve Maternal, Perinatal and Neonatal Health in Bolivia 2009-2015*. (Estado Plurinacional de Bolivia 2009; I-Bo12).

Domestic advocacy

Transnational actors brought the issue of newborn survival to the global agenda and helped facilitate national-level attention, but they could not advance attention in national political systems on their own. National adoption and sustainability required domestic advocacy.

Political entrepreneurship. Public policy scholars have found that individuals can shape policy agendas (Kingdon 1984). Not just any person can play such a role, however. Research has shown that effective political entrepreneurs possess certain features: they are knowledgeable about the issue, they are persistent, they have excellent coalition-building skills, they articulate vision amid complexity, they have a credibility that facilitates the generation of resources, they generate commitment by appealing to important social values, they are aware of the critical challenges in their environments, they infuse colleagues and subordinates with a sense of mission, and they are strong in rhetorical skills (Doig and Hargrove 1987).

Political entrepreneurs were particularly influential in Nepal and Bangladesh. In Nepal in the early 2000s the doctor leading SNL - a Nepali national - brought neonatal survival issues to the fore in safe motherhood meetings (I-N8; I-N17). She also helped give the problem national attention by producing the *State of the World's Newborns: Nepal* report, launched by the Prime Minister in 2001 (I-N17; Saving Newborn Lives 2002a). Subsequently, the directors of the Family and Child Health divisions under the Ministry of Health led efforts to develop Nepal's first national neonatal health strategy between 2002 and 2004 (I-N17; I-N25). One of these directors also guided an influential assessment of neonatal health and programs in the country (Department of Health Services, Government of Nepal & Save the Children 2007) and

championed a community-based newborn care package piloted in 2009 (I-N2; I-N15; I-N17; I-N25; I-N26; I-N27). In Bangladesh, SNL's first program director, a Bangladeshi physician, emerged as the country's foremost newborn survival champion, effectively cultivating government, donor and civil society attention for the issue. Among other activities (I-Ba3; I-Ba7; I-Ba10; I-Ba14; I-Ba26), she co-wrote a 2001 report on the state of newborns in Bangladesh that first brought national attention to the issue (Saving Newborn Lives 2001b), organized a working group on newborn survival, facilitated the creation and government adoption of a module on essential newborn care, and was behind a 2003 focusing event (see below) that led for the first time to the inclusion of a newborn survival target in the national health plan (Lawn, Sines and Bell 2004). In Bolivia, the SNL head also was influential (I-Bo1; I-Bo2; I-Bo3; I-Bo14), facilitating national attention for the issue in the early 2000s by creating a report on the state of newborns in the country (Saving Newborn Lies 2002b), and recruiting the First Lady and the health minister to participate in the report's launch (I-Bo12). In Malawi, too, capable actors have promoted newborn survival, but in contrast to Bangladesh, Bolivia and Nepal, no individual ever emerged as an acknowledged entrepreneur on the issue (I-M3; I-M12; I-M20; I-M22).

Policy community cohesion. Political scientists have argued that the membership and structure of policy communities shape how successful they will be in influencing national priorities (Kingdon 1984; Sabatier 1998). Policy communities are networks of actors from different types of organizations—government agencies, legislatures, NGOs, donor agencies and others—in regular contact who work together to promote common causes. Among the factors that shape their degree of influence are their levels of moral authority, knowledge, and coherence (Haas 1992).

Prior to 2000 none of the four countries had newborn survival policy communities. By the end of the decade three of the four did; however, these varied in levels of cohesion and capacity to influence government. In Bangladesh a policy community emerged in the early 2000s from the newborn survival working group organized by the Bangladeshi physician (Saving Newborn Lives 2001a; I-Ba 7; I-Ba 14). Among its most active members were four prominent professors, associated with medical associations that had an interest in newborn survival (I-Ba7; I-Ba14; I-Ba17; I-Ba21; I-Ba22). Members of this policy community stood behind almost all major newborn survival developments in the country, including the creation of the government-endorsed National Neonatal Survival Strategy in 2009.

In Nepal, prior to 2001 newborn health and survival largely fell under the umbrella of a safe motherhood policy community (I-N2; I-N5; I-N9; I-N10; I-N13; I-N17; I-N25). In the early 2000s, some individuals, including health ministry representatives, Nepali researchers and international agency representatives, became concerned that little attention was being paid to the neonate, and called for action to address this omission (I-N3; I-N4; I-N5; I-N6; I-N8; I-N13; I-N17; I-N25). They succeeded in developing a national newborn health strategy in 2004, and backed the community-based newborn care package piloted in 2009 (I-N2; I-N10; I-N17; I-N27).

In Bolivia in the early 2000s a network of actors – mostly health experts specializing in neonatology, pediatrics and maternal health – began to coordinate to address Bolivia's neonatal mortality problems (I-Bo7; I-Bo13). With the support of SNL they formed the Neonatal

Alliance in 2002 to give more specialized attention to newborn issues than an existent safe motherhood board offered (Neonatal Alliance 2002; I-Bo4; I-Bo12; I-Bo13). They helped to shape neonatal IMCI programming in the country (Saving Newborn Lives 2005; I-Bo 1; I-Bo4; I-Bo7; I-Bo9; I-Bo12; I-Bo13). Mid-decade the Alliance merged with the Safe Motherhood Board. To date the balance of attention in this forum has gone toward maternal rather than newborn health and some newborn health advocates have stopped participating (I-Bo3; I-Bo4; I-Bo9; I-Bo10; I-Bo12; I-Bo13; I-Bo14; I-Bo25).

In Malawi a number of organizations have addressed newborn survival, including the Ministry of Health's Reproductive Health unit, UNICEF, Save the Children, USAID and several civil society organizations. Within these organizations at least one person has considered newborn survival to be part of his or her portfolio of responsibilities. However, these individuals rarely coordinate, and only a handful identify the newborn to be their sole focus (I-M 1; I-M 3; I-M 6; I-M 7; I-M 8; I-M 11; I-M 12; I-M 15; I-M 16; I-M 17; I-M 18; I-M 19; I-M 20; I-M 22). In contrast to Bangladesh, Nepal and Bolivia, it is unclear whether a policy community for newborn survival has ever existed in Malawi.

Focusing events. Focusing events - large-scale happenings such as conferences, crises, and discoveries that attract notice from wide audiences - also have agenda-setting power (Birkland 1997). They bring visibility to hidden issues. Birkland has demonstrated that disasters, including hurricanes, earthquakes, oil spills and nuclear power plant accidents lead to heavy media coverage, interest group mobilization, policy community interest, and policy-maker attention, causing shifts in national issue agendas.

Focusing events influenced newborn survival attention in Bangladesh, Bolivia and Nepal. As noted above, SNL heads produced 'State of the Newborn' reports for their countries in the early 2000s, launched with much fanfare[6] (Saving Newborn Lives 2001b; Saving Newborn Lives 2002a; Saving Newborn Lives 2002b): in the case of Nepal by the Prime Minister, in Bolivia with the support of the First Lady and Minister of Health, and in Bangladesh by the Minister of Health and Family Welfare. Each event attracted considerable media attention.

A 2003 focusing event in Bangladesh had even greater impact than the launch of the report. At the suggestion of the SNL Bangladesh head, the Healthy Newborn Partnership - a global network of organizations concerned with newborn survival - convened a meeting in Dhaka (I-Ba14). Opened by the Minister for Health and Family Welfare, the meeting brought together 31 donors and non-governmental organizations. It was held concurrently with the first international Bangladeshi Perinatal Congress, attended by more than 500 physicians and health professionals from Bangladesh and other countries (Dhaka Declaration 2003). The coincidence of these two meetings enabled global health professionals to interact with domestic neonatologists, obstetricians and other physicians (Lawn, Sines and Bell 2004). At the conclusion of these meetings, the Secretary of the Ministry for Health and Family Welfare chaired a policy session that resulted in the 'Dhaka Declaration for Global Newborn Health,' calling for enhanced national and global attention to newborn survival (Saving Newborn Lives undated). A month thereafter in follow-up to these forums, the Bangladesh Perinatal Society, supported by SNL, convened a workshop involving the Secretary on incorporating newborn care in the national health plan. These meetings had concrete effects. Most significantly, the Ministry of Health and

[6] SNL also produced a report for Malawi but it is unclear how much attention its release generated.

Family Welfare for the first time added a newborn survival target in its national health plan: to reduce neonatal mortality from 42 to 32 by mid-2006 (Government of Bangladesh 2006).

Credible indicators. Agenda-setting scholars have demonstrated that among the factors that shape whether an issue rises to the attention of policymakers is the presence of a clear indicator to highlight the issue (Kingdon 1984; Walker 1974). These make a difference because they have the uniquely powerful effect of giving visibility to that which has remained hidden, serving not just monitoring purposes, the way they are traditionally understood, but also as catalysts that may provoke political elites to act. Where no such indicators are available, policymakers may ignore the issue either because they are unaware of the existence of a problem or are unconvinced in the absence of evidence that any problem exists.

Data from USAID-funded demographic and health (DHS) and other surveys alerted international and government officials in all four countries to the severity of the problem. Data from the Bangladesh 1999-2000 DHS (NIPORT et al. 2001) first made national health policy-makers aware of the problem (I-Ba7), revealing a neonatal mortality rate of 42 per 1000 births, comprising two-thirds of infant mortality. The 2004 DHS showed the persistence of high neonatal mortality (41 per 1000) (NIPORT et al. 2005), causing concern among health officials.

Bolivia's 1998 DHS provided the first credible indicators on the severity of the problem in that country (34 per 1000) (Ministerio de Salud y Deportes et al. 2009). These indicators combined with other domestic research concerning the nature of the problem to influence health ministry officials to adopt clinical and community-based neonatal integrated management of child illness

(IMCI) programs in 2002 and 2004 respectively (I-Bo3; I-Bo4; I-Bo7; I-Bo9; I-Bo10; I-Bo13; I-Bo14). Its high neonatal mortality compared to other countries in the Latin American and Caribbean region (lower only than Haiti's), and no change in the rate from the 2003 to the 2008 DHS, caused consternation among health officials and influenced a national health strategy that included neonatal survival (Estado Plurinacional de Bolivia 2009).

The Malawi 2004 DHS found a lower than expected rate of 27 per 1000, which represented only 21% of under-five deaths – a pattern atypical of Sub-Saharan Africa where the average is 25% (Save the Children 2007). In response (Save the Children 2007) Save the Children contributed financial resources to a 2006 multi-indicator cluster survey (National Statistical Office and UNICEF 2008), which found a figure of 33, confirming that neonatal mortality represented a significant portion of under-five mortality in the country - 26% - and helping to combat government complacency.

In Nepal, data from the 2006 DHS revealed that neonatal mortality had risen from 61 to 69 percent of infant mortality and from 43 to 54 percent of child mortality since a 2001 survey, a finding that was a spur for government action (Department of Health Services, Government of Nepal and Save the Children 2007; Saving Newborn Lives 2002a; I-N1; I-N2; I-N5; I-N10; I-N11; I-N13; I-N14; I-N15; I-N25; I-N29).

Clear policy alternatives. Agenda-setting researchers have found that policymakers are more likely to act on an issue if they are presented with clear proposals involving proven interventions that convince them that a problem is surmountable (Kingdon 1984; Sabatier 1998). If policy

communities have not generated clear and widely accepted proposals, policymakers are unlikely to pay attention to their concerns, because political elites prefer to allocate resources toward problems they believe can be effectively addressed.

The generation of convincing policy alternatives and evidence surrounding effective interventions shaped priority for the issue in all four countries. From the 1970s through the 1990s the few individuals in low-income countries who focused on newborn survival faced an environment unsympathetic to the idea that very sick newborn babies in poor countries could be saved (I-G18; I-G31). These attitudes started to shift as medical professionals became aware of the work of Indian physician, Abhay Bang. With colleagues, he had shown the effectiveness of home-based neonatal care delivered by village women, demonstrating in a controlled study a 25% decline in neonatal mortality in a treatment area, research published in *the Lancet* in 1999 (Bang et al. 1999).

Bang's research influenced policy-maker perceptions in Bangladesh, Malawi and Nepal. In Bangladesh the SNL program head introduced health ministry and other officials to Bang's work in 2001, at a meeting on preliminary results from a national assessment of newborn survival (I-Ba26). SNL organized several visits from 2002 on to Gadchiroli district in Maharashtra, India where Bang worked. Among those who witnessed the program were the Director-General of Health Services at the time and the President of the Bangladesh Neonatal Forum, who subsequently spread the word among Bangladeshi health officials on the possibility for making progress on newborn survival through community-based interventions (I-Ba7; I-Ba14). In Malawi, in 2006 UNICEF sponsored a study tour in India for Ministry of Health policy-makers,

where they viewed Bang's projects in Maharashtra (I-M6, I-M9, I-M12, I-M18). Save the Children subsequently supported a design workshop, in partnership with the Ministry of Health and UNICEF, that drew on Bang's work to develop a package of interventions tailored to the Malawian context. In Nepal, Bang's studies influenced health officials to consider scaling-up community-based care (I-N7; I-N9; I-N10; I-N26). However, in that country, as elsewhere, debates persist among newborn survival proponents concerning the relative merits of facility and community-based intervention strategies (I-N2; I-N7; I-N9; I-N10; I-N14; I-N15; I-N16; I-N17; I-N26; I-N27).

Domestic research also had influence on policy-maker perceptions of tractability surrounding community-based care. In Bangladesh, a study begun in 2002 in Sylhet district involved female community health workers identifying pregnant women, providing pre and post-natal home visits, and referring and treating sick newborns. These interventions produced a 34 percent decline in neonatal mortality in the treatment area in the last six months of the research (Baqui et al. 2008). Rather than work in isolation, designers of the project reached out to government decision-makers from its inception to ensure they would embrace its results (I-Ba11). The results convinced USAID to begin a $15 million dollar neonatal survival project in 2006 (I-Ba20), and formed a cornerstone for the government-endorsed 2009 National Neonatal Health Strategy (Government of Bangladesh 2009b). In Nepal, evidence from research conducted by Maternal and Infant Research Activities (MIRA) and the Morang Innovative Neonatal Intervention (MINI) project contributed to a decision to pilot a community-based newborn care package in 10 districts in 2009 (I-N2; I-N27).

Prior success with child survival policy alternatives also influenced strategies in Bolivia and Nepal. In Bolivia, under-5 IMCI programs initiated in the late 1990s provided the framework for introducing clinical and community-based neonatal IMCI programs in the early 2000s (ACCESS Program Community Mobilization Working Group 2007; I-Bo3; I-Bo4; I-Bo7; I-Bo13). Nepal's community-based newborn care package gained support in large measure because of the nation's record of successful community-based child survival programs, particularly with female community health volunteers (I-N2; I-N17).

Guiding institutions. Strong guiding institutions - organizations or coordinating mechanisms with a mandate to oversee an initiative - are also crucial. Initiatives might start through informal associations or as projects inside formal organizations, but they must build their own enduring institutions if they are to survive (McAdam, McCarthy and Zald 1996). For instance, national AIDS commissions have exercised strong national leadership on this disease in many countries.

Among the four countries, only in Nepal did strong guiding institutions emerge in government for newborn survival. The Family Health Division in the Ministry of Health's Department of Health Services was instrumental in elevating the status of the issue in the early 2000s (I-N6; I-N17). With the move of an influential leader of that division to the Child Health Division mid-decade, and with growing support for community-based neonatal health programs, the latter institution has since taken the lead (I-N1; I-N2; I-N17; I-N26; I-N27). In Bangladesh, leadership on the issue near the end of the decade sat with a subset of the policy community – six individuals from SNL, professional medical associations, UN agencies and the government's IMCI unit – who regularly met behind the scenes to plan national newborn survival strategy (I-

Ba11; I-Ba15; I-Ba23). The government faced difficulties in exercising effective leadership, as control of the issue of newborn survival was fragmented, with at least three units in the Ministry of Health and Family Welfare claiming some authority (I-Ba4; I-Ba6; I-Ba9). In Malawi the lead entity for newborn survival in government has been the Reproductive Health Unit of the Ministry of Health; however, resource constraints have prevented it from exercising effective coordination among the several organizations working on newborn survival in the country (I-M3; I-M12; I-M20). Moreover, no other organization or set of organizations have emerged to serve a coordinating role. In Bolivia, the Ministry of Health exercised effective leadership in the early 2000s when it introduced neonatal IMCI programming (Ministerio de Salud y Deportes 2004a, 2005). Since 2006, however, the ministry's attention has turned to broader social development issues, and actors are concerned that newborn health is getting lost among the ministry's many child health responsibilities (Tapia 2010; World Bank 2009; I-Bo3; I-Bo9; I-Bo12; I-Bo26). In all four countries – even Nepal – it has not always been clear just which unit in the Ministry of Health should exercise leadership. Tensions have existed between units oriented toward child health and those concerned with maternal/reproductive health, a function, perhaps, of the fact that the issue of newborn survival connects to each.

Civil society mobilization. Social movement scholars have shown that initiatives are more likely to generate political support if they link with grassroots organizations in civil society that are pushing for attention to the issue, rather than remaining confined to select members of a policy community (Tarrow 1998). Pressure from grassroots AIDS activists on national governments and international organizations, for instance, has helped to increase donor aid and government efforts to address the disease in developing countries (Harris and Siplon 2007).

In none of the four countries is there strong evidence that civil society pressure played a large role in generating the policy attention that emerged for newborn survival, perhaps helping to explain limits to the level of priority the issue has received. The individuals and organizations pushing for attention were well-situated elites – doctors, other medical professionals and officials working in donor agencies, government ministries, parliaments, UN agencies, and large international and national NGOs – rather than grassroots civil society organizations or community activists. This pattern of elite-directed advocacy is typical for most health issues in low-income countries; grassroots AIDS activism is an exception.

It may be that grassroots mobilization is limited by the fact that many communities do not yet view newborn deaths as a pressing concern for government action. One theme that emerged from a study of social and behavioral practices surrounding the newborn in Malawi was a sense of fatalism and inevitability concerning newborn deaths (Waltensperger 2001). As interviewees in Malawi put it:

> Culturally, the newborns are not treated as another human being…. The neonate is not talked about or treated as people, the way a one-year old or two-year old is…When a neonatal death has occurred in the village, it is not considered as a death (I-M3).
>
> Most communities think [the] death is acceptable because that is how God has made it…this is the will of God (I-M1).
>
> The tendency is not to name babies until two to six weeks because parents are afraid that the baby will die. We would rather if they die [they do so] without a name: it is not as painful (I-M8).
>
> The culture says the newborn is a thing and not a human being. Even the death of a newborn is not something that will make the community go crying…it is like it was born and just passed (I-M1).
>
> Even the term 'kupita padera' it's like you haven't yielded anything at all…when a newborn dies (I-M2).

National political environment

The quality of political advocacy by international and national organizations and advocates influenced the degree to which newborn survival received policy attention. The political and social environments in which these advocates work and over which they have little control also shaped policy attention. Many such factors were influential, including cultural barriers, weak administrative infrastructures, and endemic corruption. Two factors, however, were particularly critical in health agenda-setting: political transitions and existing health priorities.

Political transitions. Political scientists have found that major political transitions and reforms such as democratization and regime change alter public priorities by giving new actors agenda-setting power, and by changing the processes by which public policies are made and implemented (Linz and Stepan 1996; Cheema and Rondinelli 1993). The same reform may have the opposite effect on the prioritization of any given issue, depending on the context. For instance, democratization may raise prospects for attention to an issue if there is widespread concern about the problem, and hamper attention if that existed only because authoritarian leaders were imposing their policy priorities on society.

Political transitions shaped newborn survival prospects in each of the four countries. In Bolivia, the election in late 2005 of the populist Evo Morales as the country's first indigenous president ushered in a new approach to social development that emphasized broad sectoral initiatives at the expense of programs targeting specific populations (such as neonates) (Tapia 2010; World Bank 2009; I-Bo9; I-Bo12; I-Bo25; I-Bo26). Newborn survival advocates were caught off guard, and national attention to the issue has suffered under his regime (I-Bo9; I-Bo12; I-Bo26). In Nepal, armed conflict between the central government in Kathmandu and Maoist forces occupying

much of the country's rural terrain limited policy attention to the capital through 2006, and placed strains on the rural health infrastructure needed to take newborn survival initiatives to scale (Singh 2004). The Maoist party's commitments to advancing social policy and a politically engaged public could offer opportunities to further newborn survival on the policy agenda (I-N25; I-N26). In Bangladesh bitter political rivalry between the Bangladesh National Party and the Awami League has created problems for policy continuity: newborn survival proponents have had to educate new civil servants and politicians about the issue each time a new government has come to power, and enactment of a national neonatal health strategy was delayed due to a regime transition (Saving Newborn Lives 2008; I-Ba5; I-Ba7). In Malawi, multi-party democracy returned to the country in 1993 after three decades of single party rule under Dr. Hastings Banda (Patel and Svasand 2007). The opening forced ruling parties to be more attentive to social concerns and enabled civil society organizations, formerly banned or severely restricted under the one-party regime, to proliferate. It is conceivable now, as it was not a decade and a half ago, that robust civil society organizations could emerge that press the government to act on reproductive and child health issues, including newborn survival.

Existing health priorities. New health issues do not appear in a vacuum but rather amidst an already existing set of priorities. Most health sectors in developing countries are strapped for resources, and health causes must compete against one another for scarce funding. A particular health issue may lose out if there are too many problems vying for limited resources, and its advocates are unable to make a convincing case concerning its importance. On the other hand, if the health issue is congruent with existing priorities, its proponents may be able to take advantage of this situation and graft attention on to policies and institutions already in place.

In all four countries proponents were able to take advantage of existent attention to child and maternal health to advance newborn survival, but in some cases they were hampered in their promotional efforts by other health policy priorities. Nepal's community-based newborn care package gained support in large part because of the nation's record of successful community-based child survival programs, and the country's long-standing commitment to reducing child mortality (I-N1; I-N2; I-N15; I-N17; I-N26). In the 1980s and 1990s the Bangladesh government, backed by donors, had built a strong infrastructure for addressing child survival, facilitating a decline in child mortality from 133 to 65 between 1991 and 2004 (NIPORT et al. 2009). Newborn survival proponents made use of this infrastructure and existent concern for child mortality reduction to promote their cause. They also secured the inclusion of newborn survival interventions in a national maternal health strategy, enacted in 2001 (Government of Bangladesh 2001).

Malawi had prioritized maternal mortality reduction since the early 2000s, facilitating the government's adoption in 2005 of the multi-year program entitled 'the Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Morbidity' (Ministry of Health, Republic Malawi 2005). On the other hand, AIDS, health systems strengthening and maternal mortality are higher priority health issues in the country (I-M9; I-M10; I-M14; I-M21), posing some barriers on the ability of newborn survival proponents to gain the attention of policy-makers. Since the late 1990s Bolivia had in place an IMCI program; newborn survival proponents were able to use this to introduce clinical and community-based neonatal IMCI programs in 2002 and 2004 respectively (Ministerio de Salud y Deportes 2004a, 2005; I-Bo1; I-

Bo3; I-Bo4; I-Bo7; I-Bo9; I-Bo12; I-Bo13). However, as noted above, the 2006 regime change in Bolivia brought other maternal and child health priorities to the fore – particularly malnutrition – displacing newborn survival.

Discussion

As of 2000 newborn survival received little policy attention among global health organizations and health sector actors in Bangladesh, Bolivia, Malawi and Nepal. By 2010, newborn survival had emerged as an issue of concern globally and in each of these countries, although the level of attention differed across the four. Eleven factors may stand behind this difference, and help explain how the issue became a global concern in the first place. *Transnational influences* (first category of factors) played a role in putting the issue on the agenda of global health organizations and influencing national governments to address the problem. MDG 4 helped advance a child survival norm (factor 1) - an expectation that states act to protect the lives of children - and as evidence accumulated on the contribution of neonatal mortality to overall child mortality, a newborn survival norm also appeared. The formation of Saving Newborn Lives and an informal global network of newborn survival champions, and the publication of a Lancet series on newborn survival, helped to advance this norm. Financial and technical resources and support to low-income countries (factor 2) followed, particularly from USAID, the Gates Foundation and SNL, but also the WHO and UNICEF.

However, these transnational influences were insufficient to spark policy attention within countries; that required *domestic advocacy* (second category of factors). National advocates achieved varying degrees of success in promoting the issue, and were most effective in

Bangladesh and Nepal. In those two countries effective political champions (factor 3) emerged, including SNL program heads in both countries, leaders of medical associations in Bangladesh and Ministry of Health officials in Nepal. They facilitated the creation of cohesive policy communities surrounding the issue (factor 4) - linking actors in the government, the donor community, UN agencies and the NGO sector - who pressed their respective governments to develop and adopt guidelines on newborn care, enact national policies, and scale-up programs. The champions and members of these policy communities organized focusing events (factor 5) – including launches of SNL-sponsored studies on the state of newborns – to attract political support, generate media attention and gain the notice of national health officials. They also made use of credible indicators (factor 6), particularly from demographic and health surveys, to impress upon health officials the extent to which neonatal mortality contributed to under-five deaths. Through clear policy alternatives (factor 7) that included internationally and domestically-generated evidence on the efficacy of home and community-based neonatal care, they convinced politicians and health officials that the problem was tractable. In both countries guiding institutions (factor 8) helped to support policy communities in advancing the issue and bringing together actors: in the case of Nepal the Divisions of Family and Child Health in the Ministry of Health; in the case of Bangladesh an informal network of six individuals linking SNL, UN agencies, the government and medical associations – a subset of the policy community. In neither country did grassroots civil society organizations (factor 9) play a major role in advancing attention for the issue, helping to explain why priority did not advance further than it did. Rather, well-situated health professionals were the drivers.

Advocates in both countries were obstructed and facilitated by their *national political environments* (third category of factors). Political transitions (factor 10) hampered attention in both: in the case of Nepal, civil war between the government and Maoists, and in the case of Bangladesh, transfers of power between two rival political parties – the Awami League and the Bangladesh National Party. Existing health priorities (factor 11), however, facilitated attention, as newborn survival advocates were able to graft their cause on to long-standing concerns in both for countries for child survival.

Deficiencies on a number of these factors in Bolivia and Malawi may help to explain why priority did not advance as far as it did in Bangladesh and Nepal. Newborn survival advocates in Bolivia and Malawi benefited from the norm-setting influences of MDG 4, financial and technical resources from donor agencies, the availability of international evidence on home and community-based care, and credible national survey data demonstrating the severity of the problem. However, in neither country did powerful actors emerge to push the cause: no strong political champions (although there were highly competent advocates and technical officials in both), no cohesive policy communities, and no national guiding institutions exercising leadership and coordination on the issue. Moreover, the issue suffered in both due to influences from the political environment: in Bolivia, the ascendance to power in 2006 of a populist regime with a broad social development agenda that emphasized nutrition as a health priority at the expense of a focus on vulnerable groups such as the newborn; in Malawi, a weak health sector that faced difficulties in translating national policy priorities into action on the ground, cultural fatalism surrounding the death of the newborn, and competing health priorities.

The case study selection strategy imposes limits on generalizability. As noted above, two criteria that guided the choices of cases were the presence of an SNL program, and initial evidence that policy attention had advanced further in these countries than in others in the same region. There may be systematic differences among SNL focal countries - such as a legacy of concern for child survival - that mean that framework factors may not have the same causal power in generating policy attention for newborn survival that they do elsewhere. Also, it would be reasonable to infer that policy attention has not advanced as far in comparable countries, particularly those without an SNL presence. This may have particular implications for Sub-Saharan Africa, where neonatal mortality rates are among the highest in the world (Rajaratnam et al. 2010; Black et al. 2010). Malawi has an SNL presence, has been recognized for effectiveness in child mortality reduction (Save the Children 2011), and was the first country in Sub-Saharan Africa to adopt a road map for accelerating maternal and newborn mortality reduction. If even in Malawi policy attention for newborn survival has not advanced far, then one might be wonder about the state of political attention for the issue elsewhere on the continent.[7]

Another limitation of this study is that it focuses predominantly on the agenda-setting and policy formulation stages of the public policy process rather than on implementation. The appearance of an issue on a national policy agenda is only one of multiple factors that stand behind policy effectiveness and is hardly enough to ensure that the political system will carry out plans or that these plans will be successful in reducing neonatal mortality. Implementation, like agenda setting, is a politically infused process, and implementation bottlenecks may emerge at all levels

[7] Preliminary data from the 2010 Malawi Demographic and Health Survey (National Statistical Office and Measure DHS 2011) indicate cause for concern: a neonatal mortality rate of 31 for 0 to 4 years preceding the survey – largely unchanged from figures earlier in the decade, including those reported in the 2004 Malawi Demographic and Health Survey.

of the system. The subject of implementation has received little attention in public health scholarship (Task Force on Health Systems Research 2004), and like agenda setting requires considerably more research.

The study's methodology also imposes limits on inferring causality. In-depth exploration of these countries facilitated the exploration of propositions on the determinants of policy attention. In the absence of additional comparative inquiry that could facilitate examination of alternative explanations, one cannot be certain that the factors identified were the primary forces at work. Moreover, it is difficult to assess the causal weight, necessity or sufficiency of the various factors.

This being said, one means of gaining analytical leverage in the absence of additional comparative inquiry is to consider counterfactuals. Without MDG 4 or an equivalent global agreement pressing nation-states to act on child survival, would priority have advanced as far as it did in Nepal and Bangladesh? If effective champions and policy communities had not emerged in those two countries, would newborn survival have gotten on the policy agenda? If no national surveys had measured neonatal mortality levels, and no evidence had appeared that simple interventions could save newborn lives, would politicians and health officials have been willing to act on the issue? Thinking of it on these terms, we could posit that no single factor was sufficient for policy attention, but that several may have been necessary: global norms and resources, entrepreneurs, credible indicators and clear policy alternatives.

If such an assessment is accurate, there are clear implications for newborn survival advocates who wish to ensure continued attention to the issue. First, with the MDG goals set for 2015, it may be critical to ensure that newborn survival has a place on whatever set of global development agreements emerge in the post-MDG era. If newborn survival has no place, donor priorities – notoriously fickle – may shift to other issues. Moreover, the governments of low-income countries with high neonatal mortality may lack the international incentives and resources necessary to keep the issue on domestic policy agendas. Second, domestic champions may be crucial. If states have yet to embrace the cause fully, the presence of national actors such as the former head of SNL in Bangladesh and the former chief of the Child Health Division in the Nepal Ministry of Health may be required to ensure that states continue to pay attention, and that policy communities remain cohesive and act as effective political forces. Third, credible indicators may be required. If national surveys stop measuring neonatal mortality and the uptake of newborn health interventions, government officials may lack the information necessary to keep them focused on an ongoing problem. Finally, evidence on effective policy alternatives may be crucial. The problem was formerly perceived to be insurmountable; now medical communities and policy-makers see it is potentially tractable. Should that perception shift again, they may come to think they are throwing resources at a problem that cannot be solved, and their enthusiasm to address it may diminish. In sum, the fate of newborn survival in the next decade may hinge in part on the extent to which its global and national proponents ensure that these central elements of the framework - global norm-setting agreements, entrepreneurs, credible indicators and clear policy alternatives - are kept in place where they already exist, and put in place where they have yet to appear.

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