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How do global health advocacy networks seek issue attention?

*The role of actor-power and communications in the
women's and children's health network during the
Millennium Development Goal era*

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Abstract

This dissertation aims to understand how global health advocacy networks seek issue attention. It focuses particularly on how network actors use communication campaigns to exercise power for that aim.

This study is guided by Shiffman and Smith's framework on the determinants of health policy prioritisation (2007). The framework proposes actor-power, ideas, political context, and issue characteristics as interdependent categories to analyse how and why certain health initiatives gather attention, and why others fail to gain priority.

To expand on Schiffman and Smith's framework, the thesis applies social theories concerned with competition and conflict to examine the role of network-led campaigns. Processes of power and competition among network actors offer rich scope for analysis. These are examined in this study through the integration of complementary theories from Sabatier and Bourdieu.

This study found that campaigns are both a driver and product of actor-power. Campaigns unite heterogeneous actors through the production of shared messages and normative claims; they promote visibility for network messages and goals; and they contribute to network growth and replication by linking actors across different scales, from local to global, and vice versa.

Therefore, greater attention to how network actors compete, negotiate and communicate through campaigns, and to how they acquire and use network capital at multiple scales, will enrich any future use of the Shiffman and Smith framework.

Qualitative methods in this thesis included historical process-tracing of network and campaign development; document analysis; and in-depth interviews with

network actors to reveal patterns of social relations. This was triangulated by longitudinal participant-observation methods.

Once revealed and examined, how network power is legitimated and held to account is an important question for the future study of the political determinants of global health priorities.

283 words

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Contents

<i>Abstract</i>	3
<i>Acknowledgements</i>	5
<i>List of Figures</i>	10
<i>List of Tables</i>	10
<i>List of Acronyms and Abbreviations</i>	11
Chapter 1: Introduction	13
1.1 Background	13
1.2 Research focus and approach	20
1.3 Research questions	25
1.4 Chapter overview	27
1.5 Contribution of author	31
<i>References</i>	32
Chapter 2: Literature review	37
2.1 Women's and children's health	37
2.2 Global health advocacy networks: emergence, characteristics and definitions	69
2.3 Networks and policymaking processes	79
2.4 Actor-power in global advocacy networks	87
2.5 Communication campaigns and global advocacy networks	96
2.6 Summary	105
<i>References</i>	106
Chapter 3: Methodology	131
3.1 Overview of methods	131
3.2 Linking methods to questions	143
3.3 Reflections as a researcher-advocate	147
<i>References</i>	149

Chapter 4:	The role of the global women’s and children’s health network in influencing attention during the Millennium Development Goals era	151
4.1	<i>Introduction</i>	151
4.2	“Discourse, ideas and power in global health policy networks: political attention to maternal and child health in the Millennium Development Goals era” (<i>Globalization and Health</i> , 2016)	154
	<i>References</i>	166
Chapter 5:	Conflict and negotiation among network actors in the global health policymaking process	168
5.1	<i>Introduction</i>	168
5.2	“Power and politics in the global health landscape: Beliefs, competition and negotiation among global advocacy coalitions in the policymaking process” (<i>International Journal of Health Policy and Management</i> , 2016)	172
	<i>References</i>	182
Chapter 6:	Development and expression of actor-power: Mass media campaigns	184
6.1	<i>Introduction</i>	184
6.2	“Global health networks and the strategic use of mass media campaigns”	188
	<i>References</i>	226
Chapter 7:	Development and expression of actor-power: Interpersonal communication campaigns	234
7.1	<i>Introduction</i>	234
7.2	“Answer us before you give any speeches: Interpersonal communications and network power”	237
	<i>References</i>	283
Chapter 8:	Discussion and conclusions	294
8.1	Introduction	294
8.2	Summary and discussion of findings	297
8.3	Conceptual and theoretical contributions	313
8.4	Reflections on network challenges in the SDG era	316
8.5	Policy implications	319

Annex

A:	<i>Deliver Now India</i> endline household survey form	322
B:	Sample transcript: <i>Deliver Now</i> public hearing	327
C:	<i>Deliver Now</i> interview guide	334
D:	Recent peer-reviewed publications by author	336

List of Figures

5.1: The <i>Global Strategy for Women's and Children's Health</i> analysed through Sabatier's Advocacy Coalition Framework	175
6.1: People and places framework for public health influence	198
7.1: Seating plan for <i>Deliver Now India</i> public hearings in Orissa	268
7.2: Example of community dialogue during a public hearing in Bolangir district, Orissa, June 2008	272

List of Tables

3.1: Overview of thesis methods	132
4. 1: Ideas, actor-groups and political context in relation to the development of a global MNCH community, 2005-2015	159
6.1: Mass media campaign outcomes related to collective efficacy	217

List of Acronyms and Abbreviations

ACF	Advocacy Coalition Framework
ANM	Auxiliary Nurse Midwife (<i>India</i>)
ASHA	Accredited Social Health Activist (<i>community-based health educator and promoter, India</i>)
AWW	Angan Wadi Worker (<i>community-based maternal and child health worker, India</i>)
AU	African Union
BJP	<i>Bharatiya Janata Party (India)</i>
Countdown	Countdown to 2015 study and action group on maternal, newborn and child health
CDMO	Chief District Medical Officer (<i>India</i>)
CSO	Civil Society Organisation
DAH	Development Assistance for Health
Deliver Now	<i>Deliver Now for Women + Children</i> campaign
DFID	Department for International Development, UK
DMI	Development Media International (<i>UK non-profit</i>)
DSWO	District Social Welfare Officer (<i>India</i>)
GFF	Global Financing Facility in support of Every Woman Every Child
G8	Group of Eight nations
G20	Group of Twenty nations
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
Global Strategy	<i>Global Strategy for Women's and Children's Health</i>
IPC	Interpersonal Communications
LSHTM	London School of Hygiene and Tropical Medicine
JSSK	Janani Shishu Suraksha Karyakaram (<i>mother-child protection programme, India</i>)
JSY	Janani Suraksha Yojana (<i>maternity protection programme, India</i>)

MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission (<i>India</i>)
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care/Primary Health Centre (<i>India</i>)
PM	Prime Minister
PMNCH	Partnership for Maternal, Newborn & Child Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SUN	Scaling Up Nutrition Movement
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UPA	United Progressive Alliance (<i>India</i>)
VHSNC	Village Health, Sanitation and Nutrition Committee (<i>India</i>)
WHA	World Health Assembly
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background

Who influences global health policy agendas, and how, is not always visible, understood, or accountable to those whose lives are affected by these processes. For every health issue that attracts political attention¹, there are arguably issues of equal or greater severity that do not. For instance, an important issue like tuberculosis can be the subject of a high-level meeting or resolution at the United Nations (UN) General Assembly (United Nations 2018). Yet other health issues with still greater and rapidly increasing mortality burdens – for instance, road injuries or heart disease (Institute for Health Metrics and Evaluation 2019) – may never gain the global stage to the same degree.

There can be many reasons for this. Disease patterns can change, new scientific discoveries may encourage or discourage interest, or governments may decide to pursue new policy directions. Another factor is how global health advocacy networks seek to influence political attention towards, or away from, certain issues. This is the topic of this study.

The emergence of global health networks – defined as “cross-national webs of individuals and organisations linked by a shared concern to address a particular health problem, global in scope” (Shiffman et al. 2015, p. i4) – is justified by the increasing interdependence of people, goods, information, financing and technology influencing health in the 21st century (Frenk, Gómez-Dantés and Moon 2014).

¹ *Political attention can be defined as “the degree to which international and national political leaders actively give attention to an issue, and back up that attention with the provision of financial, technical and human resources that are commensurate with the severity of the issue” (Shiffman and Smith 2007; p. 1370). Pelletier et al. (2011) notes that political “attention” and political “commitment” are not necessarily synonymous – that symbolic actions such as political speeches (i.e., political attention) may occur more frequently than the development of budgeted operational plans and accountability mechanisms for policy implementation (i.e., political commitment) because political “costs” and bureaucratic hurdles may be less onerous. In this thesis, “issue attention” is used as shorthand for political attention to an issue (e.g., women’s and children’s health).*

The involvement of private business, voluntary groups and other non-state actors in public health is not new. Dating to the 19th century, such groups have engaged with state actors to form international agreements on issues of the day, such as opium and alcohol prohibition, cholera outbreaks, and workplace safety (Fidler 2001). Similarly, other social issues have an extensive history of multi-actor collaboration, including the anti-slavery and suffragette movements of the late 19th and early 20th centuries (Keck and Sikkink 1998).

What is more recent, and accelerating with globalisation, is the *transnational network* form (Keck and Sikkink 1998), in which multi-stakeholder collaboration has been undertaken, across borders and often in response to rising inequalities in power and resources at a global scale and associated with neoliberal economic policies (Della Porta and Diani 2011). The highly uneven distribution of health risks associated with privatised delivery of health services, and intensified by poverty and discrimination based on gender, race and/or geography, has encouraged a new emphasis on the political determinants of the global governance of health (Ottersen et al. 2014).

The combined effect was an “eruption” of new actors in global health in the late 1990s and early 2000s (Low-Beer 2012), starting from the 1980s (see chapter 2.2.1). Their influence continues to be felt through the dense landscape of transnational networks that characterise global health today (Shiffman et al. 2015). This influence is also evident in the current shift of governance norms and structures, from a narrow set of state obligations under international health law to a more inclusive human rights approach to health through which legal norms and principles are realized by both state and non-state actors (Meier and Gostin 2018).

A recent mapping of the “global health system”² identified more than 200 actor-groups working transnationally to improve health, with nearly half originating

² The “global health system” is defined by Hoffman and Cole (2018) as a set of “transnational actors that have a primary intent to improve health and the polyilateral arrangement for governance, finance and delivery within which these actors operate”.

during the two decades of 1990-2009 alongside the surge in global health financing of that era (Hoffman and Cole 2018). The global health map, dominated by non-governmental organizations, many based in the US, visualises the increasingly powerful role of non-state actors in global health.

Global health networks draw heavily from such actor-groups. Characterised by their “voluntary, reciprocal and horizontal patterns of communication and exchange” (Keck and Sikkink 1998, p. 8), advocacy networks are distinct from other types of networks by their principal function in advocating for “causes, principled ideas and norms” (p. 8). Participants “plead the causes of others” and/or “defend a cause or proposition” (Keck and Sikkink 1998, p. 8). In this sense, they are distinct from other forms of networked structures based on more material interests, such as hierarchies or markets (Keck and Sikkink 1998).

This thesis uses the term “global health advocacy network” to emphasise their normative function in advocating for better public health, although their specific functions may be technical or managerial in nature, including product research and development, coordination, financing, monitoring and evaluation, etc.

There are many different network-based arrangements in global health. Some networks have formal governance arrangements, including boards, constituency groups, and membership policies. These are sometimes referred to as “global health partnerships” (Buse and Harmer 2007). During the MDG era, examples of this type were the Roll-Back Malaria Partnership and the Global Polio Eradication Initiative (Shiffman et al. 2015). Other networks may be more fluid or time-bound, characterized by informal ties, leadership and governance arrangements. Their institutions may be weak, emerging or non-existent (Shiffman et al. 2015). Recent examples of informal networks include those dedicated to issues such as stillbirth prevention, mental health, and quality of care.

Collaboration through networks seems a necessity in a globalised world. Yet the influence of private interests on national health policy and global health

governance, expressed through such networks, continues to raise questions about their legitimacy, and the basis upon which they exercise their power (Kapilashrami and Baru 2018; Reich 2018). The values, ideologies and interests of health advocacy networks can shape public policies in ways not easily visible or understood outside of the network. They may succeed in attracting political attention to some issues, and suppressing attention to others, independent of scrutiny or mandate (Shiffman 2014).

For instance, technical “frames” and narratives may be deployed by networks to redirect attention from policy solutions that require fundamental, long-term social change, which network members may deem politically challenging or costly to achieve (McCoy and Singh 2014). Such choices are not only tactical, but also reflect underlying norms and preferences of powerful leaders within such networks. As documented in chapter 4, evidence-based discourse in the women’s and children’s health network in the MDG era focused on improving technical, supply-side interventions rather than grappling with structural changes to improve health inequities or community-based accountability, which demand a whole-of-government response and tackling legal, democratic and/or financing reforms.

This thesis does not seek to investigate if networks have, or have not, driven issue attention, and the extent of effects if so. There are multiple, often confounding, factors at play in agenda-setting processes, and non-networked actors such as governments, media corporations or charismatic champions may lead policy attention in important ways. Public crises and events, such as famine, wars, or economic recession, can do the same. New scientific or technological discoveries can attract or erode support for certain causes. Indeed, testing the claim that networks have played a significant role in issue attention would require consideration of counterfactual scenarios, i.e., the emergence of attention in the absence of networked activity.

Rather, this thesis seeks to analyse the nature, characteristics, and pathways through which global health networks pursue issue attention, contributing to

knowledge of how such networks operate in the field of global health. The ways in which, and the reasons why, networks seek influence through their ideas and strategies are important to understand, especially when the sources of power in global health may not be transparent or easily located, and thus unavailable for public scrutiny.

This thesis looks at these issues through the case of the global women's and children's health advocacy network, its constituent actors, and related communication campaigns during the UN-sponsored Millennium Development Goal (MDG) period, 2000-2015. This case was selected because women's and children's health issues attracted significantly greater policy attention and resources during the MDG years compared with previous years (Dieleman et al. 2016; Storeng and Béhague 2016; Smith and Rodriguez 2015).

The global women's and children's health network expanded in scale and resources in parallel to the prioritisation of women's and children's health issues in the MDG poverty-reduction framework. The eight MDG goals, including those on child mortality and maternal/reproductive health (i.e., MDG 4 and MDG 5, respectively), were agreed by all countries and all development institutions in the world, and were translated into a global measurement framework based on 21 quantifiable targets and 60 indicators.³ The negotiation and drafting process for the MDG framework was led by technical experts from northern-headquartered international organisations, including from the UN secretariat in New York, the International Monetary Fund in Washington, the Organisation of Economic Cooperation and Development (OECD) in Paris, and the World Bank in

³ MDG 4 aimed to reduce child mortality, and set a target of reducing the global under-five child mortality rate by two-thirds by the end of 2015, measured against progress from 1990. MDG 5 called for improving maternal health, and set targets of reducing the maternal mortality ratio (MMR) by three-quarters (1990-2015) and achieving universal access to reproductive health. Indicators to track improvements in reproductive health included contraceptive prevalence rate; adolescent birth rate; antenatal care coverage, and unmet need for family planning (United Nations 2018).

Other MDGs were dedicated to eradicating income poverty and hunger (MDG 1), achieving universal primary education (MDG 2), improving gender equality and women's empowerment (MDG 3), combatting HIV/AIDS, malaria and other diseases (MDG 6), ensuring environmental sustainability (MDG 7), and developing a global partnership for development (MDG 8) (United Nations 2018).

Washington (Hulme 2009). The MDG proposal drew heavily upon an existing proposal by the OECD's Donor Assistance Committee for a set of measurable international development goals (Hulme 2009).

Numerous factors may have contributed to the particular focus on women's and children's health in the MDG framework. These may have included lack of political opposition to prioritising the health of children and mothers, distinct from the battle over reproductive health in the MDGs (Yamin and Boulanger 2014; Hulme 2009)⁴; growing technical capacity for measuring maternal mortality ratios and child health mortality rates; existing global consensus on reduction targets that could be adapted to the MDG framework; and existing human rights agreements that prioritised children, particularly the UN's Convention on the Rights of the Child (2000) (Díaz-Martínez and Gibbons 2014).

Mobilisation by cross-border advocacy networks in the 1970s to 1990s (Keck and Sikkink 1998), including campaigns for primary health care, child survival, and safe motherhood, may also have been instrumental to raising attention of MDG-framers to these issues (Hulme 2009).

The agenda-setting effect of the MDG framework can be observed in relation to significantly increased financial flows for health in the first decade of the goals, including for maternal and child health. For instance, overseas aid resources for maternal, newborn and child health tripled during 2003 to 2012, rising from USD2.7 billion to USD8.4 billion in constant dollars (Arregoces et al. 2015). Growth in MNCH disbursements continued at a double-digit pace even after 2010 – a period when investment in health began to stagnate, reflecting in part the effects of the 2008-2009 global financial crisis (Dieleman et al. 2016).

It has been argued that efforts of networks during the MDG period contributed to concentrating and sustaining focus on achieving the goals, urging political

⁴ A reproductive health target was not included in the original MDG framework because it was politically divisive. MDG 5b, calling for universal access to reproductive health, was agreed in 2007 after extensive advocacy by women's and human rights groups (Yamin and Boulanger 2014; Hulme 2009).

attention at both global and national levels (Díaz-Martínez and Gibbons 2014; Yamin and Boulanger 2014). This was a period in which new global health partnerships and campaigns were launched and framed in explicit support of the MDGs, such as the Partnership for Maternal, Newborn & Child Health (Storeng and Béhague 2016) and its 2010 development of a *Global Strategy for Women's and Children's Health* (United Nations 2010), championed by the UN Secretary General Ban Ki-moon and backed by an intensive political advocacy campaign to accelerate MDG progress, called "Every Woman Every Child" (Every Woman Every Child 2018).

This study explores the norms and strategic behaviours of the global women's and children's network during the MDG period to better understand its potential contribution to issue attention for women's and children's health. In doing so, it follows Shiffman et al. (2016) in inferring that multi-stakeholder networks matter to the field of global health and health conditions for women and children, if not necessarily to a greater or lesser degree than other factors. Indeed, French (2015) argues that the 50% reduction in child mortality that occurred during the MDG era was due to coincidental economic growth during the MDG measurement period, rather than stimulated by coordinated efforts for goal progress.

This thesis also takes a cue from Keck and Sikkink (1998) in using campaigns as a lens for exploration, magnifying how relations among different network actors were structured through collaboration and how certain ideas were produced, negotiated, and framed for political influence. The following definition of campaigns is used in this thesis:

Campaigns are sets of strategically linked activities in which members of a diffuse principled network develop explicit, visible ties and mutually recognised goals in pursuit of a common goal. (Keck and Sikkink 1998; p. 6)

By focusing on global health networks and campaigns, this thesis may assist in promoting better understanding of how global health networks seek influence over current – and future – health priorities.

1.2 Research focus and approach

The dissertation builds on a growing area of policy scholarship about global health networks, health governance processes and agenda-setting (see chapter 2.3: *Networks and policymaking processes*). The importance of agenda setting has long been recognized in public policy studies as a distinct phase in the policy process (e.g., Lasswell and Kaplan 1965), and in media studies as an outcome of mass media exposure (e.g., McCombs and Shaw 1972). However, more recent approaches link priority setting processes to actors, ideas and contexts in more complex ways (e.g., Shiffman and Smith 2007, Walt and Gilson 1994, Baumgartner and Jones 1993, Kingdon 1984).

Among these, the most relevant conceptual approach for this thesis was found to be Shiffman and Smith's framework on the determinants of political priority for global initiatives (2007), which is proposed as the overarching conceptual approach to this study. In their framework, Shiffman and Smith suggest that the capacity of global health networks to influence political attention depends on a combination of four categories of determinants:

- i) **Actor power:** the strength of cooperating individuals and organizations concerned with a common issue, including grassroots civil society organisations with capacity to mobilise popular demand for change;
- ii) **Ideas:** shared understandings and representations among actors concerned with common causes;
- iii) **Political context:** the environment in which actors seek influence for their cause;
- iv) **Issue characteristics:** the main features of the problem concerned, including credibility, severity, and feasibility of proposed policy solutions.

There were three reasons for proposing this framework to guide data organisation and analysis, which are: (1) content/context; (2) validity, and (3) opportunity. These are explained below:

(1) *Content/context*: The concerns and context of this framework are highly congruent with the global health agenda-setting research interests of this thesis. Shiffman and Smith's various categories and factors explore how global health actor-networks and ideas interact, within certain political contexts and in relation to policy issues. Also, Shiffman and Smith have repeatedly applied this framework to the study of global safe motherhood and newborn health networks (e.g., Shiffman 2010; Shiffman 2015a; Smith and Shiffman 2016; Shiffman and Smith 2007), these issues are closely related to the case selected for this thesis, i.e., the broader global women's and children's health network.

(2) *Validity*: As a widely used analytical framework in contemporary global health policy analysis, the Shiffman and Smith framework has been tested and validated for its capacity to guide meaningful enquiry. The publication of the framework in 2007 coincided with a rise of interest in how global health partnerships have influenced global health priorities and governance norms and structures (Torchia, Calabrò and Morner 2013). Arguably, this interest has contributed to the wide circulation of the framework, which has now been applied to a variety of case contexts, both inside and outside of the field of global health, including studies on human resources, reproductive health, diabetes, mental health, and nutrition (Best et al. 2018; Prata and Summer 2015; Keeling 2012; Tomlinson and Lund 2012; Pelletier et al. 2011).

Extensive use of the framework has resulted in various refinements to the framework by Shiffman and colleagues over time (Shiffman et al. 2016). In a study that tested whether frameworks can inform knowledge about health policy processes, Walt and Gilson (2014), used the Shiffman and Smith framework to extract and synthesise evidence from nearly two dozen empirical studies from such countries. The study found that the framework, one of few developed in the context of low- and middle-income country research (Shiffman 2007), added

important value to cross-setting and cross-policy comparative analysis.

However, the study also found the framework lacked attention to contestability or conflict, as well as attention to the relationship between global and national policymaking levels.

(3) *Opportunity*: Just a decade old, the Shiffman and Smith framework remains flexible and open to conceptual and theoretical development by other scholars. Thus, there is scope for this thesis to enrich the framework and contribute to theory development. For instance, while the classic formulation of the Shiffman and Smith framework does not deal explicitly with the topic of power and politics among network actors, nor on relations between global and national policy actors (Walt and Gilson 2014), this thesis can expand on the framework, as well as Shiffman's more recent work (2017, 2015b, 2014), to focus explicitly on questions of how power is produced, exercised, and scrutinised in global health.

Yet, because of these gaps, the use of complementary social and political theory is required. In this thesis, therefore, the use of Shiffman and Smith's framework is complemented by Bourdieu's social relations theory and concept of "capital" (social, economic, cultural) (1986, 1977), as well as Sabatier's ideas of normative conflict among advocacy coalitions (1988).

As indicated earlier, Shiffman himself has continued to refine his interdependent framework variables⁵ while raising both normative and material questions for future and empirical theoretical investigation. These include questions about the

⁵ *Shiffman and Smith's categories and factors have continued to evolve through case application, as well as conceptual and theoretical development by Shiffman and others. For example, in a recent study of global health network effectiveness by Shiffman and colleagues (Shiffman et al. 2016), the category of "ideas" was merged into the category of "network and actor features", itself renamed from the original "actor power" category. The newly renamed category now includes not only structural features of actor-networks such as leadership and governance, but also ideational attributes. The continued evolution of the framework responds to criticisms of overlap within the Shiffman and Smith framework, requiring greater definition and clarity of both concepts and factors (Walt and Gilson 2014).*

ways in which networks exert “productive power”⁶ and how this power may be examined and held accountable (2014), as well as how the political and economic interests of networks may structure behaviours and strategies (Shiffman 2018).

This thesis explores such questions (see chapter 1.3) through four empirical papers presented in this thesis on global health advocacy network power and the role of communications campaigns.

Beginning with Chapter 4, this study uses Shiffman and Smith’s concepts as an overarching framework with which to organise and analyse case data about the global women’s and children’s health network, which grew extensively during the MDG era (2000-2015). Case research explores how global women’s and children’s health network was structured by its reliance on “actor power” for leadership and coherence; by its use of frames as competitive resources for influence (“ideas”); by the environmental conditions that it encountered during its bid for attention (“political context”); and by the particularities of women’s and children’s health issues that shaped its policy preferences, frame selection, and competitive strategies (“issue characteristics”).⁷

⁶ “Productive power”, defined by Barnett and Duvall (2005, p. 3), is the “socially diffuse production of subjectivity in systems of meaning and signification”. In an essay on the exercise of power by global health networks, Shiffman (2014) applies Barnett and Duvall’s concept to suggest that networks use epistemic and normative forms of power to produce influence in ways that are taken for granted, and often unseen. Shiffman defines productive power in this context as follows: “How we create meaning, particularly through the use of categories that lead us to think about the world in some ways, but not in others” (p. 297). This concept is discussed in chapter 2.4.

⁷ Shiffman and Smith (2007) also identify 11 factors that underpin these four categories. These are: policy community cohesion, leadership, guiding institutions, civil society mobilisation (relating to “actor power”); internal frames, external frames (relating to “ideas”); policy windows, global governance structure (relating to “political contexts”); availability of credible indicators, severity of the problem, possibility of (cost-) effective interventions (relating to “issue characteristics”). Factors are explored in the context of case discussion in this thesis. Chapter 4 considers the use of evidence-based framing by the global women’s and children’s health network, institutional development of PMNCH and its leadership, and the opening of the MDG policy window, which allowed the global women’s and children’s health network to focus efforts and achieve increased financial and policy commitments. In chapter 5, discussion focuses on policy community cohesion and the Global Strategy’s normative focus on effective interventions, indicators and severity of burden. In chapters 6 and 7, discussion focuses on the relationship of sub-national communication campaigns to global network governance structures, including through civil society-led efforts to improve women’s and children’s health.

This study then builds on those findings and uses Sabatier's Advocacy Coalition Framework (1988) in Chapter 5 to explore the question of how actor-competition over ideas and their "framing" may structure the ways in which global health networks seek issue attention.

Chapter 6 explores how networks share those frames through mass media campaigns to achieve issue visibility and expand network structures at scale. Here, the mass media can be understood as a purposive network member and framing partner, as well as a fixed channel or structure through which network frames and messages exercise influence at scale. This thesis makes use of key psycho-social theories and insights from health communications literature that have been little applied to global health governance studies. Yet social ecology behavioural theory (Storey and Figueroa 2012; Sallis, Owen and Fisher 2008; Cohen, Scribner and Farley 2000), frequently used by health communication scholars, can explain how network campaigns, uniting actors and policy structures/environments across linked spatial domains (sub-national, national, regional and/or global), may produce structuring effects across the entire policy ecosystem, from the level of individuals and communities to national and global health policy venues.

Chapter 7 examines how networks use other types of (non-mass media) communication campaigns, e.g., those based on interpersonal relations, to pursue goals related to community accountability. The use of Bourdieu's concept of "capitals" (1986, 1977) draws attention to how network capacities are historically developed and deployed in relation to the wider social field in which they are situated. This chapter responds to Shiffman's own call for greater use of social theory to assist in navigating the relationships between actors, structures, ideas and interests in global health governance (2018).

This thesis also acknowledges national and sub-national variations of the wider policy environment by providing and contextualising two case studies in India's eastern coastal state of Odisha (formerly known as Orissa), presented in chapters 6 and 7. This thesis also hints at how such policy environments continually shift and evolve, by considering recent disruptions in the global

women's and children health network and agenda caused by the shift from the MDG to the post-2015 Sustainable Development Goal (SDG) framework (chapters 4 and 5).

Finally, Shiffman and Smith's categories guide the literature review for this thesis (chapter 2), which have yielded the specific research questions presented for empirical investigation in these chapters.

1.3 Research questions

The primary question of this study is "How do global health advocacy networks seek issue attention?" This thesis uses the Shiffman and Smith framework as a broad guide to this question, and focuses its enquiry on the role of actor-power and communications campaigns in that process.

The question of how networks build and exercise power through campaigns to achieve issue attention is examined through four specific questions that guide the development of the research papers (chapters 4-7) in this thesis:

- 1. What was the role of the global women's and children's health network in influencing attention to these issues during the MDG era?*
- 2. How does conflict and negotiation between network members influence actor-power?*
- 3. How do networks use media campaigns for issue visibility and for augmenting network power at different scales?*
- 4. How do networks use interpersonal communication campaigns to increase network growth and power to gain issue attention at local and national levels?*

The first research question, on the role of the global women's and children's health network in influencing attention during the MDG era, is addressed in Chapter 4. The paper finds that shared conceptual frames and institutionalised leadership within the network played an important role in how the network pursued attention for its issues.

The finding raises questions about how heterogeneous coalitions of actors with disparate beliefs negotiate and agree on shared concepts, exercising often-hidden forms of power to produce policy based on their beliefs and strategic interests. Chapter 5 asks, therefore, how conflict and negotiation influence the development of actor power.

Chapter 6 and 7 enquire about how actor-power is developed and expressed, and focus on the production and use of power through communication campaigns. Chapter 6 takes up the question of how mass media campaigns are used by global health advocacy networks to generate issue visibility at scale, connecting actors and policy environments in this process. Chapter 7 poses a similar question on how power is generated and deployed through communication campaigns, here in the context of interpersonal (i.e., face to face) campaigns, where issues of trust and accountability may influence the capacity of networks to replicate and claim issue attention.

These four main research questions on the development, negotiation, and expression of actor power through communication frames and campaigns guide the collection and analysis of evidence in this thesis on the characteristics and pathways by which networks seek to achieve normative changes in the global health system.

As noted, this thesis does not seek to assess whether, or to what degree, global advocacy networks contributed to improving women's and children's health in the MDG era, nor the extent to which global networks may have influenced health system priorities and issue attention at global or national level. Many explanatory factors co-exist since both human and structural factors interact in

the policymaking process, making it difficult to identify causal weight to any single determinant. Complex and historical social phenomena cannot be easily replicated for study, and undertaking counterfactual investigation is likely to result in inferences more than proof.

Yet, the application of social theory to empirical studies based on triangulated qualitative methods may yield new understanding about the characteristics and pathways through which global health networks operate in the pursuit of issue attention. Insights from this study can address questions about the nature of network intervention in global health; the role of communications and campaigns in that process; as well as raise questions for future study on the normative and discursive contribution of such networks to the practice of priority setting.

1.4 Chapter overview

Following this introductory chapter, chapter 2 provides a thematic and theoretical literature review, beginning with a historically situated discussion of issue characteristics, ideas, actor networks and political context for women's and children's health at the global level, and in India, where chapters 6 and 7 are set.

The conceptual and theoretical part of the literature review includes the history, definitions and characteristics of global health advocacy networks; agenda-setting theories; concepts of power in relation to networks; and communication resources used by networks for influence, including frames and campaigns. Shiffman and Smith's framework is further discussed and situated within debates on policy and power.

Chapter 3 details the qualitative methodology of this doctoral research. Qualitative data related to the development of the global women's and children's health network was collected and analysed on an iterative basis over a period of 10 years, from 2005 to 2015, through a global and India-based case study approach based on document review, in-depth interviews, and participant

observation processes. Global and sub-national survey information relevant to the questions of this thesis is reported in summary form to strengthen qualitative observations and to suggest directions for complementary research.

The main body of this dissertation consists of four linked case studies at global and sub-national levels, written up in stand-alone research papers (chapters 4-7). Since this dissertation is presented in research paper-style, there is an inevitable degree of repetition of some ideas and references between the papers, as each paper is designed to stand alone for publication.

The first research paper (chapter 4) chronicles the rising influence of the global women's and children's health network in the 2000-2015 MDG period. Applying Shiffman and Smith's 2007 framework on political prioritisation of global health initiatives, the paper analyses what the role of the global women's and children's health network was in influencing attention to these issues during this time, including how shared conceptual frames influenced network growth. Questions are raised for further research on how changes in political context/environment during the current SDG period (2016-2030) may affect future network integration, priorities and strategies.

The second research paper (chapter 5) proceeds from findings in the previous paper about the importance of shared ideas and frames to network influence. It enquires about the process by which such ideas are negotiated within networks, and how actor-power may be constructed through debate and conflict.

In doing so, this chapter relies on the ideas of political scientist Paul Sabatier (see chapter 2.4) in examining competition in the global women's and children's health network stemming from disparate normative and technical beliefs among advocacy coalition members, and the resulting influence on network structures and practices. Therefore, how networks use ideas and frames to communicate in powerful ways, based on dominant norms, can have an important effect on their capacity to seek issue attention. This paper enriches understanding of how the categories of "actor-power" and "ideas" interact in the Shiffman and Smith

framework, which is largely silent on the question of conflict and debate among network members and its structuring effects.

The third and fourth papers (chapters 6 and 7) look at differing campaign approaches deployed by networks to communicate their ideas to increase issue attention, and how such campaigns influence actor power.

Chapter 6 asks how networks use mass media campaigns for issue-visibility and network replication. It takes up the case of a state-wide mass media campaign in Orissa instigated by the global women's and children's network with the support of sub-national policy actors. The chapter uses the lens of social ecology from the field of social and behavioural communications to guide an exploration of how networks use media campaigns to enlarge their influence over individuals, communities, as well as wider policy structures at state, national, and/or global levels.

Social ecology concepts enrich Shiffman and Smith's understanding of "political context" by suggesting that power relationships between global network actors and policy structures are formed not only within the global space, but also through linkages at national and sub-national level. Such linkages may influence issue visibility as well as network replication. In this context, mass media campaigns act as catalysts and connectors for these dialogue processes, influencing actor-power through high volume media repetition of campaign messages.

In chapter 7, this thesis considers how networks use other types of campaigns, such as interpersonal or person-to-person campaigns, to develop and express actor-power and network influence. Using the case of district-level "public hearings" led by a civil society organisation in Orissa, this paper explores how different forms of network "capital", augmented through campaigns, may act as competitive resources to enable networks to improve their influencing position with members, donors, policymakers, and external actors (e.g., at global level) who can enhance their objectives. This paints a picture of advocacy networks as

not only normative and value-driven, but rational actors with material interests, who themselves must be accountable to those whose interests they serve.

In this way, Bourdieu's concept of different and unequal "capitals" (social, economic, cultural), acquired and deployed by social actors through their histories and predispositions ("habitus"), allows networks to be understood as more than simple sites of shared ideas rising from shared moral concerns, but as historically conditioned sites of power whose actors engage in constant struggle with wider social and political structures to exert their preferences.

This social relations perspective is useful to this thesis because it offers a theorised understanding of the origins and limits of actor power in relation to wider social and political structures. It is important to bear in mind the disruptive capacity of social relations and shifting policy contexts to network stability and power when exploring the question of how networks seek issue attention.

In chapter 8, this thesis concludes with a summary of key findings in relation to the four research questions linked to a discussion of how these findings contribute to improved understanding how networks seek issue attention, and what the specific role of actor power and communication campaigns may be in that process. These findings underpin policy recommendations suggested in this chapter for improving action and accountability by global health advocacy networks in relation to their behaviours, structures and processes.

Recommendations for future research are discussed in view of this thesis topic, including with respect to the relationship of actor-power and campaigns to other important determinants of global health policymaking and governance processes, i.e., determinants beyond those of networks themselves.

1.5 Contribution of author

The author of this dissertation conceptualised, researched and drafted all chapters. Data collection and analysis was undertaken in parallel with the author's employment with the Partnership for Maternal, Newborn & Child Health (PMNCH), hosted by the World Health Organization (WHO) in Geneva, Switzerland. This includes periods of unpaid leave in 2016 and 2018-19. Chapter 3 (Methodology) discusses potential author bias and conflict of interest arising from the simultaneous role of observer-researcher and paid participant in the global women's and children's health network, habituated to certain ways of thinking and communicating about one's employer and wider network.

The research papers presented here have not been reviewed by PMNCH or WHO, nor by other organizations discussed in the papers. Analysis and interpretation lies exclusively with the author. Policy recommendations in the concluding chapter draws from a paper published by the author in an issue of the *BMJ* (McDougall et al. 2015) about the updated *Global Strategy for Women's, Children's and Adolescents' Health* for the SDG era (United Nations 2015).

Ethics approval for this study was granted by LSHTM. Qualitative data analysed in this thesis arose from published sources for the most part; non-published sources are indicated. Secondary analysis was performed by the author on data collected by Development Media International (i.e., evaluation of the *Deliver Now India* media campaign in 2009⁸) and PMNCH (surveys in 2012 and 2013 of organisations with written commitments to the *Global Strategy for Women's and Children's Health*, commissioned for the development of annual PMNCH accountability reports⁹).

⁸ Collumbien, M., Blackmore, C. and Campbell, O. (2010). *Evaluation report of DMI media campaign*. London: London School of Hygiene and Tropical Medicine; unpublished.

⁹ PMNCH 2012 report: analyzing progress on commitments to the *Global Strategy for Women's and Children's Health*. Available at: https://www.who.int/pmnch/topics/part_publications/2012_pmnch_report_full_publicaton.pdf. [Accessed 15 January 2019]

Ethics approval for interviews with global network actors about commitments to the *Global Strategy for Women's and Children's Health* was granted by the World Health Organization in 2012 for the purposes of the 2012 PMNCH accountability report on the *Global Strategy*. PMNCH granted permission to the author to observe these interviews, with the oral consent of the interviewees. An account of this process is provided in chapter 3 (*Methodology*).

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Chapter 2: Literature review

This chapter provides a thematic and theoretical introduction to the research papers presented in this dissertation. The first part of the chapter (sub-section 2.1) reviews policy literature on women's and children's health at global level and within India during the MDG period. It provides a comprehensive historical context and identifies major themes and debates in the literature, as well as current knowledge gaps in global health governance that would benefit from further study.

The second half of the chapter (sub-sections 2.2 to 2.5) introduces theoretical approaches and conceptual tools relevant to the study of power in global health policymaking. These are discussed with reference to public-private networks in global health, which expanded in scale and scope during the MDG period. This review identifies opportunities to enrich current theoretical approaches to the study of global health networks, and introduces concepts from other fields, such as health communications, that can assist in understanding the capacities of communication messages and campaigns for issue attention and network replication.

Some aspects of this literature review will re-appear in the background sections of the research papers, two of which were published concurrently with the preparation of this thesis. A degree of repetition, therefore, is contained in this research paper-style thesis, which is acknowledged here.

2.1 Women's and children's health

Shiffman and Smith's four main framework categories (i.e., issue characteristics, actor-power, ideas, political context) assist in structuring the following

discussion of current policy literature on women's and children's health in the MDG era.

This sub-section begins with a brief overview of maternal and child health indicators, measures and essential interventions (*issue characteristics*); then moves on to discuss the emergence of dedicated global networks for safe motherhood and child survival during the last quarter of the 20th century, and the development of a combined women's and children's health global network in the early 2000s (*actor-power*); the use of evidence-based advocacy frames favoured over human-rights centred approaches in the MDG era (*ideas*); and the relationship of these networks to wider health and development goal-setting processes during this time, including the MDGs (*political context*).

2.1.1 Issue characteristics: indicators, mortality burden and key interventions

In 2015, the final year of the MDGs, there were an estimated 5.9 million deaths of children under the age of five years old (UNICEF 2015) and 303,000 maternal deaths (WHO 2015).^{10,11} The estimated global maternal mortality ratio (MMR) was 216 maternal deaths per 100,000 live births; the global under-five child mortality rate (U5MR) estimate was 43 deaths per 1,000 live births (WHO 2015).

Although MMR and U5MR fell by nearly half during the 1990-2015 MDG measurement period– by 44% and 53%, respectively (World Health Organization 2016) – progress fell far short of the MDG target of two-thirds reduction in U5MR (MDG 4) and three-quarters reduction in MMR (MDG 5a).

¹⁰ *The MDG's reproductive health indicators improved modestly during the 1990-2015 period. The global contraceptive prevalence rate grew from 55% to 64%, while the unmet need for contraception fell from 15% to 12% during the same period (UNFPA 2016). Contraceptive prevalence rate (CPR) is reported among women, aged 15-49, married or in a union. Global increase in the 1990-2015 MDG measurement period disguise CPR progress of less than 1 percent during 2000-2015 for all regions of the world except sub-Saharan Africa, which began from a 1990 baseline of 8.7 percent in West and Central Africa and from a baseline of 16.2 percent in East and Southern Africa, rising to an estimated 17.6 percent and 38.6 percent, respectively, by 2015 (UNFPA 2016).*

¹¹ *Unmet need for contraception is reported here among women, aged 15-49, married or in a union, who are fecund and sexually active, but who do not want any more children or want to delay the birth of their next child for at least two years (UNFPA 2016).*

Indeed, only nine of 95 countries with MMRs of more than 100 in 1990 achieved the 75% reduction target by 2015. Nearly three times as many countries (26) were categorised as having made “no progress” in achieving MDG 5 target for MMR. (WHO 2015).

Inequities in women’s and children’s health status have long been visible. However, gaps in maternal and child mortality grew far wider during the MDG period (UNICEF and World Health Organization 2017; Graham et al. 2016; World Health Organization 2015). For example, in 1970, U5MR in the Africa region was more than four times that of Europe and the Western Pacific (without China), and more than double that of the Americas (World Health Organization 2005). However, by 2015, U5MR in sub-Saharan Africa was estimated at more than 16 times that of developed countries; six times that of East Asia excluding China; and more than four times that of Latin America and the Caribbean (UNICEF 2015).

The estimated global MMR was 216 in 2015, yet the MMR in sub-Saharan Africa was estimated as more than double, at 546 (World Health Organization 2015). This was more than 45 times that of developed countries, 12 times that of East Asia excluding China, eight times that of Latin America and the Caribbean, and three times that of South Asia (World Health Organization 2015). Differences in pace of reduction influenced the gap: Between 1990 and 2015, the average annual rate of change in MMR was 4.5 percent for South Asia but just 1.8 percent for West and Central Africa (World Health Organization 2015).¹²

¹² Precision is difficult to achieve for maternal mortality estimates. At the global level, measurement has been hampered by technical complexities and weak national civil registration and vital statistics systems, resulting in poor baseline data, divergent estimates between different research groups, and lack of certainty on progress (Gerland et al. 2014; Merdad, Hill and Graham 2013; AbouZahr 2011; Hogan et al. 2010). In 1996, WHO and UNICEF re-issued an estimate of maternal deaths in the world pegged to 1990, establishing 585,000 as the baseline against which future progress could be measured (World Health Organization 1996). The new estimate, based on updated methods, changed little during the following 15-year period, as WHO and partners estimated 529,000 maternal deaths in the year 2000 (World Health Organization 2004) and 536,000 in 2005 (World Health Organization 2007). For 1990 to 2005 overall, the global rate of maternal mortality reduction was calculated at less than 1% (World Health Organization 2007).

Halting progress in mortality reduction was not unique to the MDG period. In 2003, Black et al. reported a decline in the global U5MR by an average 2.5% during 1960-1990, but only by 1.1% during 1990-2001. Looking at the 20th century history of industrialised countries, De Brouwere et al. (1998) found that in Sweden, maternal mortality decreased rapidly from the 1870s until the early 20th century, stalled until the late 1930s, then plunged again through the 1960s, by which time the standards of professional care in pregnancy and childbirth had improved vastly in industrialised countries. In 1870, an MMR of more than 600 was common in most industrialised countries (Loudon 2000).

Disparities grew during the MDG period despite an accumulation of statistical evidence on where and why women's and children's deaths occur (Countdown to 2015, 2015), as well as programmatic evidence from country studies, including from maternal health programme studies in varying regions and countries, including Sri Lanka, Malaysia, Bolivia, Egypt, Thailand, and others (Graham et al. 2016; Renfrew et al. 2014; Liljestrand and Pathmanathan 2004; Koblinsky 2003).

By the late 2000s, evidence from country studies, clinical trials and systematic reviews enabled effective consensus-building on recommended interventions and delivery strategies. *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health* (Partnership for Maternal, Newborn & Child Health 2011) reflected this evidence, promoting greater clarity in the global women's and children's health network about "best buys" and effective delivery strategies. Importantly, the recommended 50 interventions reflected agreement among representatives of civil society, UN representatives, academics, health professionals, donors and others, brokered by PMNCH.

Even so, the evidence base for the recommendations was specific to certain types and domains of knowledge, particularly systematic reviews of randomised control trials and meta-analysis of health interventions, including evidence published in WHO technical guidelines and medical journals such as the *Lancet*. Delivery strategies from outside the health sector were excluded, as were social,

behavioural or community-based interventions, as well as health systems and policy/legislative interventions. Reproductive health was scarcely addressed; maternal health was assumed to be instrumental to child health (“Good maternal health and nutrition are important contributions to child survival”; p. 6). Both together were required for improving value for money for countries:

When linked together and included as integrated programmes, these interventions can lower costs, promote greater efficiencies, and reduce duplication of resources. (p. 6)

Many policy reports in the MDG era argued for the merits of cost-efficient biomedical interventions to reduce maternal and child mortality. Such reports often began with normative statements based on human rights, but policy problems and solutions were rarely conceptualised in terms of longer-term structural approaches to improve inequalities. This included highly cited policy documents and papers of the time such as the *Global Strategy for Women’s and Children’s Health* (United Nations 2010; see chapter 5) and *Advancing Social and Economic Development by Investing in Women’s and Children’s Health: A New Global Investment Framework* (Stenberg et al. 2013).

Widening inequalities in the MDG era, despite widely shared measurement models, clinical knowledge, and programmatic experience, raise questions not only about the types of research undertaken during this period, but about how policy problems are constructed, and solutions agreed upon. Qualitative and case study scholarship highlighting the socio-political drivers of ill health, including female illiteracy, lack of economic opportunity, and low levels of political participation, were produced with regularity (e.g., Yamin 2013; Raj 2011; Gakidou et al. 2010). Yet they were not produced with levels of funding and PR provided to global-level studies on mortality measurements, finance tracking, and intervention coverage patterns undertaken by organisations such as the Institute for Health Metrics and Evaluation and Countdown to 2015, both funded by the Bill & Melinda Gates Foundation (Storeng and Béhague 2016a, 2014).

Among global studies focused on the social determinants of maternal and child mortality, Bishai et al. (2016) tracked data from 146 low- and middle-income

countries during 1990 to 2010, finding that approximately 50% of mortality reduction during this time could be attributed to social and environmental determinants, such as literacy, political participation, and income. The other 50% was attributed to technical interventions within the health sector.

Such findings validate the orientation of the post-2015 SDG framework to a rights-based approach to development, contrasting with the far narrower MDG agenda, underpinned by the preoccupations with cost-efficiency and intervention delivery (Fehling, Nelson and Venkatapuram 2013; Hulme 2009; Saith 2006). With an expansive agenda of 17 goals applicable to all countries, an important shift in ideology is suggested, from global development through market-led practices to sustainable development as a right, realised through equity, participation and mutual accountability (Fukuda Parr et al. 2016; Death and Gabay 2015).

In relation to women's and children's health, there is a growing recognition that improved quality of care – as well as improved access to care and experience of care – is essential to human development, and therefore to SDG progress (Kruk et al. 2018; Das et al. 2018). For women and children, among the most vulnerable to poor standards of care and unaffordable care (Graham, McCaw-Binns and Munjanja 2013), how their voices are heard and how they can participate in shaping health systems and outcomes, will exemplify the relationship between health and human rights in the SDG period (Meier and Gostin 2018).

Yet the recent MDG to SDG shift is still unfolding, and new debates mark how the SDGs will be achieved. For instance, while the pursuit of universal health coverage (UHC) may now be “the central thread” of the health SDGs (Berwick et al. 2018, p. 194), there is far less agreement on UHC definitions, concepts, policy approaches, and progress measurements (Lancet Global Health 2018; Abihiro and De Allegri 2015; Behera and Behera 2015). This discord may predict how quickly and effectively global health networks can form around these issues (Shiffman et al. 2016), influencing SDG progress.

Paul et al. (2018) interviewed 17 global health experts, each with 20 years' or more experience in the region of francophone Africa, and found they agreed on the efficacy of just one of the 18 presented policy options to achieve UHC in low- and middle-income countries. While all agreed primary health care is a priority, weak consensus-building and lack of evidence has limited progress, making the UHC a new battleground in the struggle for issue priority in the SDG era.

2.1.2 Actor power: network cohesion, leadership, institutions, mobilisation

As introduced in chapter 1, global health advocacy networks grew rapidly in the 1990s and 2000s, uniting private and public actors in “webs” of common practises and concerns, and providing platforms for non-state actors to seek influence over national and global health priorities (Hoffman and Cole 2018; Shiffman et al. 2016; Low-Beer 2012; Gostin and Mok 2009).

In the MDG era, networks with disparate interests in women's and children's health consolidated their structures and strategies to achieve greater impact together (McDougall 2016). New global networks, such as PMNCH, built on a history of national and cross-border activism on reproductive health, maternal health, and child health issues, dating to the 1970s and earlier (Storeng and Béhague 2016b). For instance, in the 1970s, women's rights movements in many regions of the world translated concerns about reproductive rights into broader movements addressing gender inequities in health care, including during pregnancy and childbirth (Keck and Sikkink 1998; Weisman 1997). Encouraged by the UN Decade for Women (1975-1985), such movements called attention to the gender inequities that underpin high rates of mortality and ill health in many countries (Tinker and Jaquette 1987).

Women's and children's health activists ensured that their issues were central to concerns of the Alma-Ata Declaration on primary health care (PHC), agreed in 1978 with the goal of “health for all” by the year 2000 (Declaration of Alma-Ata 1978). In 1987, the first-ever global conference on safe motherhood, convened by the WHO, World Bank and UNFPA in Nairobi, built on the Alma-Ata call for universal care and highlighted the social, economic and political barriers that

reduce access to quality care. The Nairobi conference led to a series of regional conferences and catalysed a global movement to promote safe motherhood for all (Starrs 2006; AbouZahr 2003; Mahler 1987).

The Nairobi safe motherhood conference established agreement on a global measurable target for maternal mortality reduction, to be reduced by half by the year 2000, measured against a 1990 start date, and enabled by continued improvements in global maternal mortality measurement estimates (WHO 1996). This MMR target was repeated and endorsed by important global conferences during the 1990s, including the 1990 UN World Summit for Children in New York (United Nations 1990); the programme of action resulting from the 1994 International Conference on Population and Development in Cairo (United Nations 1995); and the programme of action from the Fourth World Conference on Women in Beijing in 1995 (United Nations 1996).

Supporting the women's rights and safe motherhood movements, health professionals in the 1980s and 1990s used their voices in powerful ways, urging greater policy attention to slowing progress for women and children. This included Allan Rosenfield and Deborah Maine from Columbia University in New York, whose *Lancet* article "Maternal Health, a Neglected Tragedy: Where is the M in MCH?" (1985), galvanised attention to maternal health, distinct from child health, and helping to spark the global safe motherhood "movement" (Starrs 2006; AbouZahr 2003).

Outside the US, doctors like Ghana's Fred Sai, known as the "grandfather of maternal health" (Aspen Institute 2018), and Egyptian obstetrics professor Mahmoud Fathalla, whose video "Why did Mrs X die?" won a global audience (WHO 1988; Fathalla 1988),¹³ carved an important leadership role for health professionals within emerging global health movements for women's and children's health.

¹³ Dr Fathalla's 'Mrs X' teaching video remained popular around the world for decades, and was re-made in 2012 as an animated video by a UK charity, accompanied by a "Walking with Mrs X" board game (*Hands on for Mothers and Babies*, 2018).

The history and challenges of the safe motherhood movement have been well documented (Smith and Shiffman 2016; Shiffman and Smith 2007; AbouZahr 2003). For much of its early history leading up to the MDG era, the safe motherhood movement was beset with challenges that hobbled progress by discouraging and dividing network members. Reasons for this included lack of robust progress indicators and the contestability of a narrow global measures like MMR in representing women's health progress (Storeng and Béhague 2016a; Yamin and Boulanger 2014); competition for attention between maternal and reproductive health advocates, and between maternal and newborn health (Starrs 2014); and the slow resolution of technical debates, such as the role of traditional birth attendants vis-à-vis professionalised care (Goodburn 2000).

Such challenges prompted extensive self-criticism within the safe motherhood movement about technical and political discord, network fragmentation, and lack of progress in achieving political attention (Freedman et al. 2007; Starrs 2006; Rosenfield, Maine and Freedman 2006; Fathalla 2006). Compared with the optimism of the post-Nairobi years, there was a sense that “the reality has not generally followed the rhetoric” (AbouZahr 2003; p. 13). Some influential network leaders credited this to overly broad ambitions and the lack of a “clear, concise and feasible strategy” for the safe motherhood movement (Maine and Rosenfield 1999).

By the early 2000s, however, there were signs of improved cohesion. Maternal health had achieved new visibility in the MDG framework through MDG 5; technical debates had resolved in favour of investing in professional delivery care and emergency obstetric care within functional health systems rather than maintaining traditional focus on antenatal care and traditional birth attendants; and messaging coherence had increased, reflecting the new norms of the MDGs and their emphasis on MMR reduction and related measurement and technical interventions (Smith and Rodriguez 2015).

The neo-liberal emphasis of the MDGs on cost-efficient interventions to reduce poverty had infused the frames and messages of many global health network

actors in the 2000s, including those in the global safe motherhood movement (Yamin and Boulanger 2014). This is exemplified by the founding slogan of the Women Deliver conference, initiated by American safe motherhood leader Jill Sheffield in 2007: “Invest in women: It pays” (Women Deliver 2018).

The language of measurement and metrics became common during the MDG era, diffused by global health leaders through speeches, articles and high-profile conferences. The commonly used phrase, “What gets measured, gets done” (Chan 2015), was borrowed from American business management guru Tom Peters (1986). Yet as the MDG project continued, debate rose in human-rights and academic circles – if not to the same extent in UN agencies and public-private partnerships – about the distorting effects of global measurement and estimate processes in the development process (Fukuda-Parr et al. 2014).

Some governance scholars sought to flag these norms for scrutiny, producing studies that illustrated how the prioritisation of quantitative indicators could induce shifts in thinking about standards, norms and decision-making within global governance processes, and thus could be understood as “technologies” of governance (Davis et al. 2012, p. 74). Health policy scholars argued that quantitative MDG measures narrowed debate and distracted attention from wider issues related to health system reform (Fukuda-Parr 2016). The effects of MDG norms also induced research spending on sophisticated statistical models based on weak data, when money could be better spent on improving national data systems (Yamin and Boulanger 2014).

During the 2000s, the practice of evidence-based advocacy by the safe motherhood movement and related networks was accelerated by a shift in network institutional arrangements (Storeng and Béhague 2016b). The Partnership for Safe Motherhood and Newborn Health grew out of the Inter-Agency Group for Safe Motherhood in 2004, and promoted the idea of a *continuum of care* between reproductive, maternal, newborn and child health (Lawn et al. 2006; Tinker et al. 2005). Increasing availability of mortality estimates revealing the high global burden of not only maternal and child deaths,

but also of newborn deaths, encouraged greater research and programmatic investments, as well as greater links between maternal and newborn health advocacy (Lawn, Cousens and Zupan 2005).

Donors believed that longstanding competition for resources and attention between maternal, newborn and child health advocates could be quelled through a unified global advocacy platform such as The Partnership for Maternal, Newborn & Child Health (PMNCH). In 2005, PMNCH was created through a merger between the Partnership for Safe Motherhood and Newborn Health (which grew out of the Inter-Agency Group for Safe Motherhood), hosted by WHO, and two related partnerships: The Child Survival Partnership, hosted by UNICEF, and the Healthy Newborn Partnership, supported by a multi-year grant from the Bill & Melinda Gates Foundation (McDougall 2016).

PMNCH, hosted by the WHO in Geneva, advocated for the achievement of MDGs 4 and 5 through a continuum of care strategy, engaging both public and private institutions in a global “super-network” (Storeng and Béhague 2016b; Shiffman and Smith 2007). Advocacy and accountability efforts would draw upon evidence produced by groups such as Countdown to 2015, as well as UN agencies and others (McDougall 2016).

Countdown to 2015 itself was one of several highly-cited multi-stakeholder research groups arising in the MDG era. It grew out of the work of the Bellagio Study Group on Child Survival, which had published a widely read set of articles in the *Lancet* in 2003, drawing attention to faltering progress in under-five child survival (Bellagio Study Group on Child Survival 2003). The Bellagio group included many of the world’s leading child health academics and technical experts, such as epidemiologist Bob Black of Johns Hopkins, paediatrician Zulfiqar Bhutta of Pakistan, WHO child health expert Jennifer Bryce, and equity expert Cesar Victora of Brazil (Bellagio Study Group 2003).

Its work was spurred by faltering progress in the 1990s on child survival, and undertook the urgent “translation of current knowledge into effective action for

child survival” (2003; p. 323). Supported by PMNCH as its secretariat and fundraising partner, Countdown partners published frequently in the *Lancet* and became an enduring source of evidence on women’s and children’s health (McDougall 2016). As of December 2018, the first paper of its 2003 child survival series (“Where and why are 10 million children dying every year?” by epidemiologists Robert Black, Saul Morris and Jennifer Bryce; 2003) had been cited nearly 1,500 times in peer-reviewed journals (Scopus 2018).

By the end of its 2005-2015 lifespan¹⁴, Countdown to 2015 had expanded to track the progress of more than 70 reproductive, maternal, newborn and child health indicators in 75 high-burden countries. Evidence was disseminated through journal articles, reports, policy briefs, and conference sessions. From 11 initial partners, Countdown grew to more than 40 institutional members, including academic institutions, government donor agencies, UN organisations, non-governmental organisations (NGOs), and health professional groups (Victora et al. 2016b).

Other noted health research networks that developed in the MDG era included the University of Washington’s Institute for Health Metrics and Evaluation, funded by the Bill & Melinda Gates Foundation and publisher of the Global Burden of Disease studies and annual reports on development assistance for health; HRP (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction); the UK-funded IMMPACT maternal and newborn health project at the University of Aberdeen in Scotland, initiated by obstetrician and epidemiologist Wendy Graham; the Child Health Epidemiology Reference Group (CHERG), coordinated by WHO and UNICEF; and the Saving Newborn Lives initiative, hosted by Save the Children.

¹⁴ Countdown to 2015 was reconstituted in 2016 as Countdown to 2030, to track SDG progress (Victora et al. 2016a).

A scan of web listings of research papers and reports from these groups during the 2000-2015¹⁵ MDG period indicates that, while many study networks produced qualitative studies related to programme and/or intervention evaluation and policy formulation, many highly cited papers and reports pertained to mortality and coverage measurements, population distribution and burden estimation, intervention efficacy, and cost-efficiency analysis.

Such research groups were highly dependent on the global women's and children's health network, and its private sector members, for financial support. Donors, many American, included the Rockefeller Foundation of New York (Bellagio Study Group/Countdown to 2015), Ford Foundation of New York (HRP), MacArthur Foundation of Chicago (HRP), Gates Foundation of Seattle (Institute for Health Metrics and Evaluation, Countdown, Saving Newborn Lives, HRP, IMMPACT), and Packard Foundation of California (HRP), among others.

These research programmes, and the donors that supported them, have provided important content for the development of evidence-based ideas, frames and messages deployed by the global women's and children's health network for issue attention during the MDG era (McDougall 2016).

2.1.3 Ideas: internal and external frames

The field of global women's and children's health has been dominated by two largely opposing ideas of the past several decades. One idea follows the principles of the Alma-Ata Declaration and calls for a broad approach to achieve PHC through structural reform; the other idea favours more specific

¹⁵ Scan conducted on 7 November 2018 of the following web pages:

Countdown to 2015: <http://countdown2030.org/reports-and-publications/>;
Institute for Health Metrics and Evaluation: <http://www.healthdata.org/results/policy-reports/>;
Institute for Health Metrics and Evaluation: <http://www.healthdata.org/results/research-articles/>;
HRP: <http://www.who.int/reproductivehealth/publications/en/>;
IMMPACT: <https://www.abdn.ac.uk/iahs/research/immimpact/research.php>;
CHERG: <http://cherg.org/publications.html>;
Saving Newborn Lives: <https://www.healthynewbornnetwork.org/resources/>

interventions to improve women's and children's health. During the MDG era, the latter idea seems to have been dominant, not least with the increased influence of private actors in global health. These competing ideas formed the basis of internal frames used within the network to express certain policy preferences, as well as external frames used by the network to portray priorities for action.

For instance, the Bellagio Study Group on Child Survival, including representatives of the World Bank, Gates Foundation, Rockefeller Foundation and Packard Foundation, partnered with the influential *Lancet* medical journal in 2003 to publish a high-profile series of papers calling for greater attention to child survival. Many more child deaths could be averted in future, they argued, if integrated delivery approaches could be guided by new population evidence, using proven technologies and behavioural change strategies to increase coverage at scale (Bellagio Study Group 2003). Integration could be improved if child survival programming and messaging could be embraced by global health partnerships devoted to single-focus issues such as polio, HIV, malaria and guinea worm. In an editorial in the *Lancet* child survival series, the Bellagio authors wrote:

First, renewed action on child survival is called for because advances in child health epidemiology have strengthened the basis for sound child survival programmes. More is known than ever about the proportional distribution of child deaths, the cause-specific contribution of undernutrition to those deaths, and how those patterns vary across countries.

Second, interventions to prevent or treat the major causes of child death are more effective now than in the past, and new interventions are on the horizon ...

Third, findings from large scale population surveys show that these child survival interventions are not reaching those who need them. Fewer than 5% of children in regions of Africa with very high prevalences of malaria are using insecticide-treated materials to prevent malaria. Fewer than four in ten infants are breastfed exclusively for 6 months, partly because their mothers are unaware of the protective effects of this practice ...

These, and other delivery failures, and the recognition that a health child needs many and coordinated preventive and therapeutic interventions, demand renewed attention. (p. 327)

The focus of the Bellagio Group on the technical channels, tools, targets of mortality reduction recalled the programmatic thrust toward “selective” primary health care (PHC) in the 1980s and 1990s (Cueto 2004), rather than a more comprehensive approach.

The Alma-Ata Declaration put forth the idea of health as a human right, comprehensive of physical, social and mental well-being, “not merely the absence of disease or infirmity” (1978). Health was conceptualised as a lever for wider socio-economic development, to be founded on accessibility to community-owned health systems and services. The Alma-Ata vision was conceived against a backdrop in the 1960s and 1970s of increasing investment and provision of specialised care and imported technologies in urban hospitals in many developing countries, viewed by many as an unsustainable, elitist model of health (Newell 1988).

The feasibility of the Alma-Ata agenda, including the goal of achieving “health for all” by the year 2000, provoked extensive debate among health planners and policymakers (Litsios 2002). In 1979, American authors Julia Walsh and Kenneth S. Warren published a paper in the influential *New England Journal of Medicine* entitled “Selective Primary Health Care: An Interim Approach for Disease Control in Developing Countries.” The paper argued for a step-wise approach to “health for all”, beginning with the cost-effective delivery of a limited package of proven interventions to prevent and control disease, especially for young populations where significant gains can be achieved.

The Walsh and Warren article served as the discussion paper for a conference on population and health in Bellagio, Italy, in April 1979, sponsored by the US-based Rockefeller Foundation – later to sponsor the Bellagio Study Group on Child Survival in 2003 – and attended by the heads of the World Bank, UNICEF and others. The “selective” approach to PHC, emphasising cost control, proved highly influential among donors and UN agencies (Cueto 2004).

For example, from the early 1980s, Jim Grant, UNICEF's energetic new director, spearheaded a new "GOBI" strategy based on the selective PHC approach discussed in Bellagio (Jolly 2014; Cash, Keusch and Lamstein 1987). The package consisted of Growth monitoring, Oral rehydration therapy for diarrhoea, Breastfeeding, and Immunisation, later complemented by "F-F-F" (Female education, Family spacing, Food supplementation). The GOBI-FFF campaign was delivered to communities with the support of behavioural change communication strategies, assisted by the rapid expansion of TV and radio reach in the 1980s and 1990s in many countries. Visibility and resources were further galvanised by Grant's recruitment of popular champions and celebrities for the campaign (UNICEF 1996).

The "child health revolution", as it became known, relied on vertical management and delivery systems of commodities such as vaccines and oral rehydration therapy kits, supported by an extensive network of non-state and private sector actors collaborating with government. The campaign delivered rapid results: Coverage of the combined diphtheria, tetanus toxoid and pertussis (DTP3) vaccine soared from 21% in 1980 to 75% in 1990 (World Health Organization 2018a). Production of oral rehydration solution packets increased by more than 15 times in less than 15 years, from 51 million packets in 1979 to 800 million in 1992 (Santosham et al. 2010).

The success of the child survival campaign in reducing global child mortality revealed a deep chasm between the "idealistic" redistributive and structural goals of the 1978 Alma-Ata declaration and the "pragmatic" short-term strategies of selective PHC in the 1980s and early 1990s. The emphasis on diffusing cost-effective technologies to the greatest number of people at the lowest possible cost was ideologically compatible with the neoliberal policies of structural adjustment imposed by the World Bank and the International Monetary Fund on debt-burdened countries in that era (Maciocco and Stefanini 2007; Wisner 1988; Rifkin and Walt 1986).

Indeed, the rise of global health financing partnerships in the early 2000s, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization (GAVI), grew from the public-private delivery platforms of the child survival revolution of the 1980s and 1990s, setting the path for increasing privatisation of public health in the MDG era (Low-Beer 2012; Maciocco and Stefanini 2007; Fidler 2001).

The call to action launched by the Bellagio Group in 2003 arrived amid growing disquiet by many policy actors with vertical delivery systems, single-issue advocacy, and weak accountability in the growing arena of “global health”. The economic stagnation in many lesser developed countries and the effects of structural adjustment policies in the 1980s and 1990s had taken their toll on national health systems, and on women and children (Peabody 1996).

Meanwhile, the rise of new threats like HIV, especially in Africa, contributed to divergent progress among regions (Ahmad, Lopez and Inoue 2000), even though other epidemiological challenges had not changed fundamentally since the 1980s – diarrhoea, pneumonia and malaria remaining major threats for children under age five, and birth asphyxia and neonatal sepsis for newborns (Bellagio Study Group 2003). To many, dwindling progress in the 1990s in reducing child mortality suggested inherent limitations to the “selective PHC” approach in the absence of strong community health systems (Ahmad, Lopez and Inoue 2000; Claeson and Waldman 2000; Werner and Sanders 1997). This included the integrated delivery of maternal and child health services, including newborn health (Lawn et al. 2006).

Yet, the idea of a narrow set of top health priorities remained sufficiently attractive to influence the structure of the new MDG framework, prioritising three main health goals: MDG 4 (reduce child mortality), 5 (improve maternal health) and 6 (combat HIV/AIDS, malaria and other diseases). The framework, in turn, began to influence how the emerging global women’s and children’s health network structured its priorities and institutions, with both PMNCH and

Countdown to 2015 created with explicit reference to the goals (McDougall 2016).

Statistical evidence on mortality burden, coverage trends, and costing often dominated the media messaging produced by Countdown and PMNCH. Structural issues that contribute to these problems, such as gender bias or weak social accountability structures, were little reflected within the external frames used by the network to attract issue attention. Women were often depicted as mothers, and instrumental to child survival. One PMNCH/Countdown press release from 2010 was headlined as follows: *“Lack of skilled birth care costs 2 million lives each year: Report shows both mothers and newborns at risk”* (Partnership for Maternal, Newborn & Child Health 2010).

The existence of competing beliefs, priorities and frames within the global women’s and children’s health network occasionally slipped into public view. One example arose in 2004, when *Lancet* editor Richard Horton – an organising committee member for the first Countdown report in 2005 (UNICEF 2005) and publisher of many authors associated with the Countdown network – wrote an editorial charging Jim Grant’s successor at UNICEF, Carol Bellamy, with diluting attention to child survival in her new cross-sectoral “beyond survival” agenda, which integrated health with education, gender, and child protection issues. Horton wrote:

A preoccupation with rights ignores the fact that children will have no opportunity for development at all unless they survive. (cited in McDougall 2016, p. 7)

Recent studies and commentaries have remarked on the contrast between the broader social justice framing put forward by the early safe motherhood movement of the 1980s and 1990s (Storeng and Béhague 2014) and the comparatively narrow “evidence-based” frames deployed by global level maternal health advocates in the MDG era – a time in which quantitative MDG goals for women’s and children’s health reflected the dominant poverty reduction “supernorm” of the time (Smith and Rodriguez 2015, p. 53).

Political attention is a scarce resource: How attention is conveyed to others through political speeches, legislative agendas, budgets, media reporting and so on, reflect how certain issues are understood by a particular group of people at a certain time, rather than an issue's "intrinsic" or objective conditions (Hilgartner and Bosk 1988). Therefore, how women's and children's health networks succeeded in uniting behind a projecting a common set of ideas during the MDG era – i.e., those based on "scientific information" models of health and neoliberal concepts of development – is a measure of network strength and coherence during that time (Dearing and Rogers 1996).

Yet "information" itself is shaped through social and political relationships. Prevailing technocratic norms in public health of "evidence-based medicine" often ignore or obscure discussion of social relations (Hunter 2015; Storeng and Béhague 2014; Smith 2013). That health policy should be informed by rigorously researched evidence, and unbiased by ideology or myth, seems irrefutable (Fafard 2015). But the incentives and agendas of researchers are not always clear, nor those who fund their research (Hanefeld and Walt 2015). Evidence alone is rarely sufficient for influence; policymakers themselves have their own incentives and disincentives in deciding how, and if, to take evidence into account (Hawkes et al. 2015).

2.1.4 Political context: policy windows, global governance structures

In Shiffman and Smith's framework of political determinants for global health priorities (2007), the wider political context, or environment, contributes to shaping the ideas and choices of global health networks in powerful ways. This includes the opening or closing of "policy windows" (p. 1371), when global conditions align in such a way as to favour or disfavour action. Global governance structures and action frameworks also shape scope for collective action by policy actors.

The endorsement of the MDG framework by the UN General Assembly in 2001 (United Nations 2018)¹⁶ offered important scope for action by emerging global health networks. The MDGs consolidated existing human development targets, including the maternal and child mortality reduction targets set out in the 20-year programme of action agreed by 179 countries attending the International Conference on Population and Development in Cairo in 1994 (UNFPA 2014). In doing so, the MDGs gave new visibility to these goals, including through global summits to report on progress, held once in five years to 2015.

Reproductive health was deleted from early drafts of the MDG framework after strenuous lobbying by the Vatican and several Muslim governments, and not restored to the framework until 2007, after the conservative lobby began to falter (Hulme 2010). At that time, advocates took advantage of this policy window to press forward with tactical arguments that not only recognised human rights, but new findings in epidemiology and cost-effectiveness research that demonstrated the benefits of reproductive health to economic growth and population health, including of mothers and children (Hulme 2010).

Despite extensive criticism for its “one-size-fits-all” approach, with common measures applied to all countries (Storeng and Béhague 2016a; Fukuda-Parr, Yamin and Greenstein 2014), and technical, depoliticised view of human development (Ziai 2011, Saith 2006), others argued that a narrow set of goals can also focus or sustain political attention, generating significant material and technical resources. Dieleman et al. (2016) reported that financial aid in the first decade of the MDGs. Development Assistance for Health (DAH) grew 11.9% during 2000-2009, including by an average of nearly \$300 million per year for

¹⁶ A significant influence on MDG development was the work of the OECD’s Donor Assistance Committee (DAC), which in 1996, proposed quantifiable set of poverty-reduction, social development, and environmental sustainability targets to be achieved by 2015 (Organisation of Economic Cooperation and Development 1996), including reproductive health (Fehling, Nelson and Venkatapuram 2013). Some argued that the OECD goals, designed by northern donor governments and aid agencies, were more obviously aligned in both content and form with the MDGs than the UN Millennium Declaration agreed by 191 UN member-states (Hulme 2010). This contributed to lagging knowledge and support of the goals by many UN members from inception, as well as the influence of neoliberalist values and logic in their framing. Hulme (2010) observed that both the MDGs and the OECD goals were “constructed as tools for results-based management to make public policy more effective” (p. 5).

issues prioritised by the MDGs – significantly more than for non-MDG issues during these years, or also compared with years before the MDGs. Issues with the greatest share of DAH in the final year of the MDGs (2015) were identical to those prioritised by the goals, i.e., HIV/AIDS (30% of DAH), child and newborn health (18%), and maternal health (10%).

Yet these issues were also those with high-profile goals prior to the advent of the MDGs, and thus growing attention and resources during the MDG period built upon a prior history of attention to such issues. Díaz-Martínez and Gibbons (2014) argue, however, that the MDGs and related global health networks contributed to consolidating and sustaining attention for child and women’s health issues, despite worthy claims and evidence of global burden from many other issue-networks, including those that represented issues with high and growing burdens of death and disability, such as non-communicable diseases.

As the MDG period continued, human rights scholars produced a growing number of health and rights-based conceptual frameworks, principles, definitions, resolutions, reports and guidelines (World Health Organization 2017; Yamin and Farmer 2016; Yamin 2013; Hunt and Backman 2008). In the sphere of women’s and children’s health, such work challenged then-prevalent depictions of accountability as largely apolitical processes based on tracking and reporting of numerical indicators, such as levels and trends in intervention coverage, financial inputs, and population outcomes. This technical approach to accountability is made visible, for example, in the 2010 *Global Strategy for Women’s and Children’s Health* (McDougall 2016; United Nations 2010).

By 2014, however, the influence of health and human rights scholarship and the interaction of such experts with the WHO and partners, was represented in the final report of the Commission on Information and Accountability for Women’s and Children’s Health – coordinated by the WHO to support the *Global Strategy*. The report introduced a conceptual framework for global-national accountability, based on the iterative process of “monitor-review-act” (World

Health Organization 2014), underlining the importance of legislative remedy and response, and not only data collection and reporting.

The findings of the Commission on Information and Accountability and other human rights-related work on women's and children's health, guided discussion of accountability in the updated *Global Strategy for Women's, Children's and Adolescents' Health*, published in 2015. The updated document suggested an important normative change in the discourse and behaviours of the global women's and children's health network in response to the shifting political environment of the SDGs (McDougall 2016). The era of the MDGs, which contributed to evidence-based advocacy practices based on biomedical and economic concerns, was giving way to the messier landscape of the SDGs, and a renewed recognition of the social, economic and political determinants of health.

In 2015, the global women's and children's network acknowledged the changing policy environment and the opportunity of the SDGs by developing an updated strategy. The new *Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030* (United Nations 2015) promoted a rights-based approach to development policy and practice, acknowledging the need to tackle structural barriers to achieve both survival and well-being. These included gender bias, social exclusion, and health inequities within countries and regions.

Unlike the 2010 *Global Strategy*, which focused largely on technical interventions, financing, and innovation delivered by the health sector, the new strategy called for a cross-sectoral approach to implementation, requiring new partnerships between health and other sectors, such as education, nutrition, water and sanitation, labour, gender and others. Such changes in political context in the SDG era seem likely to influence the global women's and children's health network in relation to strategies, alliances, and even issue scope, as they did in the MDG era.

2.1.5 National policy context: India

India, and the state of Orissa, serves as the case setting for two chapters in this thesis (see chapter 3.1: *Overview of methods*). This section provides a broad introduction to characteristics of women's and children's health issues, political contexts, actors and ideas in India during the MDG period, touching briefly on health indicators in Orissa.¹⁷

At the end of the 2015 MDG period, the UN reported that India contributed 15% to the global burden of 303,000 maternal deaths, second only to Nigeria (19%) (World Health Organization 2015). In relation to child mortality, India accounted for 20% of the global toll of 5.9 million deaths of children under age five in 2015 (UNICEF 2015).

Yet rapid progress was made in India during the MDG period, if short of the MDG 4 and 5 targets. India's MMR fell from 560 maternal deaths per 100,000 live births in 1990 to an estimated 174 in 2015 (World Health Organization 2015); the U5MR fell from 126 deaths per 1,000 live births to 48, with an average annual rate of reduction of nearly 4% (UNICEF 2015).

Disparities in progress within and among countries and regions in the MDG era were mirrored within India. In 2014, the infant mortality rate in the southern state of Kerala was 12 per 1,000 live births compared with 52 per 1,000 in the north-central state of Madhya Pradesh (Registrar General of India 2018), driven in part by north India's comparably higher levels of female illiteracy, gender bias, and health system gaps.

India's "Empowered Action Group" (EAG) states (i.e., eight of the most populous states, located in north India: Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Orissa, and Uttaranchal, plus the small northeastern state of Assam) were together assigned an MMR of 188 during the most recent reporting period of 2014-2016, well above India's national figure of 130 for the

¹⁷ Detailed discussion of actors, ideas and the political context in Orissa is contained within the case studies, in chapters 6 and 7.

same period, as well as that of other regions in India, particularly, including the southern states of Kerala, Tamil Nadu, Karnataka and Andhra Pradesh, which together had an MMR of 77 (Registrar General of India 2018).

Orissa¹⁸, which became a site for campaign activities of the global network on women's and children's health and thus the setting for chapters 6 and 7 in this dissertation, made a certain degree of progress in reducing both infant and maternal mortality during the MDG period. It topped all states in India in reducing its infant mortality rate during 2005-2012, a 22-point reduction compared with an all-India figure of 16 (Government of Orissa 2012). However, during the last five years of the MDGs, progress slowed for some indicators: During 2011 to 2016, MMR declined by only 42 points, from 222 to 180, just slightly above the national average and the least progression by points among EAG states (Registrar General of India 2018).

In 2015, the Indian government spent 3% of its budget on health, representing 4% as a share of GDP and just USD63 on a per capita basis. Public spending accounted for just 26% of all health spending in the country in that year; the 74% balance was financed privately, largely through out-of-pocket expenses (World Health Organization 2018).

Health is decentralised in India, with states holding primary responsibility for financing and policy implementation, including through locally elected bodies at district and sub-district level. The central government is responsible to India's parliament for central funding, including contributions to state funding (contributing approximately one-third of public health budget totals, with states responsible for two-thirds). The central government is also responsible for the implementation of international agreements and providing funding to correct imbalances as needed.

¹⁸ Orissa is one of 29 states and seven union territories in India, and is located on the eastern coast of India, between West Bengal to the northeast and Andhra Pradesh to the south. As of the most recent national census, its population was 42 million (Government of India 2011).

Early in the MDG period, the political context in India began to shift and federal policy attention to women's and children's health expanded rapidly. An important reason for this was the election in 2004 of the welfare-oriented centre-left coalition, the United Progressive Alliance (UPA) led by Sonia Gandhi's Congress Party. The UPA came to power on a comprehensive reform agenda, prioritising equalised economic growth and social sector improvements. Gandhi, widow of former prime minister Rajiv Gandhi, appointed economist Manmohan Singh as prime minister, architect of India's successful market liberalisation reforms under a previous Congress-led government in the early 1990s.

During his decade-long tenure (2004-2014), Singh oversaw a series of ambitious institutional reforms to reduce health inequities and rural unemployment, and improve economic growth and public transparency in India. One of the most notable initiatives, the creation of the National Rural Health Mission (NRHM) in 2005, sought to improve provision and access to quality health services, particularly among women and children in poorer and marginalised areas of India, including the EAG states¹⁹.

NRHM built upon a long, often contentious, history in India of policy efforts to improve women's and children's health. Up until the 1990s, public health campaigns had often focused on population control and child survival rather than rights-based approaches to maternal and reproductive health (Shiffman and Ved 2007). One of the most notorious efforts was the target-based family planning campaign instigated by the Indira Gandhi government during a 21-month period of "Emergency" rule, from June 1975²⁰. In September 1976 alone, 1.7 million voluntary and involuntary sterilisations were reported, equalling the annual average of the previous 10 years (Gwatkin 1979).

¹⁹ *In 2013, NRHM was folded into the more comprehensive National Health Mission, including urban health. In 2018, the National Health Mission accounted for 57% of the federal Ministry of Health and Family Welfare budget, with NRHM accounting for 80% of the National Health Mission budget (Government of India 2018a).*

²⁰ *On the grounds of protecting national security, Indira Gandhi requested the president of India to invoke his constitutional authority to suspend democratic norms and practices, including free elections, press freedom, and the functioning of NGOs, unions and other civic rights groups (Guha 2007).*

The Emergency and the population control drive contributed to Gandhi's loss of power in March 1977 once Emergency rule was lifted and elections were re-established (Guha 2007). By the time she re-gained office early in 1980, signs of a moderated approach to health had emerged. Population control efforts in India, supported for decades by northern donors, were now embedded within a broader package of public health and welfare programmes (Ledbetter 1984). Efforts towards strengthening primary health care, echoing Alma-Ata's call of health for all, were seen in the revival of village health committees across India in the 1980s (Srivastava et al. 2015).

Women's and children's health has been long intertwined with India's democratic aspirations of inclusion and equity (Guha 2007). Indian women's rights movements took up right-to-health campaigns, inspired in part by the UN Decade of Women in the 1970s and 1980s (Shah 2004). Child nutrition and immunization drives in India were heavily promoted by NGOs and other civic organisations in India as part of the child survival revolution (Jolly 2014).

Even so, progress in reducing maternal and child mortality remained insufficient, demonstrated by India's first national Family Health Survey in 1992-1993 (Shiffman and Ved 2007). Also, programme evaluations in the 1990s and early 2000s of large-scale integrated child and maternal health programmes, supported by the World Bank and others, reported disappointing results, including low functionality of childbirth facilities across India's vast northern region, marked by significant class, caste, and religious differences (Vora et al. 2009; Shiffman and Ved 2007).

The advent of NRHM in 2005 was intended to act as an architectural correction to fragmented public health initiatives, insufficiently grounded in the social determinants of health (Narwal 2015; Vora et al. 2009). NRHM consolidated vertical programmes and integrated maternal and child health programmes with related initiatives on water, sanitation and nutrition at local governance levels. It also became the operational platform for India's national Reproductive and Child

Health II program, now with explicit reference to India's aim to meet the MDG goals (Vora et al. 2009; Government of India 2005).

NRHM's rights-based framework sought to improve health equity among India's states, and promote greater public accountability for service delivery. Civil society groups were invited to partner with government in the consultation, design and implementation process, including *Jan Swasthya Abhiyan*, the Indian chapter of the global rights-based People's Health Movement (Gaitonde et al. 2017).²¹

Consistent with a decade of neo-liberal approaches to development in India, private actors such as NGOs were seen by government as flexible, cost-efficient partners in the delivery of state, district and village-level support packages for NRHM policies and programmes, including those related to community education and mobilisation, data collection and programme monitoring, training and capacity building, among others (Scott et al. 2017a; Government of India 2013, 2005; Tandon and Mohanty 2005).

Civic movements in India have long been concerned with reducing inequities imposed by caste, religion and geography (Shah 2002). In the post-colonial landscape, NGOs have played important role in navigating the relationship between civil society and what is often perceived as an unresponsive state, described by Tandon and Mohanty as:

... the gap between what is constitutionally provided and its frequent violation, the way the poor and subaltern relate to the state and to the society, and collective action in the public sphere against dominant interests and an unresponsive state. (2002, p. 20)

²¹ Formed in 2001, Jan Swasthya Abhiyan is a civil society coalition made up of 21 national networks and organisations in India, coordinated through state-level chapters. More than 1,000 organisations participate in the work of the coalition, including raising awareness on adverse effects of globalisation and promoting decentralised health planning and community participation in India. These organisations include NGOs, women's groups, service delivery networks, and trade unions (Jan Swasthya Abhiyan 2018).

In the MDG era, globally connected civic alliances in India, such as the India branch of the global White Ribbon Alliance for Safe Motherhood, were adept at galvanising media attention and building political relationships between Delhi, state capitals, and global capitals (Shiffman and Ved 2007), linking India's rising attention to women's and children's health with a broader movement for change across borders.

Civic pressure in India contributed to the emphasis of India's ruling coalition on pro-poor approaches during the MDG era (Yadav, Gould and Ganguly 1996). Yet to an increasing degree, civil society and the private sector were also business partners of the pro-market UPA government, which privatised certain health services by engaging NGOs and others (Kapilashrami and Baru 2018; Mitra 2017). These conflicting roles – as activists and business partners – created differing forms of pressure and opportunity for civil society (Scott et al. 2017a). This is explored in chapter 7.

The UPA's commitment to decentralising health systems in India was represented by NRHM in myriad forms. This included financing, from state-level down to the village level; improved provision and management of human resources for health at village level; improved programme management through capacity building at district and block levels; monitoring, evaluation and citizen-led accountability against newly established public health standards and the provisions of a citizens' charter of rights and entitlements; and community engagement in intersectoral planning (Narwal 2015; Government of India 2005).

Initiatives included the creation of a nearly million-strong cadre of female voluntary community-based health workers, "Accredited Social Health Activists" (ASHAs), to strengthen links between village households and the public health system. ASHAs are the first port of call for community health-related demands, and are assigned to communities on a 1 per 1000 basis. They are paid on a performance-only basis to undertake varied duties, including mobilising child vaccination drives, and linking families to the provision of essential commodities such as oral rehydration salts and contraceptives. They support the work of

auxiliary nurse-midwives and other health workers by linking women and children to professional antenatal, delivery and postnatal care (Government of India 2017).

To address the social determinants of health, ASHAs were made responsible for integrating village-level nutrition, education, water and sanitation activities. This includes convening monthly meetings of Village Health, Sanitation and Nutrition Committees (VHSNCs). VHSNCs are mandated by the NRHM to act as locally appointed committees of elected village officials, health workers, local women's and self-help group members, and health system users.

VHSNC members, half of which must be women, are tasked with cross-sectoral community planning and promoting uptake of government health services, including through community monitoring and grievance redressal processes. VHSNCs are granted untied funds of Rs. 10,000 per year (approximately USD145) for health improvements, and function as a sub-committee of the locally elected village council, or *gram panchayat* (Government of India 2013).

As new sites for democratic participation, VHSNC structures under NRHM have been studied extensively in recent years (Ved et al. 2018). Findings include high levels of participation by women and socially disadvantaged classes, but little formal training of members, weak understanding of planning processes, irregular meetings, little monitoring of data on malnutrition, and difficulties in accessing and disbursing untied funds (Srivastava et al. 2015). Women may have learned to speak in front of men and to perform public roles, but evidence is lacking about whether this has influenced power relations outside of the VHSNC space itself (Scott et al. 2017b).

Lack of strong links between community health structures and the formal health system may also limit accountability and improvements to policy implementation (Srivastava et al. 2015). For example, in a case study on NRHM's community-based monitoring approach, Gaitonde et al. (2017) applied Sabatier's Advocacy Coalition Framework – an approach also adopted in chapter 5 of this

thesis – and found wide gaps between the beliefs and discourses of civil society and state actors. In the study, state actors saw NRHM village health structures as instruments for gathering information to improve government supply chains, while NGOs saw local monitoring as a collective tool for community empowerment and greater policy influence. Divergent interests and ideational competition influenced patterns of trust among local policy actors – crucial to normative projects like community accountability²².

In addition to community monitoring structures and staffing, another important NRHM initiative was the development of a conditional cash transfer scheme to drive uptake of institutional delivery, which was less than 50% in some states. *Janani Suraksha Yojana* (JSY), or “Maternity Protection Scheme”, sought to reduce reliance on traditional unskilled care and prevent adverse maternal health outcomes. Women who deliver at a public facility or accredited private facility qualify for a government payment of Rs. 600-1,400 (USD 10-20), depending on location of care. ASHAs who supported women through antenatal care, birth and postpartum care also qualified for payment (Government of India 2015a).

The results were dramatic at both national and state level. For example, in Orissa, the skilled delivery rate doubled in the first five years of the JSY scheme, from 35.6% in 2005-2006 to 75.5% in 2009 (Government of India 2015b). Evaluations have found linkages also between JSY payments and uptake of child immunisation and increased post-partum check-up rates, but also a greater decline of maternal mortality in richer districts compared with poorer ones (Carvalho et al. 2014; Randive et al. 2013; Lim et al. 2010).

Powell-Jackson, Mazumdar and Mills (2015) found no association between JSY cash payments and reduction of neonatal mortality, although they did find correlation with greater incidence of pregnancy, which they speculate could have been stimulated by JSY’s financial incentives for child delivery. Other unintended

²² *Trust dynamics are explored in detail in Chapter 7 of this thesis, applied to the case of NGO-led public hearings on maternal and child health in Orissa.*

effects relate to quality of care. Government reports from India found that more than 80% of the increase in services during the first five years of the JSY programme was fulfilled by less than 20% of government facilities (Government of India 2015b), suggesting risk of over-crowding and weakened quality of care stemming from JSY's popularity.

Others have argued that JSY, supported by political stability and fiscal growth in India, has had an important effect on narrowing health equity gaps and improving health systems. Thomas et al. (2015) found that institutional delivery rates among scheduled tribe²³ women in Orissa rose from 12% in 2005-2006 to nearly 70% in 2011, and that equity gaps also reduced for other maternal and child health services during this time, including in relation to antenatal and postnatal care, and immunisation. Vellakkal et al. (2016) observed larger pro-equity effects in uptake of institutional delivery and antenatal care in later years of the JSY programme (2011-12) compared with earlier years (2007-2008), but no positive effect on antenatal care in the earlier years of JSY.

"JSY effects" can also be seen on policymaking practices. In 2011, growing experience with the JSY programme prompted the Government of India to introduce the JSSK programme (*Janani Shishu Suraksha Karyakaram*, or Mother-Child Protection Programme), recognising that facility delivery rates could be further enhanced by reducing out-of-pocket expenses. JSSK introduced fully cashless delivery and post-partum services, including free C-sections, diagnostics, drugs, food during hospital stays, transport, and care for sick newborns (Government of India 2018b).

The rapid expansion of maternal and child health programmes in India during the MDG era indicated a high degree of policy attention, consistent with MDG intent and a rising recognition of India's power to influence global health trajectories (Gupta et al. 2017). By the end of the MDGs, intensified policy attention to improving inequalities contributed to rapid improvements: In the

²³ *Scheduled Tribe is a classification recognised under India's constitution for administrative and social welfare purposes.*

EAG states, MMR declined more rapidly than in other regions of India, with MMR falling from 246 to 188 during the period of 2011-2016, compared with 93 to 77 in the southern states (Registrar General of India 2018, 2014).

Indian political attention may have been influenced in part by global goal-setting, but new leadership toward the end of the MDG period also indicates India's determination to influence global goals and practices. A year after the defeat of the UPA in 2014 by the nationalist *Bharatiya Janata Party* (BJP), India's new Prime Minister Narendra Modi hosted a global meeting of health ministers and experts on women's and children's health experts in August 2015. His keynote remarks sent a new message to ministers and others gathered: India would no longer be a recipient of foreign aid and a mirror for foreign goals, but a global pace-setter itself:

As we transit from the Millennium Development Goals to Sustainable Development Goals, let us ... send a very, very strong message – not only to ourselves, not only to the 24 countries present here, but to the entire world. The message is of our commitment, that we will ensure that every woman, every child who can be saved will be saved.

India stands committed to not only allocate resources towards this in our country, but also to help the world and all those countries which need any support. India has done well in many ways and would be extremely happy to share its experience with other countries. (Modi 2015)

Since 2015, India has followed up on that promise, using global platforms such as PMNCH to influence policy on women's and children's health through financial donations, technical inputs, and political leadership.²⁴ Global networks can present domestic opportunities, signalling power and influence on the global stage while also answering domestic critics who decry a nationalist trend to

²⁴ In November 2018, India's health secretary Preeti Sudan assumed the role of acting PMNCH board chair from Michelle Bachelet, former president of Chile, who became the UN's High Commissioner for Human Rights (Partnership for Maternal, Newborn and Child Health 2018). Prime Minister Modi accepted an invitation by PMNCH to preside over its global meeting on women's and children's health in New Delhi in December 2018, accompanied by a related press event in Delhi in April 2018 announcing India's hosting role of the global meeting, advertised to the global media by actor and adolescent rights advocate Priyanka Chopra, whose Twitter and Instagram followers total nearly 80 million (Economic Times 2018).

“authoritarian populism” in Modi’s India and receding space for civil society (Chacko 2018).

The iterative relationship between India and the global network collaboration is profiled in two case studies presented in this dissertation. These cases analyse the characteristics and effects of the *Deliver Now for Women + Children* campaign (2007-2010), financed by the global women’s and children’s health network to accelerate progress of the maternal and child health MDGs, and matched by technical and financial resources from NRHM in Orissa for a state-level mass media campaign associated with the global campaign.

2.1.6 Summary

An important implication from this discussion of women’s and children’s health globally, and in India, is that the rising policy attention to these issues during the MDG period emerged, in part, from the coordinated efforts of disparate stakeholders, in multiple locations, both inside and outside of governments and traditional multilateral governance systems. This justifies attention in this thesis to the origins, characteristics, motivations and behaviours of transnational private-public networks in this process.

The following section of this literature review considers such networks in relation to theoretical concepts and frameworks that may guide understanding of how and why such processes take place. Empirical investigation then follows in the form of four case studies, presented in chapters 4, 5, 6 and 7.

2.2 Global health advocacy networks: emergence, characteristics and definitions

2.2.1 Growth of the global health governance arena

The wave of new global private-public health institutions in the late 1990s and the early MDG period – including those related to women’s and children’s health – represented a structural and normative challenge to the traditional functions,

operations and structures of the global health governance system (Kickbusch 2015; Fidler 2001). This is because, since the post-WWII advent of the United Nations and the WHO, the priorities and policies of international health had been negotiated among cooperating nation-states, legitimated and held to scrutiny by member-states – and not to private, democratically unelected actors – based on agreed public health principles.

However, from the 1990s, the growing capacity of non-state actors, such as private businesses, civil society groups, academic institutions, and health professional organisations, to intervene both individually and collectively in international health decision-making was enhanced through the creation of private-public networks and institutions, supported by growing financial, technical and normative resources produced by these platforms (Kickbusch 2015; Low-Beer 2012).

The growing engagement of non-state actors in public health in the 1990s and 2000s is attributable to historical events and economic policies (as discussed in chapter 2.1 in relation to the vertical campaigns of the child survival revolution of the 1980s and the increasing privatisation of health delivery due to economic liberalisation policies), but also to insufficient opportunities for non-state actors, including civil society representatives from the south, to participate meaningfully in policy processes dominated by nation-states and international organisations (Kickbusch 2015).

In the 1980s, economic and political crises in many regions of the world led to increased privatisation of public services, encouraged by the pro-market policies of organisations like the International Monetary Fund and the World Bank. Donors in the 1980s increased aid flows to NGOs to take on service functions in the health sector, with aid often channelled through multilateral organisations (Torchia, Calabrò and Morner 2013; Buse and Walt 2000).

By the early 1990s, these state-multilateral-NGO partnerships had broadened to include an array of other non-state actors, including businesses and private

foundations, academia, health professional agencies and others. This proliferation was partly in reaction to dwindling confidence in the multilateral system, its agencies weakened by overlapping mandates and inter-agency competition. Non-state actors offered new research and development funding, as well as scientific, programmatic and managerial innovations to improve health delivery. Through such contributions, non-state actors gained new opportunities in the 1990s and 2000s for influencing policy priorities at national and international levels, including those related to such issues as “neglected diseases” and health system strengthening (Buse and Tanaka 2011; Buse and Walt 2000).

From a governance perspective, the result has been the development of a complex new global architecture, with highly networked actors and multiple incentives and interests (Ruckert and Labonté 2014). Increasing cross-border ties, including through these globalisation processes, have challenged traditional state and UN leadership of public health, and contributed to the transition from “international health” to “global health” (Brown, Cueto and Fee 2011), in which dense ties among individuals, organisations and nation-states enable shared health security risks and benefits, new norms of private-public collaboration, and more participatory forms of global governance (Kickbusch 2015; Frenk, Gómez-Dantés and Moon, 2014; Low-Beer 2012; Castells 1996).

The rising scale, speed and intensity of these linkages have prompted new debates about the risks of market liberalism and income inequality on public health (Coburn 2004), as well as the opportunities of improving population health through the cross-border transfer of health knowledge and therapies (Deaton 2004). Questions also arose about necessary changes to the architecture and governance of public health, including rules, institutional mechanisms, and organisational forms in this new era of multiple actors and interests (Dodgson, Lee and Drager 2002). If health is to be understood not merely as the biological consequence of individual choice, but through the effects of social participation and standing (Marmot and Wilkinson 1999), the social and political environment in which public health is governed is of consequence to many.

The declining budgets and contested normative and technical influence of the WHO stood in contrast with the rising influence of non-state actors in global health in the MDG era, including new financiers such as the Bill and Melinda Gates Foundation and the Global Fund, as well as important new research centres, such as the Institute for Health Metrics and Evaluation. Lee (2015) asks whether global health is better governed through the dispersal of material and ideational resources across multiple centres of influence, or concentrated for greater effect. Some scholars argue that if private-public global health networks and institutions are to be viewed as legitimate actors because they highlight overlooked issues and enable participation of non-state actors, then greater attention must also be paid to their effects on fragmentation and weakening accountability within the global health system (Ottersen et al. 2014; Buse and Harmer 2004).

Indeed, an extensive literature documents both positive and negative effects of private-public networks in global health (Torchia, Calabrò and Morner 2013; Widdus 2005; Reich 2002). Benefits include consensus-building, knowledge-sharing and action on issues that no one actor can easily tackle alone; increased attention to health within global development and resources for overlooked issues; expanding access to new technologies, medicines and vaccines; and pressure on multilateral agencies, including the World Health Organization, to embrace institutional reform (Buse and Tanaka 2011).

However, challenges are also manifold, including fragmenting effects on national health systems (Ooms et al. 2018; Ruckert and Labonté 2014); clashing incentives and conflicts of interest among public and private partners; weak transparency and accountability for practices and effects (Reich 2018); lagging attention to gender policies and practices (Hawkes, Buse and Kapilashrami 2017); and ineffective engagement of civil society (Storeng and de Bengy Puyvallée 2018).

2.2.2 Network characteristics

When we say that policies are decided by analysis, we mean that an investigation of the merits of various possible actions has disclosed reasons for choosing one policy over others. When we say that politics, rather than analysis, determines policy, we mean that policy is set by the various ways in which people exert control, influence or power over each other. (Lindblom 1968)

This thesis focuses on networks as strategic and political actors in the making of global health policy. Contrary to networks that exist for material purposes of individual or organisational financial or political gain, the primary tools and resources of advocacy networks are socially constructed, and include shared information, knowledge, and symbolic “frames” of meaning, enabling heterogeneous network members to seek social power by shaping public perceptions of problems, causes, and solutions through shared ideas and perspectives (Keck and Sikkink 1998). For example, in the 1990s, the global safe motherhood network struggled to position maternal deaths as the consequence of gender bias, deserving of singular attention, and not only because maternal deaths influence child survival.

Since policymaking is a social process, and policy is set – as Lindblom suggests (1968) – by the ways in which people exert power or influence over each other, the differing access of global health networks to resources (money, expertise, information, diversity of members, etc.) contributes to their capacity to wield power and influence (Walt 1994). Thus, access to scientific knowledge, information, and persuasive frames are central to the interests of value-driven networks as they compete for policy influence, using such ideational tools to gather and unify members for greater dominance and impact in policymaking processes (Sabatier 1988).

Such responsive, actor-based networks contrast with less sensitive and more static structure-based networks, characterised by influential studies such as Travers and Milgram’s experimental study of the “small world problem” (1969), which demonstrated and quantified social inter-connectedness across large

population groups, and Granovetter's "The strength of weak ties" (1973), recognising the "embeddedness" of economic relations in social systems.

Such early network studies were concerned with organisational forms that Kahler (2009) described as "structure-based" networks, i.e., relatively unyielding, structures populated by members who are largely unaware of the fixed hierarchies in which they are embedded, and how such structures shape human behaviours to produce desired effects. In Kahler's depiction, "structure-based" networks do not emerge from the intentional designs of network members, and network members are largely unconcerned with changing the structure itself. In contrast, "actor-based" networks are characterised by the purposive behaviours of individuals and organisations within such structures, including those behaviours concerned with network formation and reform. Such networks can be recognised by the "fluid and open relationships between knowledgeable and committed actors working in specialised issue areas" (Keck and Sikkink 1998; p. 8).

This study is concerned with understanding how and why global health actor-based networks advocate for principles and ideas, and not with measuring and defining the relational patterns and properties of network structures themselves. Accordingly, this thesis places emphasis on qualitative methods to explore network characteristics, and not quantitative methods and tools associated with the growing field of "social network analysis" (Scott 2017; Carrington, Scott and Wasserman 2005), increasingly applied to public health (Valente 2010).

Kahler's idea of purposive, self-aware actor-based networks (from now on, simply referred to as "networks") is relevant to the case of the global women's and children's health advocacy network because of its focus on normative and moral framing undertaken by such networks. Given that collective needs must be balanced against individual rights – for example, the need to reduce HIV prevalence must be squared with individual freedom to have sex – networks perform an important function in generating political debate and resolution to legitimise moral judgements that guide policy decisions. Such decisions may be

necessary not only in relation to public health itself, but also to reduce risks to global security and political stability invoked by public health issues, such as political crisis caused by pandemics (Oliver 2014).

As members of global health networks debate and agree on which information and frames to disseminate, they contribute in important ways to the public perceptions of risk and threat. But which frames, and what types of information are privileged in this process, reflects on who holds power within networks, and why.

In their review of global health diplomacy literature, Ruckert et al. (2016) describe growing scholarly attention to problems of distortion and accountability within networks. For instance, individuals and organisational members may provide funding for global health partnerships – i.e., institutionalised forms of private-public health networks – as a strategy for shifting public debate toward their preferred problem definitions and policy solutions. For instance, wealthy private foundations may fund global health partnerships as a mechanism to argue that certain public health problems are best approached through market-led and/or technology-based solutions, rather than public sector reforms, often subject to contention and requiring greater time to achieve compared with less structural, shorter-term fixes (Kapilashrami and Baru 2018; McCoy et al. 2009).

Yet, it may be difficult to disentangle the motives of actors within networks from the influence of the broader political environment in which they operate. This was the case during the MDG period, governed by a global health system dominated by biomedical and neoliberal perceptions of health as instrumental to economic development, foreign policy and political security (Fukuda-Parr, Yamin and Greenstein 2014; McInnes et al. 2012; Rushton and Williams 2012).

How global health policy is made is influenced by political context, as well as the history of power relations among actor groups (Smith and Katikireddi 2012), and is explored in chapters 4, 5, 6 and 7 in this thesis. The growing magnitude of

the global health system as an arena for struggle among diverse actors and interests is illustrated by Hoffman and Cole's finding (2018) that 203 global health actor-groups were created between 1864 and 2011, i.e., an average of 2.0 actors established per year during the post-war period of 1945-1952 compared with an average 4.91 per year from 1986 to 2006, as development assistance for health surged in the first decade of the MDGs (Dieleman et al. 2016).

Within this arena, Hoffman and Cole observe an "overwhelming presence" of global civil society organisations (CSOs), including NGOs. Private-public partnerships involving CSO members accounted for 10% of all groups surveyed, many with dense links to other partnerships, acting as webs of connectivity within the larger global health system.

The networked presence of civil society groups in global health suggests that such institutions possess particularly strong social positioning and advocacy influence with other global health actors, meriting further attention to the questions posed in this thesis on the role of the global women's and children's health network during the MDG era, including that of PMNCH – a dominant global advocacy partnership for women's and children's health during the MDG era (Storeng and Béhague 2016b).

This thesis suggests that the global women's and children's health network is best understood not as a single, narrow organisation or institution, but as a comprehensive *policy sub-system* within global health (Sabatier 1988) – i.e., a web-like domain consisting of both public and private organisations and individuals concerned primarily with women's and children's health issues (Shiffman et al. 2016). Within this shared domain, different organisations and individuals hold different policy beliefs and resources, aligning into separate but related "coalitions" that compete to shape the dominant ideas of the sub-system (Sabatier 1988).²⁵

²⁵ Examples of these coalitions in the global women's and children's health network are discussed in chapter 5.

Various efforts have been made to address lack of clarity in terminology and definitions in global health arrangements (Hoffman and Cole 2018; Buse and Harmer 2007). These efforts exist in parallel to efforts by social movement scholars seeking to distinguish between such concepts as “interest groups”, “advocacy coalitions”, and “social movements”. For instance, Weible and Ingold (2018) propose four different attributes to characterise these different forms of political association, i.e.: membership (formal/informal); type of actor involved (experts, citizens, etc.); “binding” factors (shared beliefs, values, knowledge, material interests, etc.); and stability (stable or ephemeral). For instance, an interest group may be characterised by its specific policy goals, quasi-organisational structure, professionalised membership and identifiable brand name, whereas a social movement may involve ordinary citizens who band together for a broad change related to power imbalances, such as anti-poverty or anti-racism movements.

In this thesis, Sabatier’s concept of an advocacy “coalition”, i.e., groups of interested individuals and organisations who form informal alliances on policy issues (1988), which guides chapter 5, can be characterised as broader in scope than an interest or lobby group, but also more stable in structure and outlook than a social or consumer-based movement, which may form and then disband campaigns as political events shift (Weible and Ingold 2018).

Shiffman et al.’s definition of global health networks (2016) aligns closely with Sabatier’s concept of stable, belief-based advocacy coalitions. While Shiffman does not specify if ordinary citizens are part of such web-based networks or policy sub-systems; Sabatier believes they are not, and that individuals active in advocacy coalitions would be mainly those who work for government or non-state organisations (Weible and Ingold 2018; Sabatier 1988).

This thesis uses Shiffman’s more open-ended definition, aligning in most respects otherwise with Sabatier, and thus allowing scope for network participation by ordinary citizens, as well as individuals working for policy-oriented organisations. This is because there are many examples of concerned

citizens working directly or indirectly with health experts and professional organisations on issues of common concern at various levels of activity. Global level examples include HIV-positive individuals who collaborate with the Global Fund or parents of preterm babies who post Facebook messages on the World Prematurity Day campaign site. At local level, as discussed in chapters 6 and 7, this may include women who participate in community-based social accountability activities linked to global network activity, or express intent to do so.

Yet boundaries are important for understanding who is – and who is not – part of a given network. Based on the above example, this thesis depicts network members as individuals and organisations dedicated to improving women’s and children’s health as their *primary* intent for collective action, and not equal or secondary to other development concerns they may have, and activities they may participate in. This “boundary” understanding is shared by Hoffman and Cole in their global health system mapping project (2018, p. 4), i.e.,

The global health system includes the transnational actors that have a primary intent to improve health and the polyilateral arrangements for governance, finance and delivery within which these actors operate.

Thus, in characterising policymaking for women’s and children’s health as a socially constructed process (Walt 1994), network-based relations between actors offer an important lens through which to understand the priorities that motivate personal and organisational behaviour, and how these priorities are further shaped by wider social and political environments, influencing how power is produced and reproduced by such networks.

Further, the proliferation of private-public global health initiatives in the first decade of the MDGs (Hoffman and Cole 2018, Ruckert et al. 2016; Low-Beer 2012) offers a rich historical period in which discourse, strategies, relationships and dominant knowledge forms of these networks can be traced, enabling study of how and why the global women’s and children’s health network sought to influence priorities during this period.

2.3 Networks and policymaking processes

Over the past two decades, the expanding study of global health governance reflects significant interest in the changes and innovations that have shaped its policies, institutions and practices, echoing wider globalisation processes (Rushton and Williams 2012). Diplomacy efforts in this field are defined by the “practices by which governments and non-state actors attempt to coordinate efforts to improve public health” (Ruckert et al. 2016, p. 61), and have been accompanied by a broad range of scholarly efforts that seek to describe, assess and explain the social discourses, norms, legitimacy and accountability of actors within it (Kickbusch 2015; Adams Novotny and Leslie 2008).

Global health governance studies have drawn on a heterogeneous set of theories and frameworks, including those from international relations, law, political science, history, sociology and anthropology (Dodgson Lee and Drager 2002). During this time, dominant economic and biomedical paradigms rooted in a state-centred system of global health (Rushton and Williams 2012) have been challenged through rising debate on health inequities and the participation of non-state actors in health decision-making, delivery and accountability, even though such actors themselves may contribute to reduced health service quality, public sector staff retention, and out-of-pocket expenses (Bennett, McPake and Mills 1997).

In this literature, global health relations are increasingly understood as a matter of practice embedded in processes of social negotiation and competition (Katz et al. 2011), with individual health status determined not only biomedically, but by shared ideas and collective human action structured by power relations (Marmot and Wilkinson 1999).

Shiffman and Smith’s 2007 framework on the determinants of political priority arises in this tradition, bringing attention to the capacity of collective action through global health networks to intervene in important ways in public health.

In doing so, this framework offers an important analytical tool and research challenge to this fast-expanding study of global health governance: How do we understand why certain global health issues attract priority, while others do not, especially when priorities do not necessarily reflect “evidence” on health burden status, trends or risk?

The following sub-chapters of this literature review situate the Shiffman and Smith framework in the history and context of agenda-setting theories in public policy, and provide further detail on the framework itself.

2.3.2 Agenda-setting theories

In public policy studies, the idea of agenda-setting is recognised by the classic “stages” heuristic, which depicts a steady progression from problem formation and agenda-setting to selection of policy, implementation and evaluation (Lasswell and Kaplan 1965; Brewer and deLeon 1983). While agenda-setting is identified as an important and formative phase in the policymaking process, the overall characterisation of policymaking as a series of steps, disconnected from one another, and forward-marching under government direction, has been much disputed. Sabatier (1988) and others have led an effective critique against this linear and “top down” model, placing emphasis instead on how the competitive interaction of ideas, values and actors, including those from civil society, science, media, as well as government, shapes the policy process in an iterative fashion.

More recent approaches therefore proposed a less sequential and more interactive policy process involving diverse actors; they paid more attention to how policy ideas evolve, and with whose intervention (cf. review articles by Smith and Katikireddi 2012, Walt et al. 2008). For instance, Hecló (1978, 1974) suggested an incremental, backward-and-forward process of continual learning through uncertainty and “puzzlement”, with social learning through “issue networks” connecting politicians, bureaucrats, and interest groups. However, this incrementalist view was soon criticised by other scholars (e.g., Kingdon 1984, Baumgartner and Jones 1993, Hall 1993), demonstrating that important

changes may occur in a more rapid fashion, by which new ideas suddenly gain influence and shift policy priorities quickly.

For instance, Kingdon's influential 1984 study of public health and transport policy in the U.S. characterised the policy process as random in nature; many problems, policy ideas and political conditions co-exist, but these "streams" only converge infrequently. The "streams" approach emphasised that even if persuasive issue frames exist (policy ideas, or "policies"), they are insufficient if the wider political environment ("politics") is unfavourable. All streams must be flow together for change to occur. Policy "entrepreneurs" play a critical role in this process. They force open "windows" for policy change, i.e., moments in time when preferred policy ideas gain political traction because of sudden demand for innovation or change. They contribute to producing these windows by building perceptions of certain conditions as policy "problems", building up arguments and well-connected supporters over time, including those with political clout. Entrepreneurs may be experts, corporate leaders, or an influential member of an interest group; their capacity lies in their ability to bring ideas, networks and political connections together to achieve change when opportunity calls.

In a similar vein, Baumgartner and Jones (1993), suggested that persuasive ideas have the capacity to capture public opinion at certain moments of time, "punctuating" the equilibrium of an otherwise stable policy process. While policy changes tend to occur incrementally, rising public attention for certain ideas can cause "punctuations", or policy shifts, within stable systems. Such punctuations arise in response not only to persuasive ideas, but wider political context.

Hall (1993), furthermore, brought attention to the importance of social debate and political competition on values and ideologies: His study of the shift from Keynesian to monetarist economic policy in Britain, for example, showed that new ideas gain traction through "paradigm shifts" in thinking, and less through experiential evidence and gradual learning over time, as incrementalists like Hecló, Lindblom (1968) and others had earlier suggested.

Sabatier's Advocacy Coalition Framework (1988) offers a schematic treatment of public policymaking as a dynamic competition of actors through ideas and values (Weible and Sabatier 2007), rather than the linear expression of material interests by state-based structures. In this framework, coalitions of actors united by similar ideas and beliefs compete against other coalitions for policy dominance. Within relatively stable parameters, this continual competition is structured by both external events, which enlarge or limit the competitive resources that coalitions can call upon. Consistent with the "punctuated equilibrium" theory (Baumgartner and Jones 1993), Sabatier's work suggests that "core beliefs" in policy sub-systems rarely change, and that actor dynamics are influenced mainly through "policy learning" processes, in which new scientific or technical knowledge may influence coalition beliefs at a "secondary" level. These ideas are particularly useful to the questions asked in this thesis because they seek to explain how competition and negotiation among coalitions of heterogeneous actors who share common values and ideas help to shape policy outcomes (see chapter 2.4: *Actor-power in global advocacy networks*).

In the context of global health policy and the proliferation of public-private partnerships, Shiffman and Smith's framework (2007), built upon Sabatier's ideas about the importance of actor-networks as coherent forces of normative influence, as well as ideas from Kingdon (1984) and Baumgartner and Jones (1993) about policymaking as a punctuated process, rather than an incremental one. In this framework, the dynamic interaction of policy process, context, and actors produce global health policy, drawing on Walt and Gilson's idea of a health "policy triangle" (1994).

This literature from public policy provides important elements for enquiry in relation to global health agenda-setting processes. However, complementary insights are to be gained from the field of media studies, which suggest an important role for media and campaigns in this process. Nearly a century ago, *Public Opinion* (1922), Lippman's classic study of governance and public behaviour, identified the mass media as a persuasive force in public life because it disseminates synthesised and simplified versions of complex realities, based

on the cognitive frames and “pseudo-environments” of those who influence news reporting. Public opinion is shaped through media-based propaganda, thus “manufacturing consent” for state decisions and manipulating democratic processes in doing so. McCombs and Shaw (1972), produced the first widely circulated study in the field of media-led agenda-setting, asking 100 undecided voters in a community in the U.S. about their interests in an upcoming election, finding important correlations between political opinion with news media coverage, including which issues were selected for coverage and the prominence given to those issues. Observational studies in the U.S. have also demonstrated the direct influence of mass media on U.S. foreign policymakers (Cohen 1963).

Thus, environmental influence on the ideas of policy actors has been a longstanding theme in agenda-setting studies, including those that consider processes of “priming” (i.e., how media coverage prepares consumers to accept or reject certain policy ideas when they arise), as well as “framing”, or the process by which people construct and adopt preferred ways of seeing and communicating to make sense of the world around them (Scheufele 2000; Goffman 1974).

In summary, the literature on agenda setting from the fields of public policy and media studies suggests that social ideas and networked structures, developed in relation to wider environments, may be important in explaining agenda-setting effects in global health too. These and other elements have been taken up and further developed in the Shiffman and Smith framework of 2007.

2.3.3 Determinants of political priorities: Shiffman and Smith (2007) and beyond

The Shiffman and Smith framework guides attention to the role of social ideas and actor-based processes in global health, providing a set of inter-dependent categories and factors, as seen in chapter 1.2, for exploring how and why power may be exercised by such networks in the policymaking process. The framework suggests that cohesive groups of actors with common interests and values use social ideas and related resources (norms, narratives and frames) in engineering issue attention and transforming the forms and terms of global health debate

(Benford and Snow 2000; Keck and Sikkink 1998; Stone 1989). While policy change may be incremental in nature, favourable conditions or “windows” for action open at certain moments in time (cf. Kingdon 1984), enabled and facilitated by networks in building political support for their policy ideas.

In the MDG era, the framework developed from country-based empirical studies conducted by Jeremy Shiffman on national priority for safe motherhood issues in five developing countries in Latin America, Africa and India (Shiffman 2007). In adopting global-level health networks as their main unit of analysis, Shiffman and Smith responded to the growing scale and presence of transnational private-public networks and institutions in global health, as well the paucity of conceptual approaches through which to analyse health policy and power in the context of low- and middle-income countries (Sriram et al. 2018; Walt and Gilson 2014).

Apart from public policy literature discussed in the previous sub-section, the Shiffman and Smith framework drew from sociological concepts of movement creation and the use of ideas and frames as strategic resources for network cohesion and power (McCarthy and Zald 1977), as well as from social constructivist concepts in international relations and political science on agent-led norm production through transnational networks (Finnemore and Sikkink 1998; Keck and Sikkink 1998). In taking up questions of actor-power and policy process in global health, the framework also arises from a long history of debate in public policy between the role of structure and actors, interests and ideas, and state and non-state actors.

The categories in Shiffman and Smith’s framework (i.e., actor-power, ideas, issue characteristics, and political context) and their related determining factors have been refined and tested by Shiffman and other scholars in subsequent global level agenda-setting studies since 2007 (Hafner and Shiffman 2012; Pelletier et al. 2011; Shiffman 2010). These conceptual refinements illustrate the openness of the framework to continued evolution and theorisation, as well as its broad applicability to interdisciplinary policy studies at both global and national levels.

As such, it is a highly suitable conceptual tool for this thesis, particularly given similar issue contexts, research concerns, and the use of qualitative methods (cf. chapter 1.2). Furthermore, the Shiffman and Smith framework is regarded as one of the most tested and valid conceptual framework in global health agenda-setting studies (Walt and Gilson 2014).

This is not to say that improvements to the framework are not required for increased analytical power. Critiques made of the Shiffman and Smith framework include the need for greater conceptual clarity between certain factors and categories. These may overlap at times and suggest practical indivisibility; for instance, “actor-power” may be inseparable from the “ideas” that underpin that power (Walt and Gilson 2014). It is also the case that causal weights are not assigned to the four framework categories and 11 factors; despite their multiplicity, each one is presented as equally important as the next.

Yet weighting of factors may raise the difficult question of whether it is possible to determine empirically if networks influence political attention, and if so, to what extent. Shiffman and colleagues approached this question in a study that applied historical process-tracing methods to six different global health networks in three matched pairs to assess how networks emerge and evolve.

The study (2016) found that while network influence can be assumed to exist, it cannot be measured conclusively.

While other factors were influential, the networks played central roles in raising global attention This finding was not an obvious one. The networks might have failed in their efforts. Or attention may have emerged due to other factors, such as the individual, rather than the networked activity of involved actors, the influence of powerful nation-states or donors, growth in the severity of the problem, and new solutions.

Possibly other forces may have converged to produce the same agenda-setting effects. However, it seems reasonable to assume that this is unlikely and that networks accelerated policy change, if not always to the extent that they hoped for. (p. i120)

Reflecting on this study and the difficulty of disentangling the multiple influences of policy priority, Shiffman has recently raised the question of whether networks

may indeed be “epiphenomenal”, i.e., a secondary effect or by-product that arises from global health processes, but does not causally influence it (2018). Indeed, if one seeks to determine effects with greater certainty, counterfactual questions and “robust means of assessing effects” (p. 880) must be found, and Shiffman asks whether control-based studies could detect differences in policy and health across conditions due to network activity.

Yet methods must follow questions: If one is concerned primarily with the ways in which networks seek influence and the effects of those processes, then attention must shift to theories, concepts and approaches that assist in revealing “how” and “why” networks matter in the discussion of global health. Deaton and Cartwright (2018) argue that unbiased and ahistorical evidence, such as that produced through randomised controlled experiments, can play a role in generating knowledge, but only when part of a cumulative, interdisciplinary research process, grounded in history, concept and theory, and based on multiple methods:

Without knowing why things happen, and why people do things, we run the risk of worthless casual (‘fairy tale’) causal theorising, and have given up on one of the central tasks of economics and other social science. (p. 21)

Shiffman too argues for the application of appropriate theory to empirical, cross-disciplinary and historically rooted research (2018).

Thus, this thesis does not seek to address the question of “Do networks influence attention?”, and focuses instead on questions influenced by Walt and Gilson’s critical review of the Shiffman and Smith framework (2014), including those relating to how conflict and negotiation operates within global health networks, and how such processes may influence dimensions of actor-power, such as network cohesion and growth. Further questions are raised in relation to the review of media and health communication literature undertaken for this thesis, i.e., what is the role of communication processes in shaping related elements of actor-power, such as issue framing, issue visibility, and network replication at scale?

This thesis treats the production and use of communication campaigns by global health networks as an expression of Shiffman and Smith's concept of "actor-power". It examines network campaigns to understand how network actor-power operates, both materially in terms of network growth and resource mobilisation processes, but also ideationally in terms of frame and norm diffusion at scale.

This thesis applies socio-political theories and frameworks to analyse case evidence on the origins and attributes of network actor-power (i.e., Sabatier's Advocacy Coalition Framework and Bourdieu's capitals theory). Finally, it draws on the insights of social ecology theory from the field of health communications (Abroms and Maibach 2008; Sallis, Owen and Fisher 2008; Cohen, Scribner and Farley 2000) – often overlooked in global health policy studies – to analyse how actor-power may operate at the population level, across multiple scales, through global health network-sponsored communication campaigns.

In doing so, this thesis seeks to build on the concept of "actor-power" and contribute to greater understanding of the characteristics and pathways by which actor-networks seek influence in global health.

2.4 Actor-power in global advocacy networks

Forms of financial, normative and epistemic power are omnipresent in global health and global health networks, if not always seen (McInnes et al. 2012; Rushton and Williams 2012; Buse and Harmer 2007). Power is present, for example, in the tweets and Facebook campaigns of civil society organisations; the technocratic research agendas of private health funders; the economic and biomedical frames of influential papers published in global health journals; and the focus of side events and resolutions on emerging issues engineered by member-states of the World Health Assembly. Brought together in a network, these can amount to more than their sum and so enhance network power.

Virchow's maxim may be widely recalled: "Medicine is a social science, and politics is nothing else but medicine on a large scale" (1971; cited in Lee 2015). Yet contemporary global health governance scholarship has been slow to recognise the existence, sources and forms of power, and to examine their legitimacy (Shiffman 2014).

This includes lack of scrutiny of private-public global health institutions, often assumed to act in the public good because of their efforts to establish resources and attention for deserving health issues (Buse and Harmer 2004). But what if such actors fail to debate on more deserving issues, or if their arguments reinforce paradigms and narratives that widen inequities in public health? In this light, examining power in global health is an important but overlooked task, argues Shiffman (2014).

Different explanations have been offered as to why power has been little discussed in global health governance studies. Some attribute this to the dominance of neoliberal and economic frames and paradigms in global health (Rushton and Williams 2012), produced by powerful actors as "master narratives" about the causes and effects of ill health, thus silencing discussion and debate on the origins, forms and effects of power (Nichter 1998).

Others point to the rising prevalence of networked forms of policymaking, in which competing "truths" urge a turn toward a single accepted one. Such natural science-based norms in global health would resist normative bias or politics; indeed, politics is then viewed simply as "interference to rational decision-making" (Lee 2015, p. 257; Hunter 2015).

Yet others argue that states use the tactics of "anti-politics" to avoid ideational challenges by global health networks because these may propose radical structural changes to global capitalist models upon which their economic interests and political hegemonies depend (Gill and Benatar 2016). Consensus may be hard to reach and other more important state objectives may be eclipsed or obscured in the debate on health (Labonté and Gagnon 2010).

Yet, the Lancet-University of Oslo Commission on Global Governance for Health (Ottersen et al. 2014) identified five areas where governance reform is dependent upon willingness to engage with the political determinants of global health: weak accountability, democratic deficit, missing/weak institutions, inadequate policy space, and institutional “stickiness”.

Whatever the origin and the effects, it is likely, however, that lack of attention to power in global health is produced neither by agents nor structures alone, nor by their material interests or ideas alone. Such attributes are often intertwined in global health, and such classic binary debates from the field of international relations may be difficult to recognise in an arena where global health networks are influenced by the reputational self-interests of young southern NGO leaders, the ideals of technocrats from northern bilateral donors or the interests of private actors, and where power in any case, may be better conceptualised as fragmented and dispersed between independent nodes in a polycentric governance system operating at multiple levels (Tosun 2018).

One effect of the lack of dialogue on power in global health is that actor-power has been very little categorised or conceptualised within global health governance literature, nor applied through theory to empirical studies in low- and middle-income settings, where engaging in discussions of power could shed light on root causes of persistent health system inequities (Sriram et al. 2018).

Yet, there is a vibrant literature on power, including longstanding efforts to observe, conceptualise and categorise its effects within social relations (Raven and French 1958). One taxonomy applied recently by Shiffman in the discussion of power in global health governance (2014) comes from Barnett and Duvall (2005), who define power through the idea of actor capacity to resist the constraints of wider structures around them:

Power is the production in and through social relations, of effects that shape the capacity of actors to determine their own circumstances and fate. (Barnett and Duvall, p. 8)

Their definition draws on Weber's actor-centred concept of power,²⁶ and informs consideration of how actors are enabled and constrained in multiple ways. Barnett and Duvall conceive of four main categories of power: compulsory power, institutional power, structural power, and productive power. These forms are summarised and illustrated below.

Compulsory power relates to situations when one actor exerts direct control over another, such as when one state threatens to apply sanctions to another, compelling that state to behave in a certain way. *Institutional power* refers to situations when actors exert indirect control over others, such as when powerful nations within trade or monetary organisations design norms and rules in ways that advantage themselves and disadvantage others. *Structural power* refers to the development of social capacities and interests of actors in relation to each other, such as when certain individuals are endowed with certain economic, cultural or social assets that enable them to become CEOs while others serve as their wage labourers. *Productive power* refers to social subjugation of actors through socially pervasive systems of symbols and meaning. This type of power is often difficult to see, hidden in everyday routine and language that structures how one sees the world. For instance, gender-blind practices in the workplace can suggest the presence of hegemonic discourse that relies on silence for its power.

Through this classification, we can interpret contemporary experiences of power in global health through the ideas of Weber, Marx and Foucault, and relate them to prevailing paradigms in international relations and global governance debate. Barnett and Duvall's concept of structural power, for example, recalls Marxist political economy concerns with class relations under capitalism, and the reproduction of power through historical and social conditions that limit individual agency. Marxist concerns with class focus on economic and material aspects of conflict and power are influential in current global health governance

²⁶ In a translation of Weber's *Economy and Society*, Roth and Wittich (1978) defined power as: "the chance of a man or a number of men being in a position to carry out his own will even against the resistance of others who are participating in the action."

debate in many ways, including through Wallerstein's World-system socio-economic theory (1974), often applied in International Relations.

Wallerstein argued that it was by placing states in relation to each other that patterns of exploitation can be seen, as global forms of capitalism encourage coherence among industrialised powers and enable their collective exploitation of peripheral, lesser-developed economies. In global health, an example of structural power could be seen at the World Health Assembly in 2018, when the US government threatened to impose trade and security sanctions if certain states supported a resolution on breastfeeding that threatened the corporate interests of American baby milk producers. At least a dozen countries, mostly poorer countries in Africa and Latin America, backed away from the resolution, fearful of retaliation (Jacobs 2018).

Productive power is closely related to Foucault's post-structuralist concept of discursive power, i.e., the influence of dominant discourses (socially shared perspectives) and narratives in the acquisition of knowledge, if rarely recognised and often hidden from view. Productive power can be seen, for instance, in how influential members of the global women's and children's health network unwittingly adopted highly technical frames for evidence production and advocacy in that era. By prioritising the use of evidence-based logic and methods drawn from medical science, network leaders – many with clinical and economic backgrounds – focused substantially on the goals of mortality reduction rather than the social determinants of health, which might have received more attention if different systems of knowledge prevailed (see chapters 4 and 5).

Productive power is also related to Lukes's concept of the discursive "third face of power" (1986), as well as to constructivist epistemology (Finnemore and Sikkink 1998), conceptualising actors as propagators of norms, values and identities that shape institutions and structures. In this sense, global health networks are produced and reproduced through shared ideas, values, and identities, and therefore socially created and animated by the collective will of its actors. Thus, such heterogeneous public-private networks represent a challenge,

both practically and theoretically, to the nation-state hierarchies that have traditionally dominated global health policymaking.

The Shiffman and Smith framework offers a widely tested tool by which power and conflict can be recognised and negotiated. Its agentic perspective is recognisable in its social constructivist approach, which prioritises “actor-power” as a key category of influence, interacting with issue characteristics, ideas, and political context to produce structural effects.

Yet, without attributing causality nor predicting future effects on issue attention, the aim of this thesis is to improve understanding of the role that the global network may have played during a period of rapid multiplication of actors and resources for women’s and children’s health, and how processes of power, including negotiations among actors, may have shaped the network during this time. Locating and analysing dimensions of power are thus central to normative inquiry and the redressal of inequities in global health, i.e.: “To locate power is to fix moral responsibility” (Isaac 1987, p. 5).

To pursue this aim, this thesis engages actor-oriented social and political theories to explore and interpret characteristics of network development and selected two main power-based concepts for this purpose. Each is conceptually aligned with the Shiffman and Smith social constructivist approach to understanding the role of actor-power and their ideas in relation to policy issues and contexts. These are Paul Sabatier’s Advocacy Coalition Framework (1988; see chapter 5) and Pierre Bourdieu’s capitals theory (1986; 1977; see chapter 7).

Sabatier’s Advocacy Coalition Framework

Paul Sabatier is an American political scientist, whose work on the belief systems of political elites and policy-oriented learning processes underpins his model of how policy changes occur over long periods of time through the negotiation of goal-based and technical-based conflicts among multiple, specialised actors that operate at multiple levels in a common policy sub-system or network (1988).

The Advocacy Coalition Framework, conceived by Sabatier and developed with Hank Jenkins-Smith (1994) in the study of American energy and environmental policymaking, has continued to develop over the past three decades through testing and theoretical development. It has been applied to a variety of different political settings and comparative contexts, as well as at the global level, with some 400 papers dedicated to its use (Weible and Ingold 2018; Weible et al. 2011 and 2009), including a recent exploration of ideational competition in constructing India's NRHM (Gaitonde et al. 2017).

In Sabatier's framework, the behaviour of policy actors is influenced by the characteristics of the problem – generally stable in nature – which dictate the resources and constraints of the network, as well as by the “external shocks” they encounter, such as shifts in socioeconomic conditions, network leadership changes, and the policy decisions of other policy sub-systems. In this sense, Shiffman and Smith's concept of “issue characteristics” and “political contexts” are quite similar, with both frameworks emphasising the importance of actor agency, ideas, and participation.

Yet Sabatier's explicit focus on normative conflict and negotiation brings attention to the role of ideational power within networks, and the structuring role it plays in policymaking. In the Advocacy Coalition Framework model, actors within complex policy sub-systems identify as different coalitions through shared beliefs, and battle with other coalitions to move their beliefs into policy before others do.

Competing actor-coalitions are understood to use all possible resources at their disposal to achieve their goals and are thus instrumentally rational, but they are also limited or enabled in their pursuit through their own cognitive biases and the frames they create to translate their beliefs into forms of “productive power”. In this way, the framework draws less on economics than on social psychology to explain sources of actor power.

Sabatier's iterative and participatory model rejects linearity and the idea that policy is made from the top-down by state officials; here a productive role is ascribed to conflict among interested actors in the network. This model is useful, therefore, to the question asked in this thesis of how conflict and negotiation influence actor-power, and is applied to the case presented in chapter 5 of competing advocacy coalitions within the global women's and children's health network – i.e., one motivated by core beliefs about the reproductive rights of women and adolescents and one motivated by core beliefs about maternal and child survival.

Sabatier's framework adds to the meaning of "actor-power" in the Shiffman and Smith framework by understanding such power not only as an externally directed behaviour by network actors in seeking attention in relation to other health or non-health issues, but also an internally directed behaviour within global health networks (sub-systems), necessary to create or sustain ideational coherence and network leadership, as well as to promote debate and accountability for the effects of power.

Bourdieu's capitals theory

Pierre Bourdieu's capitals theory (1977) navigates the space between structuralist and agentic perspectives on power by describing a "field" of struggle between differently enabled actors, each marked by their possession of different types of "capital", economic, social and cultural, that structure their capacities in historically determined ways. Economic capital relates to material possessions such as money or property; cultural capital, such as that cultivated by education or social pedigree, is recognised by its symbolic power of authority; and social capital depends on a network of relationships of "mutual acquaintance" (Bourdieu 1986, p. 51; Bourdieu 1977).

Power is not to be understood reductively as the product of class relations within a capitalist economic system, human will bending under weighty structures, as depicted in Marxist analyses. Rather, actor-power depends on how people "play

the games of society” (Bourdieu 1986, p. 46), their capacities influenced by their own histories, habits, capital stocks, and learned behaviours.

Bourdieu, the French sociologist, is considered central to the post-structuralist school of thought of the late 20th century. His concept of social relations – interpreted by Crossley (2002, p. 171) as patterns of “interaction between actors who are differently disposed and unequally resourced, within the bounds of specific networks that have a game-like structure, and which impose definite restraints upon them” – recognises the constraints on human agency imposed by the structural conditions of their “habitus” and resources, but also the capacity for people to alter those conditions through their own strategic choices and behaviours. This focus on agency offers the prospect of reconciling both structural and productive dimensions of actor-power.

For Bourdieu, power can be seen in relation to the differing possession of material (economic) and non-material (social or cultural) capital among actors. Yet capital accumulation does not depend on the will of the state or a corporation or the outcomes of a “game of chance”, but on how an actor’s differing histories, habits, ideas and social frames of reference have predisposed his/her capacity to seek and acquire it. People and their agency, therefore, remain central to Bourdieu, rendering it possible to link his psycho-social concept of actor-power to that of Sabatier, and to Shiffman and Smith.

Bourdieu’s social relations theory is not written for the purposes of collective action analysis. However, his ideas about the structuring power of capital on actor capacity are applied in this thesis to enable both an historical and economic perspective on power, and to contextualise actor power. Specifically, it brings a deeper theoretical perspective to the Shiffman and Smith framework by investigating how network power originated, and the ways in which it may be diluted or sustained. Chapter 6, for example, explores how the acquisition of social and cultural capital by a sub-national advocacy partner of the global women’s and children’s health community enabled it to acquire reputational standing and produce influential frames on the human right to quality,

participation and dignity. Case study evidence indicates that this may have enhanced network advocacy objectives at both local and global levels.

Such approaches enrich Shiffman and Smith's framework by drawing explicit attention to the origins of actor-power and the conditioned pathways through which it is expressed. Bourdieu assists in directing our attention to the idea that actor power does not arise from a blank slate, but is accumulated through history and habit, and embodied in the different capitals held by networks. Together, these capacities determine how, and with what constraints, power may be expressed by actor-networks in an effort for dominance.

In conclusion, the application of key concepts and theories from Bourdieu and Sabatier complement the overarching use of the Shiffman and Smith framework in this thesis. It is desirable to do so because of the lack of explicit attention to contestation and competition in the Shiffman and Smith framework, and the value of grounding their framework in social theory to better understand how and why actor-power assists the pursuit of issue attention. It is therefore hoped that the use of complementary theories in this thesis will not confuse or detract from Shiffman and Smith, but rather promote understanding of the empirical findings presented here, enriching the value of the framework as a tool for knowledge development.

2.5 Communication campaigns and global advocacy networks

The normative influence of private-public advocacy networks in global health raises questions of how power is constructed, shared and used through social communication processes involving powerful frames, strategies and campaigns. For this reason, health communications theories and frameworks have much to offer to the study of global health governance and advocacy networks, although application remains infrequent within public policy and health governance literature.

The following two sub-sections summarise literature on two important types of health communication resources deployed by networks to gain issue attention – one, message frames, is a factor identified by the Shiffman and Smith framework (2007), re: *ideas*; the other, campaigns, is suggested through their factor of civil mobilisation, re: *actor power*, and introduces two different types of campaigns: mass media campaigns and interpersonal campaigns, both of which are relevant to network efforts to gain issue attention.

The final sub-section of this literature review, on social ecology concepts of health campaigns, relates these communication resources to the multi-scaled effects of global health networks. Over the years, discussions in health communications literature have shifted from the effects of communication resources and processes on individual behaviours, to a discussion of effects on wider social and policy structures that in turn influence individual behaviours in a dynamic process (Storey and Figueroa 2012; Glanz and Bishop 2010). This literature is motivated in part by rising interest in the effects of globalisation on health communication processes and actors (Rice and Atkin 2013).

2.5.1 Resources for ideation: frames

Shared ideas of what is “just” and “good” in society can motivate public action, especially when those ideas are communicated in a persuasive way. Advocacy networks facilitate this process by selecting certain arguments and types of evidence to demonstrate the urgency of a given cause and the feasibility of solutions (Benford and Snow 2000; Finnemore and Sikkink 1998). They use communication campaigns and products, such as TV commercials, news media reports and blogs, Twitter feeds, public events, and celebrity endorsements, to influence political attention by increasing the public reach and influence of their frames and messages, projecting widespread support and legitimacy for their causes (Rice and Atkin 2013; Hornik 2002).

The capacity of network members from different constituencies to communicate ideas together through persuasive message “frames” reflects their strategic and creative capacity, as well as their internal cohesion and external reach (Shiffman

and Smith 2007). Building on Goffman's view of framing as a necessary process in locating, perceiving, identifying and labelling our experiences in the world (1974), mass media theorist Todd Gitlin defines "frames" as a purposive product of "symbol-making" institutions, such as networks:

Frames are persistent patterns of cognition, interpretation, and presentation of selection, emphasis and exclusion by which symbol-makers routinely organise discourse, whether verbal or visual. (2003, p. 7)

Effective frames act as important cultural resources for network members to use, share, and exchange (Kolker 2004). The process of producing frames can also have structural effects on networks, bringing members closer together through shared production – or, on the contrary, revealing potential fissures when sub-groups of network members compete for dominance through the framing process (Sabatier 1988).

The types of knowledge systems and frames preferred by global health networks influence the type of evidence they commission and produce. The influence of multilateral agencies on the MDGs, as previously discussed, resulted in the prioritisation of health targets that could be met on an individualised basis using biomedical solutions, measured by simple quantitative indicators of progress. Seen through the lens of the MDGs, health is not a complex social product created through the interaction of people and the social, economic and political structures that surround them, but a material condition amenable to material interventions (Popova 2016).

However, the idea of frame construction as a shared endeavour of social movements (Benford and Snow 2000) raises questions of how health policy network actors use ideas to achieve both normative and material goals, and suggests that communication campaigns can be understood as an arena in which politics and meaning are constructed through communication processes and campaigns (Keck and Sikkink 1998), including at multiple levels, from global policy levels to individual/ community levels to global policy level.

2.5.2 Resources for actor power: campaigns

Health advocacy networks use campaigns for multiple strategic purposes. They use campaigns to communicate frames and narratives to trigger opportunities for policy action. Perceptions of certain difficulties as “natural” or “destined” to exist can be transformed into beliefs that certain health issues are caused by people, and therefore open to network policy solutions (Stone 1989).

Networks use campaigns as negotiating venues, where internal consensus can be formed or reinforced, or where dissent can be quelled. Shared norms on what is “good”, what is “desirable”, and what “ought to be”, reinforce network power because they shape and motivate individual and collective behaviours, contributing to the transformation of social and political relations (Finnemore and Sikkink 1998). For this reason, how people think about certain ideas can influence the structure, relationships and collective identity of social movements (Benford and Snow 2000).

Over more than 50 years, an extensive literature has developed on communications for social change, including in relation to public health and human development (Neuman and Guggenheim 2011). Post-World War II “modernisation” theories of development argued that mass transmission of information could address global underdevelopment by diffusing modern ways of thinking, spreading technical and social innovations (Schramm 1964, Rogers 1962). Social and behavioural communication studies have evolved over time through practice and theory, drawing on diverse disciplines such as sociology, psychology, economics and law to debate issues of inter-disciplinary concern. Such debates include the role of top-down information dissemination versus bottom-up participation, the role of individual agency versus social norms and structures; the structuring power of different forms of communication knowledge and evidence; and the comparative attributes of different media delivery channels in social and behavioural change communications (Storey and Figueroa 2012).

The idea of communications as a social process was advanced in the 1970s by Brazilian educationalist Paulo Freire (1970), who saw group dialogue as essential to liberation from oppressive socio-economic conditions. Freire's ideas aligned with those of dependency theorists of the 1960s and 1970s, who believed that underdevelopment was not a function of lack of information and poor cultural adaptation, but political and economic domination of the "Third World" by "core" countries, requiring the former to remain in a position of political and cultural dependency to support the wealth and status of developed countries (Gumucio Dagron and Tufte 2006).

The effect of information dissemination on the development and expression of individual health capacities (cognition, skills, motivation, etc.) remains a dominant paradigm in health communications study (Waisbord 2018). A large literature documents the effects of communication on individual health and public service uptake, including the effects on attitudes and behaviours of varying types of communication activities (e.g., radio and TV commercials; community theatre, "entertainment-education" drama; and interpersonal and participatory forms of communication, such as peer counselling), as well as in relation to different health issues, such as HIV/AIDS, family planning, and child survival (Naugle and Hornik 2014; Wakefield, Loken and Hornik 2010; Noar et al. 2009; Grilli, Ramsay and Minozzi 2002).

However, since the 1990s, structural and environmental influences on public health on a wider scale have been studied more frequently in health communications literature, including through the study of communication processes that address social or political system-level change, such as the relationship between media advocacy efforts, public opinion, social cohesion and health policy change (Waisbord 2018; Dorfman and Krasnow 2014; Wallack 2002; Wallack 2000).

This has included conceptual development of the dynamic between micro-level health communication processes (e.g., those focused on improving individual behaviours or skills) and macro-level processes (e.g., those focused on

stimulating national or global health policy dialogue), and in relation to the health competencies and outcomes they promote (Storey and Figueroa 2012). Yet discussion of global-level communication processes has most often focused on multilateral policy venues (Waisbord 2015), with limited discussion of how communication processes within and among global, national, and sub-national health advocacy networks may shape health behaviours and practices at multiple, simultaneous scales, including those that contribute to how policy priorities are set.

This thesis seeks to address that gap, using communication campaigns as the lens for exploring this dynamic. A definition of *communication* campaigns (Rice and Atkin 2013) complements Keck and Sikkink's definition of advocacy campaigns by bringing attention to the role of messages and channels within such efforts:

... purposive attempts to inform or influence behaviours in large audiences within a specified time period using an organized set of communication activities and featuring an array of mediated messages in multiple channels generally to produce non-commercial benefits to individuals and society (2013, p.3)

This definition also underlines the normative political purpose of global health network campaigns as instruments through which greater issue attention may be pursued. Networks, for instance, may seek to use campaigns to inculcate social capital, building trust through the productive power of messages that “enable participants to act together more effectively to pursue shared objectives” (Putnam 1995, pp. 664-665). This allows for the idea that both norms and network structures are affected by a process of “interpersonal communications” – or the “process of message transaction between people to create and sustain shared meaning” (West and Turner 2009; p. 10).

Social capital may, in turn, facilitate information flows and norms of trust between network members, enhancing their ability to work together to produce effective messages and frames for campaigns (Wallack 2000; Diani 1997). Social capital may be strengthened when campaigns transmit knowledge or ideas that

communities discuss and agree to act together upon (Viswanath, Randolph Steele and Finnegan 2006; Randolph Steele and Viswanath 2004).

Campaigns may also encourage interpersonal communications by functioning as “talking points” between people. Social dialogue can, influence how people think and act towards themselves and others (Hornik and Yanovitzky, 2003).

Interpersonal communications are complementary to the study of networks and agenda-setting because they can reveal how and why individuals prioritise or deprioritise certain issues, including messages absorbed from mass media (McCombs and Shaw 1972).

Interpersonal communications can also combine with mass media effects to influence norms and incentives, such as when smokers within a social network influence each other to change their smoking patterns in response to mass media persuasion (Durkin, Brennan and Wakefield 2012; van den Putte et al. 2011). At a wider societal or environmental level, interpersonal communications can also promote supportive environments for policy change, increasing public pressure on policy-makers to prioritise or deprioritise certain issues. Such policy changes may, in turn, influence individual habits and behaviours (Dorfman and Krasnow 2014; Randolph Steele and Vishwanath 2004).

Interpersonal communications can also promote social network cohesion through the production of social capital. This process is moderated both by material and psychological factors – how individuals or groups perceive their social position and social mobility can influence how they engage with others (Marmot 2004). Social cognitive researchers observe that people and groups may act on perceived needs because of “self-efficacy” (Bandura 2001; Bandura 2000) – i.e., people’s belief in their ability to influence the nature and quality of their life. Similarly, group motivation can be powered by the presence of “collective efficacy”, or their shared belief in the power to produce effects through collective action (Bandura 2000).

The concept of collective efficacy is important to social capital because psychosocial factors can explain why heterogeneous network actors act together. Communication campaigns can catalyse ideation, framing and message dissemination by advocacy networks (Rice and Atkin 2013). Thus, at a global level, social capital can function as a strategic asset for the acquisition of influence and agenda-setting power by global health networks: It can enhance coherence among heterogeneous network members, enabling network members to function more effectively together, attract more members, and extend network reach.

2.5.3 Social ecology perspectives on network campaigns

In the past two decades, health communication scholars have turned increasingly to international relations and social movement theory to analyse participatory communication processes in view of globalising social and technological influences on movement identity, development and dissolution. In doing so, most agree that different types and combinations of development communication approaches – whether based on information dissemination, community participation, or public advocacy – can be complementary within certain social contexts (Storey and Figueroa 2012).

While different traditions have resulted in different vocabularies, often with overlapping concepts, it is broadly agreed that communications and dialogue are central to the production and reproduction of public health (Neuman and Guggenheim 2011). For Servaes (2008), “development communications” should be a social process with clear intent – the “nurturing of knowledge aimed at creating a consensus for action that takes into account the interests, needs and capacities of all concerned” (p. 389). Storey and Figueroa (2012) describe this as an iterative dialogic process, rather than a “one-time, one-way communicative ‘act’” in which the sender of health information seeks to exercise control over the recipient (p. 70). The sharing of problems, potential solutions, and a localised appreciation of the costs and benefits of action underpin social change.

Yet within the social and behavioural change communications field, insufficient attention has been paid to changing norms in global health governance, including the relationship between communications and accountability within global health governance forums. The relationship between social and behavioural change campaigns and governance environments is explored in this dissertation. People shape places, and places shape people (Abroms and Maibach 2008; Sallis, Owen and Fisher 2008; Cohen, Scribner and Farley, 2000).

Social ecology perspectives in health campaign evaluation literature suggests that social and behavioural campaigns are more likely to produce meaningful change if they regard actor behaviour not only as part of a horizontal social process of shared concern (Servaes 2008), but as part of an inherently hierarchical and political one. Communication behaviours occur not only through individual knowledge, skills and/or motivation, but in relation to wider political structures that shape opportunities and constraints (Glanz and Bishop 2010).

Accordingly, chapter 6 of this thesis uses social ecology concepts from health communications scholarship to analyse communication campaigns as sites for collective ideation, debate and consensus-building for political action. This framework assists in the examination of these processes because it highlights the different pathways and fields in which networks exercise power through communication campaigns, including through individuals, social networks, communities, and the local and distal policy environments that shape individual and collective health behaviours.

This social ecology perspective proposes a new dimension to Shiffman and Smith's concept of actor-power: How actors interact with policy environments in one location may influence other relations at more distal points, which may be then reproduced without limit through the interaction of different communication channels, both technological (mass media) and human (interpersonal dialogue). This introduces an explicit spatial and scalar dimension to Shiffman and Smith's global framework, connecting local to global to local.

2.6 Summary

Women's and children's health in the MDG era experienced considerable, if insufficient, progress against their specific targets. Moving into the post-2015 era, the global women's and children's health network succeeded in securing new targets to extend its core concerns, now located in a more diffused and ambitious SDG framework.

The histories and values that drive different beliefs and created competitive factions in the women's and children's health network in the MDG era, are again finding expression through debates on measurements and strategies for achieving universal health coverage and quality of care in the SDG era.

Such disputes are rooted in the disparate histories and capacities of the various normative coalitions in the global women's and children's health network. The MDGs, for instance, reified dominant forms of technical knowledge and evidence-based discourse from the child survival movements of the 1980s and 1990s with the support of northern donors, UN and World Bank elites. Increasing contention through the MDG period, including rising claims for attention by human rights activists who objected to the materialist thrust of the MDGs, successfully repositioned debate in the final years of the MDGs, to a more rights-based concept of women's and children's health.

Shifting political context also offers opportunity for new voices to be heard. Important national and regional powers like India, having nearly met their MDG 4 and 5 targets, may assume new positions of leadership in global women's and children's health networks, both for normative purposes and to demonstrate power on the global stage to serve nationalist discourses at home. This too may challenge the basis of collective action and shrink space for civil society leadership.

This thesis uses the Shiffman and Smith's framework on the determinants of political priority – now a decade old – because it is a tested and validated tool for the analysis of agenda-setting processes in global health. Based on social

constructivist concepts of purposive idea-based movements equipped with powerful normative frames, Shiffman and Smith follow policy scholars like Kingdon and Sabatier in setting human agency at the centre of policy change.

In understanding public-private networks as platforms for inclusion, as well as instruments for power, the Shiffman and Smith framework calls attention to the contested nature of global health governance. This is often hidden from view because of long-held ways of thinking and seeing that deny the productive capacity of contention and debate, and prioritise “neutral” scientific evidence.

The capacity of the framework to respond to “how and why” questions about power in global health may be further refined through the application of social theory. This thesis applies key concepts that may help explain policy change in respect to the resolution of ideational conflict and competition among network members (Sabatier), as well as the origins and structuring capacities of network power through accumulation of different types of “capital” (Bourdieu). Such theories allow us to understand networks as historically conditioned, but not determined; normatively inclined, but not exclusively so. Such theories do not lend predictive capacity or causal power to the components of the Shiffman and Smith framework, but serve as guides to knowledge on questions such as, How do networks seek power, and why does this matter to global health?

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Chapter 3: Methodology

The first part of this chapter is dedicated to a discussion of the main conceptual approach and qualitative research methods applied in this thesis. The second sub-section presents the methods and processes applied for each of the four main research questions/papers in this thesis. The third sub-section reflects on the author's situated position as both student-researcher and professional network participant during the research and writing of this thesis.

3.1 Overview of methods

As discussed in the previous chapter, the Shiffman and Smith framework (2007) guided the identification of four inter-related categories of evidence presented in this thesis related to the question of how global health advocacy networks seek issue attention, i.e., through processes related to actor-power, ideas, political context, and issue characteristics.

These categories appear most explicitly in the first research paper of the thesis (chapter 4), on the role of the global women's and children's health network in seeking attention for these issues during the MDG era. In chapter 4, findings are discussed in view of the Shiffman and Smith categories and summarised in table 4.1. As such, the role of chapter 4 within this "research paper-style" thesis is to frame and introduce questions explored in the following three research papers (i.e., chapters 5, 6, 7), which use complementary social theory to further develop the concepts presented in the Shiffman and Smith framework.

The table below summarises the research methods used for this thesis, which are discussed in detail in the sub-section following.

Method	Description	Research chapter
Document review <i>published and unpublished</i>	200 written resources (1985-2017) relating to issues, ideas, actors, context of the global women's and children's health network, including speeches, policy texts, strategy documents, news articles, blogs, meeting reports	4, 5, 6, 7
	30 written resources related to differing ideas within the global network, including reports, editorials, message briefs	5
	50 written and visual resources on networks, campaigns and policy environments in Orissa and India, including messaging frameworks, public hearing transcripts, photos, TV spots, scripts, news articles, and health facility quality reports.	6, 7
Semi-structured interviews <i>secondary analysis</i>	24 telephone interviews with representatives of organisations that had made written pledges (financial, policy, service delivery) to the <i>Every Woman Every Child</i> campaign, selected from among 120 respondents to a written survey (see below, Survey: secondary analysis), each interview 60 minutes in length (April-June 2013). The author contributed questions to the interview guide, observed interviews conducted by a consultancy firm hired by PMNCH, and analysed transcripts.	5
Semi-structured interviews <i>primary analysis</i>	18 face-to-face interviews conducted by the author in English with key informants about India and Orissa health and media environment, most selected by snowball technique from among different constituency groups (e.g., civil society, government, UN, etc.), 60-90 minutes in length (conducted in Bhubaneswar, Orissa, June-July 2009)	6, 7
Survey <i>secondary analysis</i>	Written survey responses from <i>Every Woman Every Child</i> commitment-makers in two rounds: 168 responses (2012); 120 responses (2013)	5
Survey <i>secondary analysis</i>	<i>Deliver Now India</i> media campaign endline survey of married women with young children (n=1,100) in Orissa, India (Nov-Dec 2009)	6
Participant observation	2005-2015 as PMNCH staff member and consultant, based in Geneva; notes based on meetings (one-on-one and group), conferences, e-mail exchanges, non-verbal observations	4, 5
Participant observation	2007-2009 as PMNCH staff member, consultant and researcher (alternating roles) of the <i>Deliver Now India</i> campaign; notes based on meetings (one-on-one and group), conferences, e-mail exchanges, non-verbal observations	6, 7

Table 3.1: Overview of thesis methods

3.1.1 Case study approach

Each of the four research chapters in this thesis takes the form of a case study, collating evidence gathered through multiple qualitative methods. Case studies enable in-depth empirical investigation of a contemporary phenomenon, in its

real-life context, through multiple research methods, responding to questions of “how” and “why” (Yin 2014). A case study approach assists in narrowing questions for investigation and focusing research effort on specific scenarios that may replicate or extend what is understood in theory, including by grounding theory through triangulation of evidence (Eisenhardt 2002).

Different types of case studies can yield different types of information (Flyvberg 2011; Flick 2009; Patton 2002). Some are *extreme/deviant cases* that can help expose limits in existing theories by introducing new concepts or variables. Others compare certain dimensions of a phenomenon (e.g., size, form of organisation, location, etc.) to explore maximum range of variation. *Critical cases* expose why if a certain assumption is not valid for that case, it may not be valid for others, and *typical cases* illustrate what may be expected in most cases.

This thesis suggests that global women’s and children’s health network represents a *typical* case of how and why networks seek issue attention through communication campaigns. The global women’s and children’s health advocacy network can be considered a typical case for study because, like many global health issue-networks that grew in scale during the 2000s, it combined both private and public actors from disparate geographies and backgrounds; its campaigns benefitted from investments made by new private actors such as the Bill & Melinda Gates Foundation; and it used the discourse of the MDGs to structure its frames and narratives. The MDG period (2000-2015) situates this case in a historical context, allowing network ideas, actor-power, political contexts and issue characteristics to be viewed and analysed in contrast with periods of time before and after.

The case presented in chapter 4 (*The role of the global women’s and children’s health network in influencing attention during the Millennium Development Goal era*) functions as a foundational paper for this thesis, setting the context for the three papers that follow. The main finding in this chapter, that coordinated action by global health networks contributed to issue attention for women’s and children’s health in the MDG era, encouraged the development of questions for

chapters 5, 6 and 7 on how and why how processes of power and communications contributed to this. Possible case settings were identified through literature review, as well on the basis of the author's knowledge as a staff member of PMNCH during the MDG period.

Two main criteria were applied for case selection:

(1) Likelihood of dense patterns of communications and interaction among network members, enabling scope for analysing characteristics and processes of social and political relations within global health networks. Leading campaigns of the global women's and children's health network during the MDG era, such as the first campaign launched by PMNCH, *Deliver Now for Women + Children* (2007-2009), and the more ambitious *Every Woman Every Child* campaign (2010-2015) associated with the *Global Strategy for Women's and Children's Health* (United Nations 2010), were suitable for observation because they involved intense communication and negotiation among network members produced during windows of opportunity for action. Other global network advocacy campaigns could have been selected for study, such as the *Every Newborn* campaign (World Health Organization 2014), involving a broad range of partners. However, few campaigns in the MDG era integrated network members from both women's and children's health with the same scale and breadth as the *Every Woman Every Child* campaign, spearheaded by the UN Secretary-General;

(2) Communication and interaction among network members within and between different geographic locations, enabling study of how global networks work at scale to achieve issue visibility, membership growth and power. *Deliver Now* was conducted in multiple countries, including Tanzania and India at both national and sub-national level, and coordinated by PMNCH in Geneva. As Keck and Sikkink suggest (1998, p. 7), "*analysis of campaigns provide a window on transnational relations in ways that a focus on networks themselves does not*".

Further, India was selected as a national study site for chapters 6 and 7 because of its sizeable burden of women's and children's mortality; high intensity of policy activity on women's and children's health issues during the MDG period; the density of the historically conditioned links between policy actors inside and outside of India; as well as density of links between policy actors at village, district, state, and federal levels within a decentralised health system in India. Practical reasons also played a role: Because policy discussion often occurs in English in India, the author could access documents and undertake in-depth interviews in her native language and not in translation, enabling closer study.

Guided by George and Bennett's findings on the contribution of case studies to theory-testing and building (2005; pp. 6-9), this thesis therefore undertook the following research tasks in the process of development:

- *process-tracing to link causes and outcomes* (e.g., mapping the historical formation of the global women's and children's health network and related campaigns to accelerate MDG progress);
- *exploring potential causal mechanisms* (e.g., exploring the idea that joint construction and dissemination of communication campaigns contributed to the development of the global women's and children's health advocacy network in the MDG era);
- *developing and analysing historical explanations* (e.g., the possibility that disappointing progress in the 1990s led to a sense of urgency among disparate network actors in the 2000s to construct a joint campaign to elevate attention to both maternal and child issues);
- *understanding how concepts are sensitive to context* (e.g., how the normative MDG framework, and incipient SDG norms in the late MDG period, influenced network communication behaviours);
- *forming new hypotheses and research questions on the basis of findings* (e.g., the influence of mass media campaigns and related interpersonal communications processes in understanding differences between global health networks in their agenda-setting power).

A central aspect of case study work is using multiple research methods to acquire an in-depth understanding of the phenomenon in question. Rather than aiming to "validate" results and procedures in a material sense – as if a single objective reality or perspective exists and is waiting to be revealed – multiple

methods, theories, and data sources were triangulated to “produce knowledge on different levels, which means they go beyond the knowledge made possible by one approach, and thus contribute to promoting quality in research” (Flick 2009, p. 445).

Accordingly, three complementary qualitative methods were used in this dissertation:

- (1) *Document analysis* (of written texts, visual artefacts, personal notes, etc.)
- (2) *Semi-structured interviews* (with key informants at the sub-national, national and global levels)
- (3) *Participant observation* (e.g., attending global and national meetings, participating in formal and informal discussions with network members, observing how network members interact with each other).

3.1.2 Document analysis

This thesis draws upon analysis and review of approximately 200 written and visual documents created during 1985 to 2017, including speeches, policy texts, strategy documents, news articles, blogs, and meeting reports.

These documents were identified in several ways. Database searches for published literature were conducted through PubMed, JSTOR, Scopus and Google Scholar databases, using search terms drawn from the Shiffman and Smith framework and the research questions of this thesis (e.g., “policy networks”, “global health governance”, “global health networks”, “agenda-setting”, “issue attention”, “policy process”, “political context”, “advocacy coalition”, “social constructivism”, etc.).

Grey literature, both published and unpublished, such as working papers, reports, web articles and blogs, was identified through references in published literature, but also through author’s knowledge and experience as a staff member of PMNCH and the WHO during the 2005-2015 study period. Familiarity with network actors, ideas, contexts, and issue characteristics also enabled the author to source both published and unpublished documents through which

global network narratives, behaviours, history, leadership patterns, and norms could also be analysed.

Document analysis was an important method for research in this thesis because it helped to develop a historical understanding of the emergence, development, norms, beliefs, membership, and policy goals of the global women's and children's health advocacy network. This research enabled the construction of narratives, timelines and events that demonstrated the important role of political context in the development of norms and values underpinning network campaigns and policies, including the original *Global Strategy for Women's and Children's Health* for the MDG period (United Nations 2010) and the updated *Global Strategy for Women's, Children's and Adolescents' Health* (United Nations 2015) for the 2016-2030 SDG period.

Document review also revealed differences in language, presentation and thematic concerns within the network over time, assisting in understanding how network leaders drew upon normative discourse in global development consensus frameworks to amplify this through *Every Woman Every Child* and the national *Deliver Now for Women + Children* campaigns. For example, the 2010 *Global Strategy* document was updated and renamed in 2015 as the *Global Strategy for Women's, Children's and Adolescents' Health* (italics added) to reflect emerging SDG norms about the integration of youth participation and concerns in global health.

Most documents used in this thesis were retrieved from publicly available sources, including the website of PMNCH, hosted by the World Health Organization. However, a small number of documents are unpublished and noted as such; examples include meeting agendas and reports; campaign documents; research and policy reports.

Finally, it is important to note that, as a concurrent professional member of the global women's and children's health network and a researcher, the author may have overlooked or dismissed certain documents due to cognitive bias (Adler

and Adler 1987). On the other hand, close knowledge of the network has enabled access to certain documents that might not have otherwise been possible. Positionality is discussed in chapter 3.3.

3.1.3 Semi-structured interviews

Another important research method was the design and implementation of semi-structured interviews with key informants. In total, 42 interviews (24 at global level by telephone, and 18 face-to-face in India) were undertaken for this thesis, including respondents from different “constituency” groups (e.g., civil society, donor agencies, governments, health professionals, academia and at global, national and sub-national levels). This process offered an opportunity to identify and compare similarities and differences in viewpoints.

Respondent selection, question design, and document analysis took place on an iterative basis. For instance, information gained from scholarly articles and unpublished policy reports about discourses conducted by influential network leaders and constituencies informed the identification of potential participants and questions for in-depth interviews. Information gathered from these interviews informed further document analysis, interviewee selection and research question development.

The eighteen semi-structured, face-to-face interviews lasting 60-90 minutes were conducted by the author among state-level network members, all English-speaking, in Bhubaneswar, Orissa, in June-July 2009, mainly using a snowball technique to identify respondents (see Annex C). Respondents were familiar with network activity, and were purposively selected to ensure a broad mix of respondents, including those from different constituencies and geographies, e.g., some represented local organisations headquartered at district level, while others belonged to national or global organisations headquartered outside of India. This included representatives of state government (4); state-level UN agencies (2); state-level technical cooperation agencies (2); state-level media (2); state-level NGOs (3); state-level researchers (1); district-level NGOs (1);

national-level NGOs (1); and national representatives of foreign donor agencies (2). Notes were taken by hand and then typed up into transcripts for analysis.

At the global level, the 24 interviews of network actors were conducted from Geneva by telephone during April to June 2013; interviewees were selected on a random basis from among those (n=120) who had voluntarily answered a written questionnaire sent to all organisations that had made written commitments in 2012 of a financial, policy or service delivery nature to the UN's *Every Woman Every Child* campaign. Respondents were grouped into seven different constituencies, then selected from within each pool to enable a cross-section of viewpoints. Those interviewed were from low- and middle-income country governments (3), donor governments (7), private foundations (3), global partnerships (3), private business (5), and NGOs, including youth groups (3). Each interview was approximately 60 minutes in length, and included eight sets of questions posed to all respondents, within which one set of three questions was designed by the author of this thesis for the research purposes. Questions were asked of the respondents by the consultancy firm hired by PMNCH for this purpose; interviews were recorded and transcribed by the consultants, with notes given to the author for secondary analysis for the purposes of this thesis. The author attended a number of these interviews as an observer to gain information on how questions were understood and answered by respondents in ways that transcripts might not reveal.²⁷

Applying the principles of qualitative framework analysis to structure and synthesise the data (Miles, Huberman and Saldaña 2014), the transcripts were coded by theme, and then categorised into concepts and linked to the analytical

²⁷ *Eight sets of questions were asked of respondents, including: (1) What was your reason for making a commitment to Every Woman Every Child?; (2) Do you feel your commitment addresses a gap in the Global Strategy, and if so, how and why?; (3) What progress have you made in implementing your commitments?; (4) What has enabled or challenged you in implementing your commitment?; (5) What do you see as the most important constraints or gaps in making further progress?; (6) What was the added value of making this commitment in association with the Global Strategy? Would you have made this commitment if the Every Woman Every Child campaign did not exist? Why/why not? Did the Global Strategy influence your focus on particular interventions/services in your commitment? (7) How do you track progress towards implementing your commitment?; (8) Can you provide any information or evidence of results from your commitment? (Three questions designed by the author for thesis research appear as Q6 above, without italics.)*

framework. Data points were inserted into the framework and marked by category labels to highlight similarities and divergences among ideas and frames used by network actors. Labels enabled the construction of major themes and sub-themes for each research paper, drawing a clear link between evidence and reported findings.

3.1.4 Participant observation

The use of document analysis and interview methods were important in establishing a general understanding of the global women's and children's health network at a certain time (i.e., during the MDG period of 2000-2015), and in relation to certain spaces (national and sub-national networks in India). However, this was enriched by relying on participant observation methods, considered a fundamental approach to all social and behavioural studies (Flyvbjerg 2011), and to the interpretation of meaning in the evidence gathered.

In this study, participant observation methods relied on the author's long-term professional participation in the global women's and children's health network during most of the MDG period, as well as the transition to the SDGs, launched in 2015. Therefore, the observations are presented here are not only those of a researcher, but informed by day-to-day experiences as a secretariat member of the Partnership for Maternal, Newborn & Child Health (see chapter 3.3).

These experiences have included participation and co-production of key network policy texts and campaigns, including of the *Global Strategy* and *Deliver Now* campaigns discussed in chapters 5, 6 and 7. Countless meetings, interactions, and discussions over the years have contributed gradually, and iteratively, to this understanding, documented by an extensive personal archive of emails and notebooks. As documentation for observations and to reduce risk of cognitive bias (especially when many years had passed), the author consulted her archive of notes and e-mails relating to campaign activities during the MDG period to uncover information shared by different network members about joint processes and events, including direct quotes that revealed subjective impressions of certain processes. Citations are sourced as "personal correspondence" when

unpublished, e.g., when provided to the author by e-mail. Direct citations are avoided when anonymity may be at risk.

Membership in the network also enabled the identification and access of case material not easily available to non-network members, particularly documents and artefacts resulting from shared ideational processes. This includes, for instance, notes from campaign messaging meetings and strategy workshops, which yielded rich opportunity for analysis.

Such participatory processes also afforded access to informal exchanges with other network members that have led to opportunities to access different forms of data; chapters 5 and 6, for instance, report on results of secondary analysis of survey data available to the author through network participation. Many such professional collaborations over time have instructed and inspired the questions and analysis in this thesis, beyond those that may have been gained through document analysis and formal interviews.

3.1.5 Triangulation of methods

In a post-modern world, classic observational traditions in which standardised procedures “self-correct” researcher bias and produce “verification” have given way to a wider continuum of research practices (Flyvbjerg 2011, p. 467). Yet observation and analysis cannot be so subjective and lacking in rigor that scholarship and opinion merge (Flick 2009, Huberman and Miles 2002, Adler and Adler 1987).

Therefore, for this dissertation, the middle way lies in the combination of multiple qualitative methods, carefully conducted and clearly described, and guided by conceptual and theoretical approaches that can yield answers to “how” and “why” certain social phenomena occur.

Despite its analytical focus on historical network behaviours and the use of longitudinal participant-observation methods, this study is not intended as a cultural ethnography of the global women’s and children’s health network.

Rather it is a conceptually driven qualitative study of political ideas and behaviours to understand how and why network power and influence is pursued within the global health governance systems. Life history inquiry, for instance, is not employed here as it might otherwise be in a broad study of a cultural system.

Yet a case study format is highly suitable, based on the triangulation of in-depth interviews, discourse analysis, document content analysis, process-tracing, and timeline construction. Focus group discussion, common in political research, might have been added to the methods for this study, but somewhat difficult to conduct easily at the global level, given disparate geographies of network leaders. Therefore, for practical reasons, this method was excluded from study.

3.1.6 Grounded theory approach

In general, the methods discussed above reflect a grounded theory approach to this dissertation (Charmaz 2009; Glaser and Strauss 1967). Through the data collection and analysis process described above, the conceptual approach was continually questioned and refined during the research process, since data collection and analysis are understood in this thesis to be iterative and mutually influential processes. Limits to what can and should be observed are not pre-ordained, but rather flow from what is seen and experienced.

For instance, early ideas of how community networks influenced political attention changed considerably when evidence emerged on how global network effects on community-level processes, and vice versa, including those related to global development frameworks. This reinforced the decision to use the Shiffman and Smith framework to conceptualise and organise the evidence presented. As previously noted, Shiffman and Smith's framework permits space for conceptual innovation and clarity, prompting the application of key social theory concepts, including those from Sabatier (1988) and Bourdieu (1986, 1977).

3.2 Linking methods to questions

Four main questions are posed in chapters 4 to 7. The following section summarises these questions and selected research methods and processes.

Chapter 4

Question: What was the role of the global women's and children's health network in influencing attention to these issues during the MDG era?

Methods: Qualitative process-tracing of the emergence and evolution of key ideas, frames, discourses and institutional leadership in the global women's and children's health network. Two main methods for case development: document review and participant observation.

Process: Review, coding and analysis of approximately 200 written historical documents (e.g., speeches, policy texts, news articles, blogs, meeting reports, including those researched from the web-based archives of PMNCH), with the aim of constructing timelines and identifying and comparing ideas and narratives from different constituency groups and actors within the network. This process triangulated evidence collected through participant observation by the author in the PMNCH secretariat over the 2005-2015 research period. This second method enabled access to unpublished data (e.g., messaging documents, campaign strategy documents) and knowledge of published material frequently cited by influential network members. Data from the author's notebooks, as well as the document review process, was synthesised and translated into a set of codes that were then categorised into conceptual labels and themes, which formed the basis for analysis and findings for this paper.

Chapter 5

Question: How does conflict and negotiation between network members influence actor-power?

Methods: Document review, semi-structured interviews, and participant observation

Process: As discussed in chapter 2.4, the Shiffman and Smith framework is largely silent on issues of ideational conflict and use of actor power within the network, therefore, a complementary analytical framework (i.e., Sabatier's Advocacy Coalition Framework) is introduced to explain the nature and role of normative competition among network members in the policy process. This framework proposes key conceptual categories (e.g., core beliefs, policy learning) to guide the evidence search for published and unpublished documents from within the global women's and children's health network. Since much document-based evidence of discursive power within the network had already been analysed in chapter 4, the document analysis in chapter 5 builds upon this foundation by supplementing these with additional documents reflecting the priorities and normative views of different sub-coalitions within the global women's and children's health network. For example, within interview transcripts, the author looked for key words and concepts (e.g., "human rights", "empowerment", "well-being" or "mortality", "value for money", "efficiency", "measurement") that would suggest alignment with the ideas and values of one or another coalition within the women's and children's health network.

Sabatier's categories guided author's coding, labelling and categorisation of this evidence, as well as data derived by the author from the transcripts of the 24 in-depth oral interviews. The author compared results from the document analysis and in-depth interview process with evidence collected on a participatory-observation basis as a network participant over the 2005-2015 research period, enabling a comprehensive mapping of ideational divides and competitive interests based on codes and categories established through these three research methods (i.e., document analysis, semi-structured interviews, and participant observation).

Finally, secondary data analysis was undertaken by the author on two rounds of written surveys conducted by PMNCH in 2012 and again in 2013 among

organisations that had pledged written commitments of a financial, policy or service delivery nature to the *Every Woman Every Child* campaign to understand the frequency with which respondents mentioned “advocacy” for women’s and children’s health as an explicit objective of their pledge. These surveys were conducted by PMNCH for the purposes of producing reports on annual progress toward implementing commitments to the campaign. The author was granted access by PMNCH to tabulated data and written survey responses submitted by commitment-makers (168 commitment-makers responded to the 2012 PMNCH survey; 120 responded to the 2013 survey). Secondary analysis was undertaken to develop questions for in-depth interviews and to add to qualitative findings.

Chapter 6

Question: How do networks use media campaigns for issue visibility and for augmenting network power at different scales?

Methods: Document review, semi-structured interviews, secondary analysis of campaign evaluation data, participant observation.

Process: This paper builds upon the global level review of documents in chapters 4 and 5 to include analysis of approximately 50 written and visual documents produced by network members at national (India) and sub-national (Orissa) level. The documents included analysis of ideas and characteristics relating to the local policy environment; health and social conditions in Orissa and India; global and national campaign planning documents, scripts and visuals for a set of six PMNCH-sponsored TV spots (i.e., advertisements of 60- and 30-seconds in length) aimed at encouraging health knowledge and pro-health behaviours in Orissa; and Orissa media campaign evaluation documents summarising the results of a household survey carried out by a LSHTM-supervised survey team in 2009 in six districts of that state (Collumbien et al. 2010). The Orissa campaign evaluation survey involved 1,100 young married women and mothers of young

children.²⁸ Document review, combined with analysis of the 18 in-depth interviews conducted by the author of this thesis with health policy actors in Orissa, including media, was necessary to triangulate observations and potential cognitive biases of the author based on her participatory history in this case as a staff member of PMNCH. To strengthen observations about the relationship of the mass media to global health network visibility and replication, this paper presents summary descriptive statistics derived from the campaign evaluation survey in Orissa on individual attitudes and behaviours among survey respondents.

Chapter 7

Question: How do networks use interpersonal communication campaigns to increase network growth and power to gain issue attention at local and national levels?

Methods: Semi-structured interviews, document review, participant observation

Process: This paper relies upon the India and Orissa-level document analysis process undertaken for chapter 6 to guide respondent selection and questionnaire development for the 18 in-depth interviews.

Interview topics included perceptions of barriers and facilitators of civil society accountability and local level network development, including issues of trust among state and non-state actors, media engagement in women's and children's health issues, civil society reputation, and communication and campaign processes in the context of civil society-organised "public hearings" on women's

²⁸ *The Orissa household survey was commissioned by DMI to the London School of Hygiene and Tropical Medicine (LSHTM) for the purposes of Deliver Now India media campaign evaluation research. The LSHTM team was led by Professor Oona Campbell with Charlotte Blackmore and Dr Martine Collumbien. Data collection in Orissa was coordinated by HDI, a research consultancy agency in Bhubaneswar, Orissa, commissioned and supervised by LSHTM. The author of this thesis participated in discussions with DMI on survey objectives and questions, and designed the presentation of secondary analysis results in table format (Table 6.1) together with Professor Campbell, who was a member of the author's doctoral advisory committee. The author of this thesis did not participate in data collection or primary analysis.*

and children's health issues. The interview guide (Annex C) included questions such as: "How do you view the work of the White Ribbon Alliance in Orissa – strengths, weaknesses, opportunities, risks?" and "Do you trust the media to report accurately?" A set of 32 codes were applied to the collected written and oral data, then grouped into eight concepts, guiding the development of the analytical framework. Participant observation, mainly at the global level in the author's capacity as a PMNCH staff member, assisted in developing guiding questions for this study about global-sub-national network relations, and interpreting sub-national findings in view of global level processes of network development and growth.

3.3 Reflections as a researcher-advocate

As discussed above, participant observation was foundational to this dissertation. Yet in some ways, it was less important as a mechanism for extracting data about the behaviours of others than as a wider "context" in which the author's personal learning and understanding of the global network took place (Angrosino and Rosenberg 2011).

Many members of the global women's and children's health advocacy network were aware of the author's dual identity as advocate and researcher, and became her collaborators in both action and research. For instance, in 2015, the author convened nearly 20 women's and children's health professionals and advocacy experts from five continents to co-author an article about the challenges and opportunities of women's and children's health advocacy networks in the transition to the SDG era (McDougall et al. 2015). Those recommendations inform the concluding chapter of this dissertation.

Formal ethical approvals for this project are described in chapter 1.5 (Contribution of author). The author's identity as a doctoral researcher of advocacy networks is included in her public biography on the website of The Partnership for Maternal, Newborn & Child Health (PMNCH), and her lengthy

research absences for the purposes of this dissertation during 2016-2019 were known within the network and authorised by WHO, as the host organisation of PMNCH.

As Angrosino and Rosenberg note:

Naturalistic observation can only be understood in light of the results of specific interactive negotiations in specific contexts representing (perhaps temporary) loci of interests ... The old notion that cultures or social institutions have an independent existence has been set aside. By the same token, neither cultures nor social institutions are irreducible to the experiences of those who observe them (2011, p. 470).

Through immersion in the global women's and children's health advocacy network over a decade, the author came to recognise norms and verbal codes that could suggest patterns of network behaviour for further analysis, as well as acquire information about the venues where such patterns were described in written form. The author made extensive use of publicly available documents to ensure critical distance and to account for conclusions reached. Such documents include published reports, speeches, policy texts, press releases, transcripts, maps, TV spots, household surveys, etc. In this way, the author tried to balance the need for independent critical analysis in the casework, while benefitting from the advantages of network collaboration.

Even so, it is important to acknowledge that the author's selection of research questions, strategies, methods and evidence sources emerged from a highly situated perspective. In her case, this locates her as a professional advocate who contributed to the production of the global campaigns and networks analysed in this dissertation, beginning from 2005, when she joined a PMNCH as a consultant and on-off staff member, interspersing paid work with unpaid research.

The case study research presented here seeks to make her own assumptions and interpretive practices visible through the materials selected and represented, including those on public record as well as those produced through semi-structured interviews and personal narratives. Each research practice applied in this dissertation seeks to delineate the world of networks and campaigns to

others, displaying “multiple, refracted realities simultaneously” (Denzin and Lincoln 2011, p. 5).

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Chapter 4

The role of the global women's and children's health network in influencing attention during the Millennium Development Goals era

4.1 Introduction

This chapter, published in Globalization and Health in 2016, chronicles the development of the global women's and children's health network during the MDG era (2000-2015). Its aim is to address the first research question of this thesis: "What was the role of the global women's and children's health network in influencing attention to these issues during the MDG era?"

Qualitative methods used are described in the paper: one, a thorough analysis of documents from diverse sources (ranging from formal scientific reports to speeches and commentaries), and two, participant observation, facilitated by the author's lengthy association with the Partnership for Maternal, Newborn & Child Health. This helped identify materials from a broad range of actors and institutions, and included personal notes and observations of events and processes occurring during much of the MDG period (2005-2015). Limitations of this method are acknowledged; greater detail is available in chapter 3.

Shiffman and Smith's conceptual framework on the political prioritisation of global health initiatives (2007) guided the development of this paper. This framework, which also serves as the overarching framework for this thesis, identifies four linked analytical categories to assist in explaining network effects, i.e., actor-power, ideas, political context, and issue characteristics. Each of these categories is underpinned by related factors, such as the presence of guiding institutions, leadership, and civil society mobilisation (actor-power); internal and external frames (ideas); and severity of burden and feasibility of policy solutions (issue

characteristics). Shiffman and Smith's categories assisted in narrowing scope of evidence to be collected, and in guiding consideration of how the interplay of these factors contributed to the way networks sought to influence policy agendas. Categories were also used to structure the presentation of evidence and analysis in this paper.

This paper concluded that the development of coordinated networks of heterogeneous private and public actors accompanied the rise in policy attention to women's and children's health issues during the MDG era. The extensive use of evidence-based advocacy frames by these networks, including those based on epidemiological and economic evidence, had an important effect on discourse and leadership patterns within the network. This both echoed and reinforced the normative orientation of the MDGs to technical, rather than rights-based, approaches to global development.

This paper found that the social and political environment in which global health networks are situated have an important effect on how such networks emerge, cohere, and decide to frame their issues. However, it also found that networks exercise important agency in relation to these conditions: They can force open windows of opportunity for policy change, or prevent them from closing. Thus, rising attention to women's and children's health in the 2000s can be understood not only because of the MDG framework itself, but also because of the strategic intervention of the global women's and children's health network.

As the first of four research papers in this thesis, this paper performs two main roles: It sets the overall context and scene for this thesis and its main research question on networks and issue attention, and it introduces two themes that are pursued in the three research papers that follow: the role of actor power, conflict and negotiation (chapter 5), and how that power is exercised through communication strategies and processes, including in various campaign forms and in multiple spatial domains (chapters 6 and 7).

Cover sheet: Research paper 1

Section A – Student details

Student	Lori McDougall, LSH230644
Principal Supervisor	Gill Walt
Thesis Title	How do global health advocacy networks seek issue attention?

Section B – Paper already published

Where was the work published?	<i>Globalization and Health</i>
When was the work published?	2016
If the work was published prior to registration for your research degree, give a brief rationale	
Have you retained the copyright?	Open access
Was the work subjected to academic peer review?	Yes

Section C – Prepared for publication, but not yet published

Where is the work intended to be published?	
Please list the paper's authors in the intended authorship order	
Stage of publication	

Section D – Multi-authored work

For multi-authored work, give full details of your role in the research included and in the preparation.	
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Student signature

Date: 15 January 2019



Supervisor signature

Date: 15 January 2019

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RESEARCH

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Discourse, ideas and power in global health policy networks: political attention for maternal and child health in the millennium development goal era

Lori McDougall

Abstract

Background: Maternal and child health issues have gained global political attention and resources in the past 10 years, due in part to their prominence on the Millennium Development Goal agenda and the use of evidence-based advocacy by policy networks. This paper identifies key factors for this achievement, and raises questions about prospective challenges for sustaining attention in the transition to the post-2015 Sustainable Development Goals, far broader in scope than the Millennium Development Goals.

Methods: This paper relies on participant observation methods and document analysis to develop a case study of the behaviours of global maternal and child health advocacy networks during 2005–2015.

Results: The development of coordinated networks of heterogeneous actors facilitated the rise in attention to maternal and child health during the past 10 years. The strategic use of epidemiological and economic evidence by these networks enabled policy attention and promoted network cohesion. The time-bound opportunity of reaching the 2015 Millennium Development Goals created a window of opportunity for joint action. As the new post-2015 goals emerge, networks seek to sustain attention by repositioning their framing of issues, network structures, and external alliances, including with networks that lay both inside and outside of the health domain.

Conclusions: Issues rise on global policy agendas because of how ideas are constructed, portrayed and positioned by actors within given contexts. Policy networks play a critical role by uniting stakeholders to promote persuasive ideas about policy problems and solutions. The behaviours of networks in issue-framing, member-alignment, and strategic outreach can force open windows of opportunity for political attention – or prevent them from closing.

Keywords: Millennium development goals, Sustainable development goals, Reproductive, Maternal, Newborn and child health, Policy networks, Discourse, Agenda-setting, Issue-framing

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Background

The Millennium Development Goals (MDGs) have generated an increasing amount of reflection about how political attention has been shaped by these goals and how neglected issues could attract support in the future [1]. The MDGs, introduced in the early 2000s, include three main health goals, two of which focus on child and reproductive/maternal health. MDG4 calls for the reduction of under-five child mortality by two-thirds by 2015 against a 1990 baseline, and MDG5 calls for the reduction of maternal mortality by three-quarters during the same period, as well as universal access to reproductive health.

While neither the reproductive/maternal goal nor child health goal were reached by the 2015 target date [2], maternal and child mortality have each declined by half since 1990, and the global annual rate of reduction for child mortality doubled in the MDG era, from 1.8% during 1990–2000 to 3.9% during 2000–2015 [3]. Many have suggested that this improvement is linked to greater global political attention for maternal and child health during the MDG era.¹ Indicators of such attention² include policy statements and resource commitments, such as the 2010 launch of a “Global Strategy for Women’s and Children’s Health” by UN Secretary-General Ban Ki-moon, which attracted written “commitments” for implementation by more than 300 organisations, including 84 national governments. Estimates of official development assistance for maternal, newborn and child health (MNCH) rose from USD 2.67 billion in 2003 to USD 8.34 billion in 2012, despite a climate of declining overall aid contributions in recent years [4].

These events have taken place in a policy community marked by significant heterogeneity of actors, including those from government, donor agencies and foundations, multilateral agencies, academia, health professional associations, NGOs and private business. These actors are motivated by varying if inter-related interests, such as sexual and reproductive health, maternal, newborn, and/or child survival, and adolescent health. Further, they come from a wide range of epistemic traditions, resources, geographic networks and histories.

How did maternal and child health issues ascend on the policy agenda in the MDG era despite such heterogeneity of actor-groups? What are the challenges for sustaining attention when external conditions shift, as in the recent transition to the Sustainable Development Goals, the MDG’s post-2015 successor framework with a far-broader remit? And what might such challenges predict about the responses of such networks? These questions on political attention are explored in this paper through agenda-setting theory in political science, and discussed in the context of the rising power of

public-private partnerships within the domain of global health governance and the practice of “global health diplomacy” [5, 6].

To explore these questions, this paper starts from Kingdon’s widely applied theory of “multiple streams” of policymaking. Rather than seeing policymaking a linear process of neatly demarcated stages, Kingdon suggests that agenda-setting, policy formulation, and implementation are part of an interactive process emerging from the confluence of three largely independent “streams” of “problems”, “policies” and “politics”, each with its own highly dynamic character [7]. Kingdon refers to “problems” as those emerging from a process of competition among advocacy actors in which social conditions are successfully portrayed or “framed” as urgent and amenable to public action, thereby attracting political attention. “Policies” refers to the various ideas and solutions proposed by policy communities to address problems as agreed. “Politics” is the larger environment in which this competition plays out. This stream includes elements such as political “mood”, the inclinations of governing regimes, and prevailing social trends. Kingdon sees these streams coming together at certain moments in time through the successful manipulation by individual policy “entrepreneurs”. This process levers open “windows of opportunity” through which advocacy actors can successfully pursue their goals.

Kingdon’s theory of policymaking has been influential in drawing attention to agenda-setting as the outcome of highly dynamic interactions between ideas, actors, and context. In this tradition, Walt and Gilson’s “triangle” framework [8] for conducting health policy research is valuable in drawing attention to how actors, context and processes interact with policy content in the shaping and reshaping of that content. This triangle highlights power relations in such arenas, and as such is particularly relevant for studying the ideas, discourse, and behaviours of actor-networks in pursuit of certain advocacy goals – a key concern of this paper.

To help identify, organise and analyse this case study on agenda-setting for maternal and child health, this paper applies Shiffman and Smith’s 2007 framework of policy prioritisation [9]. Grounded in Kingdon’s concept of multiple streams, as well as Walt and Gilson’s dynamic approach to health policy analysis, Shiffman and Smith highlight four main areas – i) ideas; ii) actor power; iii) political context; and iv) issue characteristics – that combine to explain agenda-setting effects. This paper will focus on the first three factors as the most relevant to the case of the MNCH community, with specific discussion on each.

In setting out this framework, Shiffman and Smith call particular attention to the agency of actors and their “guiding institutions”, such as advocacy networks – from

the ideas that they select, to the leaders and guiding institutions that they choose, to the indicators they prioritise to demonstrate severity of their issues and the credibility of their proposed solutions. How power is mobilised, asserted and used by actors is intrinsic to these processes, and is central to this study.

While Shiffman and Smith do not assign causal weight to these four broad categories of factors within their framework, this study on maternal and child health will pay particular attention to the influence of actor-power through the formation of networks, leadership, and institutional development. A key question in this study is how actor cohesion developed in spite of heterogeneity. As noted, this diversity among actors is multi-dimensional, spanning different geographic locations and interests, constituencies (e.g., private sector, health professional, donors, NGOs, etc.), and professional training (e.g., life sciences, economics, international relations, management, finance, sociology, law, etc.).

Following Smith and Smith, actors are understood in this paper not only as individuals and organisations with their own knowledge, attitudes, practices and behaviours, but as networks of actors, including “networks of networks” such as The Partnership for Maternal, Newborn & Child Health (PMNCH), formed in 2005 to unite three previously separate global networks on maternal health, newborn health and child survival.

Keck and Sikkink characterise networks by their “voluntary, reciprocal and horizontal patterns of communication and exchange” [10]. Such networks may be closely connected or tightly structured, but as institutions, they are distinguished by their capacity to participate in collective action [11]. Kahler [12] contrasts this concept of “actor-based” networks with more static, “structure-based” networks, originally developed in economics and sociology literature of the 1960s and 1970s [13, 14] as relatively unyielding, insensitive edifices that themselves shape the behaviour of its constituent members to produce desired effects. This case demonstrates that the capacity of actors to shape their structures has enabled the timely and effective negotiation of goals, strategies and approaches, which has in turn helped force open policy windows and facilitate access to policymakers. In this way, the structure of the network itself is a determinant of success of advocacy goals, and participants continually retool that structure in line with shifting opportunities and political conditions.

How ideas are negotiated and portrayed to both internal audiences (e.g., network members and allies) and external audiences (e.g., policymakers, media and others influencers) are key aspects of the Shiffman and Smith framework. Benford and Snow [15] see the framing of problems and policy solutions as outcomes of contested process among actors. Given the wide array of social

issues and conditions that policymakers are confronted with every day, advocacy actors vie with each other to construct effective “causal narratives” [16] and storylines to manipulate how issues are perceived and what policymakers believe can be done about such “problems” [15]. This view assumes that empirical evidence alone is insufficient to motivate action, especially when certain issues – such as maternal, newborn and child mortality – have been regarded habitually as longstanding issues with complex and expensive policy solutions. To counter this, actors must negotiate among themselves to agree and communicate collective action “frames” that cast a new, actionable light on their issues, and promote network coherence by assisting members in locating, perceiving, identifying and labelling their experiences [17].

In Gitlin’s definition, frames are as “the persistent patterns of cognition, interpretation, and presentation of selection, emphasis and exclusion, by which symbol-makers routinely organise discourse” [18]. McInnes et al. identify five frames most frequently used in global health: biomedicine (i.e., evidence-based medicine), economics, security, development, and human rights [19]. The positivist approach of “evidence-based medicine” describes a world in which material outcomes can be shaped by applying epidemiological and biostatistical analysis and solutions to the policymaking process. In the field of public health, the evidence-based medicine frame is often combined with an economic frame to assert significant returns on investment by scaling up coverage of “packages” of biomedical interventions, such as contraceptives, vaccines, and skilled care at birth, supported by improved health delivery systems. Through this equally positivist frame, the emphasis on cost-benefit analysis and return on investment dates arises from a neoliberalist concept of development popularized in the 1980s and still widespread today. Development problems, such as maternal and child mortality, are thus seen as amenable to market solutions, such as more money, more information, and greater operational efficiency. In comparison, structural barriers rooted in inequalities of place, race or class often have a less visible explanatory role in this narrative.

Evidence-based framing in public health has risen significantly in the past decade as part of a wider thrust towards evidence-based medicine and clinical practice. For example, evidence-based framing has been adopted by the maternal health community in a bid to “professionalize” its advocacy through biomedical and economic framing, thus reducing reliance on moral arguments in swaying the attention of political leaders [20, 21]. For many in public health, the maxim of “What gets measured, gets done” remains a literal statement of truth, emphasizing the power of quantifiable measurements to attract attention and motivate action. As Foucault observed, such discourses are

practices that systematically form the objects of which they speak, investing power and authority in the projection of an objective measurable “truth” [22]. Indeed, problems and solutions can be oversimplified when framed and promoted by those in positions of influence, taking on the status of “master narratives” that in themselves shut down debate and limit the scope of ideas for change [23].

The emphasis on quantitative targets and measurements in the MDG framework has clearly influenced the discourse of actor-networks, as well as the policy audiences they have sought to influence. This can be explained because frames are most likely to be accepted by policymakers when they resonate with public understandings and provide new ways of talking about and understanding issues [24]. Ideas, therefore, must be considered central to the relationship between evidence and public health, suggesting a more complex relationship than the oft-depicted linear, causal link between science and policymaking.

At the same time as the MDG discourse, the re-orientation of development practice to foreign policy concerns has also had a structuring effect on how multi-stakeholder networks have framed their issues, aligned their members and built their alliances. This includes a tactical recognition of “high politics” [25] as a driver of attention to issues deemed vital to state survival, including security and economics – and a corresponding influence in how issues are agreed and portrayed.

The conceptual shift from the MDGs to the SDGs – from a neoliberal market-oriented view of development to a “people-centred” view of development – raises questions, therefore, about how actor-networks and their ideas respond to such conceptual and contextual shifts in a bid to retain power, resources and attention.

This question summarises the central concern of this paper with the agenda-setting process. Against a background of the MDGs and new forms of global health governance, how was attention for maternal and child health achieved in an arena populated by disparate organisations with different experiences, different measurements, and different causal stories? Who set the terms of the “frame development” process, what history did that build on, and what trade-offs were made during the process of consensus-building?

To succeed in the SDG era, networks will be challenged to behave in ways that frame health not as an isolated technical domain, but as a determinant, outcome and indicator of sustainable development itself [26]. What do those conditions suggest to networks in reshaping norms, behaviours, and structures to sustain attention for maternal and child health issues?

Methods

This study approaches agenda-setting from a social constructivist perspective [10], taking a detailed case study approach to understanding how and why ideas are constructed by communities of actors, and how those ideas influence power and policy.

Case studies enable researchers to analyse “real life” processes through a combination of observatory, textual and process-tracing methods, revealing underlying information that can help explain “how” and “why” such processes occur [27].

Given the interest of this paper in how networks use frames to achieve political attention, a participant-observation approach was used to identify the process by which key ideas and frames are negotiated, agreed and contested. Access to this network discourse was privileged by the author’s employment in the secretariat of The Partnership for Maternal, Newborn & Child Health (PMNCH), beginning from PMNCH’s formation in 2005, through to the events described in this paper. PMNCH is a “network of networks” where information from different member-organizations comes together. From 2005 to 2015, PMNCH grew from less than 100 member-organizations to 725 member-organizations across eight constituencies: national governments, donors and foundations, NGOs, multilateral agencies, health care professional associations, private business, youth and adolescents, and academia. Potential problems of being an employee and a researcher at the same time were avoided as the main subjects of the study were constituent organizations rather than the secretariat itself.

Data was collected on a regular basis through direct observation of global, regional and national meetings, verbal and written exchanges among network members and informal discussions. For example, public speeches at assemblies and conferences were analysed to identify changes in mainstream policy discourse. Ethical approval for this study was granted by the London School of Hygiene and Tropical Medicine as part of the author’s doctoral dissertation research. Within the wider maternal, newborn and child health community, the author’s research interests were widely known and referred to on the secretariat biography page of the PMNCH website.

To address self-bias inherent to a participatory approach [11], a review of approximately 200 published and unpublished documents was also undertaken. These documents were produced by several different epistemic and professional groups, including those with specific reproductive, maternal, newborn, child and adolescent health interests and expertise. These documents were assessed to triangulate narratives on the historical development of the global maternal and child health

community, including perceived milestones, successes, challenges and risks in the current period of transition from the MDGs to the SDGs. Most of these documents were identified through the PMNCH web archive covering the years from 2005 to 2015, which reported news and reports from many constituent organizations, including web links to their major reports, press releases and speeches. Additional documents that predated the PMNCH archive were found through references in the reviewed documents. The evolution of framings could be mapped through these publicly available documents, including through reported speeches, policy papers, strategic plans, annual work plans, and reports. Furthermore, a number of peer-reviewed papers, co-published by practitioners and political actors in academic journals, were included in the document analysis due to their normative nature reflecting the framing of the policy discourse.

The method of analysing the data from participant observation and the documents was based on open-ended coding of relevant conceptual labels and themes and their subsequent merging into broader categories that eventually coincided with the observation scheme. A timeline was developed to identify key moments in the development of frames, products, and external events relevant to network structure and operation (Table 1).

Results and discussion

The interconnected needs of women and their babies have been long recognised. Declarations of the 1990 World Summit for Children and the 1994 International Conference on Population and Development both articulated this concept. This was further elaborated by the World Health Organisation in 1996 through its “mother-baby” technical guidelines [28]. Even so, the proposed interventions, institutional leadership, historical development and analytical frames associated with each cause were sufficiently different as to engender largely separate advocacy movements, with a fair degree of resource-competition between them [29–32].

The advent of the MDGs in the early 2000s set the stage for a shared advocacy approach. The MDGs allocated two of its eight goals for child and maternal health: MDG 4 (reduce under-five child mortality by two-thirds by 2015 from 1990 baseline) and MDG 5 (reduce maternal mortality by three-quarters by 2015 from a 1990 baseline). Reproductive health, sidelined from the MDG agenda, was eventually added as a sub-goal to MDG 5 in 2008. The MDGs, though widely criticised for promoting a depoliticised, decontextualised view of development [29, 33, 34], began to gain support for their agenda-setting power, drawing high-level attention and consensus around a simple, easily communicated set of goals.

Since maternal and child health advocates were positioned by the MDGs as equal partners in this high-level political project, it seemed strategic to join forces with each other to maximise policy attention and results by presenting a combined burden [21, 35]. However, to do so, it was critical to align conceptual and organisational approaches to serve the interests of a wide range of heterogeneous partners. In the mid-2000s, this gave rise to the creation of the “continuum of care” framework as an inclusive operational approach. This framework was popularised by a new joint institutional base founded to promote a collective identity for advocacy, The Partnership for Maternal, Newborn & Child Health, as discussed below.

Using Shiffman and Smith’s framework of ideas, actors and political context, this paper will explore each of these concepts in turn to explore the case of the MNCH.

Ideas: MNCH frames and evidence-based discourse

The “MNCH continuum of care” conceptual framework, promulgated through a series of high-profile publications by key policy actors in 2005 [35, 36], expanded the concept of the mother-baby dyad to incorporate determinants and outcomes of healthy pregnancies and safe deliveries, including strong health systems. It proposed the seamless delivery of health interventions through an integrated view of time (from pre-pregnancy to pregnancy, delivery, and early childhood), as well as space (from community level up to facility level). The assumed logic of the framework was better care through, in part, greater resource efficiency. Investments in one area would benefit others, reducing pressure on maternal, newborn and child health advocates to compete for resources and attention [35–37] as a PMNCH ‘fact’ sheet commented:

The Continuum of Care recognises that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life [38].

Early descriptions of the continuum of care positioned rights at the centre of the frame, acknowledging the politics that surrounded it. Rejecting the vertical approaches that had dominated global health in the 1990s and early 2000s, including through the rapid rise of new global health partnerships dedicated to particular diseases and technical interventions [39, 40], proponents such as the authors of the 2005 World Health Report, *Make Every Mother and Child Count*, called for a broader health systems approach rooted in equity concerns:

Table 1 Ideas, actor-groups, and political context in relation to the development of a global MNCH community, 2005–2015

2005–2010			
Ideas	Political context governments	Political context multilateral	Political context civil society
<i>MDGs 4 & 5 present opportunity to create a joint "MNCH" identity for greater mutual impact</i>	2006: African Union (AU) announces Maputo plan on sexual and reproductive health to accelerate MDG results	2005: World Health Report, <i>Make Every Mother and Child Count</i> , promotes continuum of care, calls for enhanced progress in reducing mortality	2005: PMNCH formed as "super-network" of maternal, newborn and child groups to advocate for joint achievement of MDGs 4 and 5
<i>"Continuum of care" created as operational framework for integrating maternal and child health service delivery</i>	2006: Norwegian PM Stoltenberg convenes new Global Business Plan for MDGs 4 & 5; 2007, announces \$1b for MNCH, launches head of state network on RMNCH	2007: MDG5b created on reproductive health	2005: Countdown to 2015 progress report grows out of <i>Lancet</i> special reports on child and newborn health
<i>Evidence-based advocacy, based on epidemiological and economic measurements, adopted by wide range of MNCH actors. Rights/moral-based messaging declines.</i>	2008: Inter-Parliamentary Union co-hosts global meeting with Countdown to 2015 on RMNCH	2009: UN Secretary-General Ban Ki-moon identifies maternal and child survival as priority for action; calls for development of global plan of action	2006: <i>Lancet</i> produces evidence series on maternal health, anchored by new global epidemiological analysis
<i>Norms and beliefs articulated through the Global Strategy for Women's and Children's Health (2010)</i>	2009: AU launches national CARMMA campaigns to advance Maputo plan	2009: High-Level Task Force on Innovative Financing influences first-ever costing of gap in reaching MDGs 4 and 5	2007: Women Deliver holds first global conference in London, uniting advocates and marking pivot to evidence-based advocacy
<i>Multi-stakeholder "partnership" narrative asserted to promote delivery of Global Strategy and influence of MNCH policy community in global health arena</i>	2010: G8 pledges US\$5b for MNCH at Muskoka summit in Canada 2010: AU heads of state hold summit on RMNCH	2010: <i>Global Strategy for Women's and Children's Health</i> led by UN Secretary-General Ban Ki-moon attracts US\$40b in pledges through a new partnership platform, <i>Every Woman Every Child</i>	2009: MNCH Consensus agreed among broad range of UN, civil society, donor, and health professional partners: first-ever technical and financial consensus
2011–2015			
Ideas	Political context: governments	Political context: multilateral	Political context: civil society
<i>Accountability discourse takes hold in MNCH community to measure progress towards MDGs and Global Strategy – technical orientation cedes gradually to rights-based measures of accountability as SDGs take shape (2011–2015)</i>	2011–12: Parliaments intensify support for MNCH through Inter-Parliamentary Union resolution and Pan-African Parliament resolutions	2011: Commission on Information and Accountability for Women and Children, chaired by leaders of Canada and Tanzania, sets out goals and targets based on the Global Strategy. Calls for creation of an "independent Expert Review Group" to track progress, reporting to UN Secretary-General	2011: PMNCH opens private sector constituency, recognising contributions in innovation and efficiency
<i>Increasing complexity of MNCH architecture underlines need for global health governance reforms</i>	2012: DFID, BMGF and UNFPA convene London Family Planning Summit, raising \$2.4b in pledges; FP2020 created to support and track progress, linked to the Global Strategy	2013: Global Investment Framework for Women's and Children's Health launched in conjunction with <i>Lancet</i> Commission on Investing in Health	2012: First annual report of independent Expert Review Group emphasises need for stronger global health governance, national data, human rights and participation
<i>Rising economic power of LMICs and stagnating donor aid prompts greater shared concern with national leadership and financing</i>	2014: Open Working Group report on post-2015 SDGs emphasises integrated health and development goals, based on sustainability and human rights, including adolescent and reproductive health	2014: Global Financing Facility for Every Woman Every Child created to harmonise aid and leverage domestic funds	2014: PMNCH publishes <i>Success Factors</i> study to advocate for stronger links between health outcomes and social and economic determinants in post-2015 era
<i>Emergence of integrated SDG framework highlights focus on social, political, economic and environmental determinants of health</i>	2015: MDGs end, SDGs launched	2015: Updated <i>Global Strategy on Women's, Children's and Adolescents' Health</i> developed in support of SDG agenda	2015: "Citizen Hearings" on women's and children's health led by NGO coalitions at sub-national, national, and global levels to demand greater accountability

Maternal, newborn and child health cannot be reduced to a set of programmes to be delivered to a target population. Rather, mothers and children must be in a position to claim a set

of entitlements as their right. This implies an adjustment of macro-level health policies and resource mobilisation, at country level and internationally [36].

While the continuum of care concept was appropriately large and ambitious, at a practical level, it remained difficult to quell longstanding tensions related to a large range of issues embedded within the framework. These included broader issues relevant to all network actors, such as attention to community-based vs professional and facility approaches or health system investments vs disease-specific investments, but also tensions among communities, such as how sexual and reproductive health and rights would be recognised and prioritised within an integrated “MNCH” approach that focused largely on the supply and monitoring of biomedical interventions and clinical services.

Such debates had run deep in the era of the “safe motherhood movement” in the late 1980s and 1990s [9, 20]. The child health community, too, had also experienced tensions about how best to set a course for progress, including the role of community-based care versus facility care. By the early 2000s, there was a general concern of slowing progress in both the maternal and child community. Leading scientists, public health specialists and journalists affiliated with the child survival community, for instance, expressed public concern that the momentum in child mortality reduction achieved in the 1980s and 1990s during the “golden years” of Jim Grant’s leadership at UNICEF had waned dramatically [41].

Grant’s focus on scaling up coverage of key interventions such as treatment of diarrhoea and pneumonia, immunisation, protection from malaria, and attention to nutrition, had achieved important gains in survival during his tenure. However, Grant’s successor, Carol Bellamy (1995–2005), shifted the focus from intervention coverage to a broader agenda, uniting health with a range of related concerns, including girls’ education and child protection. Bellamy argued that the child survival agenda needed to adapt to changing times, moving “beyond survival” to focus on human rights, reflecting the conclusion of the “World Fit for Children” agenda of a major UN session on children in 2002 [42]. Tensions surfaced in a *Lancet* editorial in 2005, in which editor Richard Horton charged Bellamy with dropping the ball on the “essential” health needs of children:

A preoccupation with rights ignores the fact that children will have no opportunity for development at all unless they survive. The language of rights means little to a child stillborn, an infant dying in pain from pneumonia, or a child desiccated by famine. The most fundamental right of all is the right to survive [43].

Horton was not a neutral party: In 2003, the *Lancet* had published a highly influential series on child survival by the “Bellagio study group”, whose members included senior epidemiologists and academicians of global repute

such as Bob Black and Jennifer Bryce of the US, Cesar Victora of Brazil, Zulfiqar Bhutta of Pakistan and Hassan Mshinda of Tanzania. Together, the Bellagio group put forward a powerful case for renewed global attention to child survival, demonstrating through statistical, economic and policy analysis where and why problems lay and how they could be addressed [41].

The message of the Bellagio group was clear: To generate greater investment and political will, monitoring and reporting on progress was crucial. Governments, donors, the UN and other policy actors could be better held to account through high quality data and analysis on health indicators; interventions, including inequities in coverage; resource flows; and health system policies and legislation.

Given the combined status and reputation of the *Lancet* and Bellagio authors, their call to action held considerable sway over the global child health community, as well as within their respective geographic networks. Given the overall normative thrust of the MDGs towards technical and managerial solutions to development and health as reported in numerous academic studies [1, 33, 34, 44], the emphasis of the Bellagio group on quantifiable scientific evidence was widely accepted as an important contribution to monitoring progress on the MDGs. This example of evidence-based advocacy in public health was a sign of the times, echoed in the metrics of the MDGs as well as in the neoliberal economics in many donor countries at the time [19]. The concept of “selective primary health care” itself was a re-interpretation of the idealistic 1978 Alma Ata agenda, now focusing on “practical”, time-bound and measurable health interventions [21].

The emerging “evidence-based” advocacy approach of the MNCH community was cemented in the launch of the “Delhi Declaration on Maternal, Newborn and Child Health” in April 2005, which announced the formation of a new combined platform for action, the “Partnership for Maternal, Newborn & Child Health” [45]. Sexual and reproductive health, while clearly evident in the concept of the continuum of care, was mentioned in the Delhi Declaration, if lacking in emphasis. The word “equity” and “rights” appeared just one time each in the text of the Declaration, compared with eight combined references for “coverage” and “resources” [45]. Reproductive health organisations, perhaps preoccupied in part with the struggle to gain belated inclusion of reproductive health within the MDG framework [44], appeared content to let maternal and child advocates get on with their work in forming an “MNCH” super-network. Indeed, PMNCH seemed to be understood by the reproductive health community as a creature of the MDGs, reflecting its techno-managerial framing, and therefore, perhaps of limited long-term strategic value in the struggle to recognise rights [30].

Within the MNCH community, issues like abortion rights and sexual health education – controversial to some members of PMNCH, including conservative governments and faith-based NGOs – were often omitted or downplayed in public messaging. The adoption of “neutral” scientific framing and discourse was instrumental in reducing scope for friction among the many sub-communities of the continuum of care.

Indeed, Countdown to 2015, a scientific collaboration growing out of the Bellagio Group to track the progress of MDGs 4 and 5, did not include abortion-related indicators in its flagship reports until 2014 [46], when it published a box about preventing unsafe abortion and the number of Countdown countries with legislation permitting abortion. Although well regarded for its pioneering and innovative approaches to tracking health inequities, Countdown’s reporting on trends in national coverage of key health and nutrition interventions is the dominant focus of reporting, complemented by tracking of financial and policy indicators. In this sense, Countdown to 2015 reflects the dominant discourse of the MNCH community over the past 10 years, legitimising and disseminating evidence-based framing through the “gold standard” authority of its work.

This discourse is echoed throughout key policy documents in the MNCH community during the MDG era [45, 47]. This was clearly reflected in the original *Global Strategy for Women’s and Children’s Health* (2010–2015), launched by the UN Secretary-General to accelerate progress on the MDGs:

Together we must make a decisive move, now, to improve the health of women and children around the world. We know what works. We have achieved excellent progress in a short time in some countries. The answers lie in building our collective resolve to ensure universal access to essential health services and proven, life-saving interventions as we work to strengthen health systems. ... Often the solutions are very simple – clean water, exclusive breastfeeding, nutrition, and education on how to prevent poor health are only a few examples. ... With the right policies, adequate and fairly distributed funding, and a relentless resolve to deliver to those who need it most – we can and will make a life-changing difference for current and future generations [47].

In this view, mortality is seen as the dominant problem, and the Global Strategy set out a prescription for more money, better policy and programme support, greater efficiency through harmonisation of actors, better data and information, and above all, “more resolve” by all stakeholders.

Even attention to health systems, which has grown significantly from the mid-2000s in response to the

proliferation of global health initiatives and vertical initiatives [40], is framed in managerial terms, i.e., that weak systems represent threats to MDG progress and “bottlenecks” to organisational objectives [48]. Health systems are projected mainly as technical delivery channels of commodities, interventions and workers, not as social institutions shaped, and shaped by, the interaction of people, policies and services. Demand-side policies and community voice in the context of political reform were nearly entirely absent from the 2010–2015 *Global Strategy* – now corrected in its successor strategy, the *Global Strategy for Women’s, Children’s and Adolescents’ Health*, launched in September 2015 to align with the equity and rights-focused Sustainable Development Goals for 2016–2030.

In summary, the use of quantitative data and the deliberate scientific framing of maternal and child health by network leaders, such as by the leaders of the Countdown movement and PMNCH, satisfies two key conditions required for political attention: severity of the issue, and the feasibility of solutions proposed [15, 49].

Shiffman and Smith’s framework of ideas, actor power, political context and issue characteristics treats these categories in a dynamic fashion, recognising the mutual influence of these domains. Frames in this study are seen in a similar fashion – they are agreed by actor-networks within a certain political context, whose behaviours in turn are shaped by their use of such frames.

Actor power: MNCH advocacy networks in the global health arena

The formation of these MNCH networks and their political use of frames occurred in the midst of a major shift in global health governance, in which the concept of “international health” among sovereign states was replaced by the idea of “global health” characterised by the interdependence of nations and sectors through globalisation processes [5, 6, 39, 50].

A new cohort of health actors claimed power and contested the traditional governance arrangements of international health. From the early 2000s, and spurred in part by the MDGs, came a wave of 100-odd new private-public “global health initiatives” [51]. Issues included HIV/AIDS (e.g., Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002; PEPFAR in 2003), TB (Stop TB, 2001), child health (GAVI in 2000, Child Survival Partnership in 2004), maternal health (Partnership for Safe Motherhood and Newborn Health in 2004, emerging out of the longstanding Inter-Agency Group for Safe Motherhood), and newborn health (Healthy Newborn Partnership in 2000) among many others.

By the mid-2000s, global health discourse had shifted to the need for coordination, harmonisation, and accountability among all of these actors. This discourse

introduced concepts of partnerships for “aid effectiveness” and intensified discussion on global health reform and the need for “global solidarity”, given increasing cross-border, cross-constituency issues such as the rising burden of non-communicable diseases, climate change and other environmental crises, pandemics, population migration and information flow [51].

This set the scene for the birth of The Partnership for Maternal, Newborn & Child Health in 2005, uniting three previously separate partnerships: the Partnership for Safe Motherhood and Newborn Health, the Healthy Newborn Partnership and the Child Survival Partnership [52]. Members were divided into different “constituencies”, representing institutional affiliations (governments, NGOs, academia, multilaterals, health professional associations, donors/foundations, and later private business).

Since leaders from all three networks had agreed to the continuum of care framing, tensions between the networks focused less on ideational differences than realpolitik, such as which member would host the new secretariat and enlarge its reputation accordingly. The PMNCH board was deliberately large to accommodate representative seats from multiple constituencies and communities, removing a potential source of tension.

In PMNCH, maternal health networks spotted a fresh opportunity for “evidence-based advocacy”, turning the page on a complex past of internal dispute and slow progress as other studies suggested [9, 20, 53]. Child health networks, spurred to action through the emerging Countdown movement and the “rhetorical power” of MDG 4 [42], saw an opportunity to expand their support base; and newborn advocates, still few in number, saw an opportunity for growth through alignment, justified by the continuum of care concept. To most concerned, including those concerned with better aid coordination, PMNCH seemed like a win-win.

In its 10-year history, PMNCH has developed into what Shiffman and Smith would describe as a “guiding institution” [9] of 725 member-organisations, assuming a leadership role in producing consensus among network members.

A historic analysis of PMNCH board documents (2005–2015) published on its web site [54] finds extensive evidence of a culture of diplomacy and member cooperation, regardless of underlying tensions between constituencies and members, including on issues such as abortion and sexuality education among adolescents. Debate on such “red flag” issues are largely absent from the official record, suggesting they are not raised (or not reported).

When evidently sensitive issues do appear on the agenda, such as those related to financial resources or

governance arrangements, the the public discourse can be highly diplomatic, with official notes referring only obliquely to issues of power and transformation. For example, the note of the PMNCH December 2014 strategic board retreat quoted its board chair in relation to the clear challenges that lie ahead in transitioning from the MDGs to the SDGs, and the need for negotiation among actors in this process, but framed such political considerations as almost “technical” in nature:

Graça Machel noted the considerable challenges of the new agenda for women and children, and stressed the priority of ‘leaving no one behind’. The magnitude of the task ahead will require scaling up activities significantly and negotiating the inclusion of robust accountability mechanisms that will track progress for women, children’s and adolescents’ health in the years to come [55].

Formal governance meetings and related written reports often have little direct focus on challenging dynamics. For instance, the note from the December 2014 PMNCH board meeting made little reference to divided opinion about the Global Financing Facility for Every Women Every Child, which was the subject of a public consultation coordinated by PMNCH at the time [56].

Public suppression of conflict is observed to be a tactical behaviour in the MNCH community, borne out of the political need to achieve coherence among institutions, epistemologies, and professional backgrounds within the network. As such, the “neutral” scientific framing adopted by the community can also be understood as a tactic for suppressing conflict and facilitating coherence within the network, as well as a powerful external frame in the “high politics” arena.

With internal tensions carefully managed within its governance structures, the MNCH community has been successful overall in presenting a cohesive public face – a key “actor power” attribute of the Shiffman and Smith explanatory framework. An example of this actor coherence – and its contribution to attracting political attention – is the production of the *Global Strategy* by PMNCH members in 2010, and its contribution to the mobilisation of an estimated USD60 billion in related financial resources through more than 400 written commitments to the strategy [55].

Such cooperation, however, does not suggest lack of tensions between sub-communities – reproductive, maternal, newborn and child. In 2013–14, the newborn health community developed a high-profile action plan, *Every Newborn*, which was supported by a resolution among 192 member-states of the World Health Assembly in 2014 [57]. Some maternal advocates had tried to persuade the newborn advocates to slow down and

develop a fully integrated maternal and newborn health plan, concerned that a newborn-focused plan would distort attention and undermine longer-term goals of maternal-newborn integration. Reasons for friction were explained in the *Lancet* by former PMNCH co-chair Ann Starrs soon after the Every Newborn launch:

The maternal and newborn health communities must move beyond the lingering tensions that limit full cooperation and acceptance of each other's priorities. On the maternal health side, this wariness reflects a concern that embracing the newborn baby would inhibit efforts to address reproductive health and to anchor programmes and policies in a rights framework. On the newborn health side, there are concerns that embracing the full maternal health agenda might slow the momentum of the Every Newborn Action Plan and compromise its achievements [32].

Political context: MDG to SDGs

The MNCH case discussed in this paper justifies this important focus on actor behaviour, as seen through the manipulation of frames and strategic development of multi-constituency networks (Table 1). However, the efficacy of these behaviours has been determined, in part, by two key external factors: the MDGs and the expanding power of non-state actors within the global health governance arena more generally.

The MDG 4 and 5 “dyad” has provided a focus and justification for ideational alignment between policy sub-communities (i.e., based on the continuum of care concept, communicated through the evidence-based framing of the Global Strategy). This conceptual agreement has, in turn, provided a catalyst for structural and behavioural alignment between sub-communities (e.g., the development of PMNCH and the creation of Every Woman Every Child and related campaigns, such as Every Newborn).

As a result of this alignment, stakeholders have been able to advance on two fronts. One is the acceleration of progress towards the 2015 MDG goals. The second is the shaping of the new post-2015 SDG goals and their delivery mechanisms. Several goals in the SDGs are conditioned by the need for greater progress on women’s and children’s health, including those on education, gender, water and sanitation and others. This brings the concern of health into the centre of the SDGs, away from the margins, where many fear it will lose attention as just one among 17 competing goals [26, 58]. At the same time, the operational model of the Global Strategy, through its Every Woman Every Child private-public partnership platform for leveraging resources and tracking results, is also promoted as an innovative delivery model for the SDGs themselves.

These examples suggest at least a partially reciprocal relationship between political context, actors, and ideas. Political context and policy windows, while often far beyond the domain of advocates, can also be influenced to some extent through collective action to secure political attention.

But what happens when political conditions change, as in the current shift from the MDGs to the SDGs? Some advocates fear, for instance, that a much-expanded framework will tilt political attention away from health, no matter how effectively such issues have been “embedded” in several goals. Can such risks be mitigated through the realignment of ideas and behaviours, or is context simply more powerful?

Early signs of adaption are occurring in the MNCH network in relation to ideas and frames, as well as network behaviour, structure and leadership. For example, the updated Global Strategy for the SDG era reflects updated technical evidence, but its chief characteristics are the broadening of its scope of concerns and the universality of its application. The 2010 edition had a tight focus on interventions related to maternal and child mortality in low-income countries, with far less prominent attention to social and economic determinants of health, as well as adolescent and reproductive health, infectious disease, and nutrition. The 2015 document, by contrast, adopts a “beyond mortality” lens, proposing a rights-based vision of “survive, thrive and transform”. Boundaries of concern are therefore greatly expanded, including to fragile and humanitarian settings [59].

The SDG framework is similarly ambitious, developed through an extensive country-led consultation process during 2012–2015. The resulting framework speaks to its democratic process, and includes 17 goals, 169 targets and an even greater number of performance indicators. By comparison, the MDG framework had just 18 targets and 48 indicators, leading to focused political attention – as well as extensive backlash among those who saw the MDGs as far too utilitarian to produce meaningful social change.

The development of the updated Global Strategy has followed the SDG themes closely, sending key messages about the primacy of national leadership, equity, and mutual accountability of stakeholders. Virtually no dissent has been heard about the primacy of adolescents and youth in the new Global Strategy, including greater attention to related issues such as early and child marriage, family planning, and adolescent access to health services. This stems from several reasons. First, shifting demographic patterns and rising youth populations in many countries with growing economic power, including those in Africa, have triggered new recognition of the importance of sexual and reproductive health policies. For instance, the African Union’s CARMMA campaign,

launched in 2009 to support continental policies on sexual and reproductive health, is now active in 44 countries.

Second, at a global level, the long-standing struggle to secure attention to reproductive health, resulting in the belated achievement of MDG 5b in 2007, cemented strong networks for action that have continued to yield results. The Women Deliver global conferences, beginning in 2007, have brought advocates together from all regions. Donors such as the Bill & Melinda Gates Foundation have partnered with the UN and countries such as the UK, India, Ethiopia and others to push family planning issues ahead, creating the “FP2020” global network in 2013.

Together, reproductive and adolescent health have pushed the MNCH community to refresh its discourse, members, and strategies, creating what is known as the “RMNCH” community (or “RMNCH + A”, including adolescents). This emergence been marked by important new commitments. At a global level, Overseas Development Assistance for reproductive health has increased significantly in recent years, from USD3.6b to USD4.5b between 2009 and 2012 [4]. Among countries and donors, a pledging conference for family planning in London in 2012 set targets for contraceptive use, creating the basis for the FP2020 reference group and secretariat. In addition, the UN has scaled up attention to child, early and forced marriage, passing a resolution in 2014 that put pressure on member-states to develop national legislation and protective policies [60].

As in the HIV/AIDS space, civil society groups have been central to the process of getting family planning and sexual and reproductive health on the global policy agenda. However, MNCH advocacy networks – while successful in positioning the Global Strategy as a key platform for consensus and commitment – continue to identify a mutually reinforcing set of technical and political barriers for greater action, including lack of funding, technical capacity, coordinating platforms, information flow, and inclusion in national planning and financing dialogues.

Power and participation is a particularly key issue. It was not until 2013, for example, that a civil society leader – Graca Machel, humanitarian and widow of Nelson Mandela – assumed the chair of PMNCH, even though NGOs account for two-thirds of the PMNCH membership by number [61]. In October 2015, youth and adolescent members of PMNCH finally succeeded in establishing their own constituency and seat on the board following a multi-year advocacy process. While youth are now often included on panels at global and regional events, they are often treated as symbols rather than experts, waiting their turn to speak as representatives of governments, donors and the UN take on more prominent roles.

The question of how civil society groups claim and use power is beyond the scope of this paper. However, as a large constituency within MNCH advocacy networks, civil society movements are crucial to promoting social justice claims within national policy dialogue through the legitimacy and authenticity of the voices they represent. While stillborn babies, newborns, and small children cannot of course speak to their experiences, other community representatives, including adolescents, women, and parents, can provide powerful public testimony that transform how claims are heard.

In sum, the technical framing of causes, solutions and accountability within the global MNCH community, influenced by powerful scientific leaders and the MDG framework itself, has made it difficult for the network to fully benefit from its inherent claim on social justice. Community leaders, essential to expressing the interests and experiences of those most affected by MNCH policies, need greater support to play this political role and to engage in technical discourse.

As the experience of the HIV community in the MDG era has shown [62], civil society groups have the capacity to bring rights-based claims to centre stage, converting even complex technical problems into broad-based social movements that attract political attention.

Conclusion

This paper applies the Shiffman and Smith framework on political attention to guide a discussion on the dynamic relationship between actor-networks, framing, and political context. This case study on the MNCH policy community concludes that global development frameworks have exerted significant pressure on ideational processes and framing, as well as network structures, behaviours and leadership, catalysing the alignment and realignment of both frames and networks to achieve and sustain influence.

This illustrates the challenges and opportunities of shifting political contexts. On the one hand, the shift from the MDGs to the post-2015 SDGs have presented the MNCH network with a vast action agenda. These include the urgent need to strengthen the links between MNCH and adolescent and reproductive health; promoting a stronger relationship between MNCH and infectious disease and non-communicable diseases; and in recognizing MNCH and public health more broadly as a product of social, economic and environmental determinants. This shift challenges network identity, membership and underlying conceptual concepts that have facilitated successful alignment and network coherence during the MDG era.

To date, networks have been opportunistic in embracing these changes. Changes been framed by network leaders as opportunities to assert rights-based narratives

that accord with SDG norms as well as network core values. In this vein, network leaders have embraced youth groups to provide authentic leadership in response to the SDG focus on reproductive and adolescent health concerns, contributing network expansion and ambition.

While these recent changes have been adopted with little friction to date, network stability may be threatened if the SDG agenda narrows in practice, and choices in political attention begin to be made. At the same time, network structures that revolve around global secretariats in New York or Geneva must shift substantially if a truly country-led approach to planning, financing, advocacy and accountability is to be realised.

Therein lies important questions for the future: How will the lengthy SDG agenda be interpreted in practice by political leaders? Will “MDG era” concerns be sustained, or will attention shift to newer frames and networks, provoking a struggle for power and resources within this joined-up reproductive, maternal, newborn, child and adolescent health community focusing on national leadership? The strategic alliances between sub-communities forged in a more technocratic and apolitical MDG era may come under strain in an era focused on elevating concerns about equity and human rights. Indeed, the continuum of care concept – the “conceptual glue” between RMNCH + A sub-communities – may itself lose value in the context of a comprehensive SDG health goal that promotes a life course approach, moving beyond the mortality concerns of the MDGs: “Ensure healthy lives and promote well-being for all at all ages”.

Such struggles may not be contained within the women’s and children’s health community. The history of implementing the Alma Ata primary health care approach tells us that, when comprehensive agendas are seen as too ambitious or expensive to implement, they are subject to re-interpretation and narrowing through counter-movements, regardless of the formal consensus process that legitimised their creation. Whether that political struggle will occur, to be led by whom, is yet to be seen in relation to the broader SDG agenda, where health is now one of 17 inter-related goals.

In conclusion, this case of the MNCH policy community finds that idea-framing, actor behaviours and network development are highly interdependent processes, with political context exerting a significant impact on all such constructions. However, context alone cannot govern outcomes – the agency of networks to determine and sustain success through strategic realignments and reframing remains key.

Policy communities and their ideas are neither static nor impervious to change. The current transition between global development frameworks creates new space for advocacy networks to re-imagine and re-invent shared ideas

that structure membership, leadership, and behaviours. At the same time, risk is inherent to change, presenting challenges to network coherence and cohesion and limiting overarching efforts to maintain political attention. When resources and attention are seen to shift too far to one side, policy sub-communities may retreat to their core values and disparate interests compete for dominance.

Can the MNCH/RMNCH + A community sustain the success of the past 10 years? Can techno-managerial discourses adapt to a more rights-based environment, in which the concept of accountability extends beyond quantitative measures to a truly social and political process of inclusive development and participation? In this sense, ideas and the framing of those ideas are part of a discourse within networks, which use their power and the surrounding political contexts to introduce shifts in policy, such as more political attention for women’s and children’s health.

The opportunities of change lie in adaptation, partnership and reinvention. These are the challenges that the women’s, children’s and adolescents’ health community will face during its ongoing ambition to bring health and well-being to the centre of the post-2015 framework.

Endnotes

¹French [63] provides a contrary explanation for improvements in child mortality during the Millennium Development Goal (MDG) era, attributing such reductions to coincidental economic growth during this time rather than the focusing power of global policy frameworks or even national public health expenditure. Critics, however, could rebut that while income is clearly a key determinant of household purchasing power of such things as nutritious food, mosquito nets and medicine, a confounding factor is that rising GDP often brings greater formal employment opportunities for women, which can exert a negative effect on mothers’ capacity to invest time in activities with proven child health benefits, such as antenatal and postnatal visits, breastfeeding, cooking healthy meals, collecting clean water and so on. As Murray [64] notes, the significant rise in Development Assistance for Health from USD11.6b in 2000 to USD33.1b in 2012 can be correlated with a strong emphasis on health in the MDGs, which itself had “broad societal appeal” (p.1391) and the capacity of influencing household investments.

²“Political attention” is defined by Hafner and Shiffman [48] as occurring when “leaders of organisations express concern about issues publicly and privately, and when they back up this concern by allocating resources.”

Competing interests

LM was a staff member of The Partnership for Maternal, Newborn & Child Health during the research and writing of this article, which was undertaken to fulfil, in part, the requirements of a doctoral dissertation at the London School of Hygiene and Tropical Medicine. The findings and interpretation in

this paper do not represent those of The Partnership for Maternal, Newborn & Child Health, and are attributable only to the author.

Author's contributions

LM is the sole author of this study.

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Chapter 5

Conflict and negotiation among network actors in the global health policymaking process

5.1 Introduction

This chapter was published in the International Journal of Health Management and Policy in 2016. Its aim is to explore the second research question of this thesis: "How does conflict and negotiation between network members influence actor-power?" This paper chronicles how coalitions within the global women's and children's health network competed and negotiated among themselves to produce network frames and campaigns that reflected their normative beliefs and strategic interests during the MDG period.

This paper builds from the finding in chapter 4 that how networks agree to frame and express their ideas is important to understanding how they engage with their external environment, as well as their internal structures and strategies. It also establishes campaigns as a useful lens for observation, to be explored in chapters 6 and 7. Yet processes of contention and ideational debate within networks may be hidden from view, and the discursive power of "winning" narratives, discourse, and forms of knowledge may be difficult to see. This chapter seeks to add to understanding of networks by exploring the nature and role of normative debate among network actors, guided by Sabatier's Advocacy Coalition Framework (1988).

Sabatier's framework illustrates how continuous internal struggle among coalitions of network actors for dominance, rooted in differing beliefs and policy ideas, is integral to the external positioning and behaviour of that network, and to the policymaking process at large. Data collection and interpretation was guided by Sabatier's conceptual approach to identifying the contrasting beliefs, resources

and policy outputs of disparate coalitions within the global network. The Global Strategy for Women's and Children's Health (2010) was identified as a rich source for qualitative evidence for this study because of its development as a consensus-based project undertaken by the global network, accompanied by the ongoing accumulation of financial, policy and service delivery commitments through the Every Woman Every Child campaign.

Four main methods were used to gather evidence and construct this case, as detailed in chapter 3:

- *document analysis built upon information collected in chapter 4, with supplementary review of approximately 30 written resources (e.g., reports, editorials, messaging documents) produced by different coalition leaders;*
- *semi-structured interviews (24) enabled comparison and contrast of priorities and ideas among different coalitions;*
- *secondary analysis of two rounds of self-reported survey data collected by PMNCH on commitments to the Global Strategy for Women's and Children's Health through the Every Woman Every Child campaign, including 168 responses in 2012 and 120 responses in 2013;*
- *participant observation assisted in identifying competing coalitions, leaders, and discourses for in-depth research, as well as in interpreting emerging findings derived from other qualitative methods.*

Methods were limited by lack of focus group discussions with respondents, which could have triangulated understanding on how and why beliefs, resources and policy outputs were produced by disparate coalitions of network actors. This was hampered by barriers in geography, time-zones, expense and other factors. However, careful triangulation of methods attempts to address weaknesses.

In conclusion, this paper found that network contention and debate over the framing of the Global Strategy and the Every Woman Every Child campaign served a productive purpose: It drew attention to important but underfunded issues, such as adolescent health and family planning, and it challenged network

members to recognise human rights more explicitly in issue-framing. This encouraged the global women's and children's health network, long dominated by evidence-based ideas and norms relating to maternal and child survival, to reposition itself in line with the emerging rights-based norms of the post-2015 Sustainable Development Goals, in which women, not only as mothers, are prioritised. The analysis suggested that when windows for opportunity are sufficiently wide, even network competitors can collaborate for short-term mutual gain.

Global health is often framed as an evidence-based space that "should be" free of interest-based politics; this paper suggests that global network campaigns may play a productive role as arenas for ideational conflict and debate that can improve network legitimacy, accountability and transparency. For this reason, such campaigns are important to the further study of how and why actor power is produced and expressed in global health.

Cover sheet: Research paper 2

Section A – Student details

Student	Lori McDougall, LSH230644
Principal Supervisor	Gill Walt
Thesis Title	How do global health advocacy networks seek issue attention?

Section B – Paper already published

Where was the work published?	<i>International Journal of Health Policy and Management</i>
When was the work published?	2016
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Have you retained the copyright?	Open access
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Section C – Prepared for publication, but not yet published

Where is the work intended to be published?	
Please list the paper's authors in the intended authorship order	
Stage of publication	

Section D – Multi-authored work

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Date: 15 January 2019



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Power and Politics in the Global Health Landscape: Beliefs, Competition and Negotiation Among Global Advocacy Coalitions in the Policy-Making Process

Lori McDougall*

Abstract

Background: Advocacy coalitions play an increasingly prominent role within the global health landscape, linking actors and institutions to attract political attention and resources. This paper examines how coalitions negotiate among themselves and exercise hidden forms of power to produce policy on the basis of their beliefs and strategic interests.

Methods: This paper examines the beliefs and behaviours of health advocacy coalitions using Sabatier's Advocacy Coalition Framework (ACF) as an informal theoretical lens. Coalitions are further explored in relation to the concept of transnational advocacy networks (Keck and Sikkink) and of productive power (Shiffman). The ACF focuses on explaining how policy change takes place when there is conflict concerning goals and technical approaches among different actors. This study uses participant observation methods, self-reported survey results and semi-structured qualitative interviews to trace how a major policy project of the Millennium Development Goal (MDG) era, the Global Strategy for Women's and Children's Health, was constructed through negotiations among maternal, newborn, and child health (MNCH) and sexual and reproductive health and rights (SRHR) advocacy coalitions.

Results: The Global Strategy represented a new opportunity for high-level political attention. Despite differing policy beliefs, MNCH and SRHR actors collaborated to produce this strategy because of anticipated gains in political attention. While core beliefs did not shift fundamentally and collaboration was primarily a short-term tactical response to a time-bound opportunity, MNCH actors began to focus more on human rights perspectives and SRHR actors adopted greater use of quantifiable indicators and economic argumentation. This shift emphasises the inherent importance of SRHR to maternal and child health survival.

Conclusion: As opportunities arise, coalitions respond based on principles and policy beliefs, as well as to perceptions of advantage. Global health policy-making is an arena of contested interests, power and ideas, shaped by the interaction of coalitions. Although policy-making is often seen as a process that should be guided by evidence rather than interest-based politics, this study concludes that a participatory process of debate among different actor-coalitions is vital to progress and can lend greater legitimacy, accountability and transparency to the policy process.

Keywords: Global Policy Networks, Agenda-Setting, Beliefs and Norms, Issue-Competition, Reproductive, Maternal, Newborn and Child Health

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Key Messages

Implications for policy makers

- The increase of global resources for reproductive, maternal, newborn, and child health (RMNCH) is a result of intensified coordination of actors in the effort to achieve the Millennium Development Goals (MDGs).
- Understanding how transnational policy coalitions think, compete and negotiate with each other is vital to understanding how they have come to wield increasing influence in global health at a time of declining state dominance.
- Global-level policy-making is legitimated and made more accountable by the participation of multi-constituency actor coalitions, including coalitions in which government representatives participate.
- In global public health, scientific, evidence-based policy-making is frequently presented as an ideal, asserting principles over politics; this approach discourages recognition and assessment of the productive role of power and politics in policy-making, particularly important to debates about equity and human rights.
- Supporting and enabling platforms for public debate at the global level, including through policy advocacy coalitions, is essential to improvements in public health and lends greater transparency to global policy-making.

Implications for public

New opportunities have arisen for public participation and debate in global health through the growing scale and reach of cross-border advocacy coalitions. In the domain of women's and children's health, the implementation of the *Global Strategy* promoted the allocation of new resources and greater accountability. At the same time, competition among coalitions within this community continues to shape how resources for women's and children's health are raised and used. This has created tension that exposes the global health policy-making process as a fundamentally political process that cannot be understood purely in terms of science and evidence. Competition and debate enables a wider democratic process to prevail and creates opportunities for participation and greater accountability, including those most affected by health policy decisions.

Background

The rising number and power of transnational partnerships in the global health arena have prompted greater attention to who makes global health policy, how this happens, and with what effects.^{1,2} Actor-groups within these partnerships prioritise differing forms of knowledge, hold differing values, and assert differing behaviours. Advocacy coalitions compete against each other for political attention by constructing persuasive narratives of problems and solutions. In the midst of this, policy-makers are faced with a widening array of competing issues and claims, yet have a finite set of resources to select, prioritise and act upon these. Therefore, policy-making is a fundamentally political and social process in the field of global health, despite the frequent assertion that global health policy should rest on a scientifically neutral, evidence-based foundation, marked by principled decision-making, rather than interest-based politics.³

Indeed for some, evidence-based advocacy is seen as deliberately political in nature, projecting public health as an outcome of correctly applied technical and operational solutions, and downplaying the complexities of social and political change.⁴ What is accepted as evidence-based in global public health areas often rests on the power of scientific and technical elites to determine the themes and terms of debate, which can exclude non-technical actors or non-elites from that process, creating a “de-democratising” effect in the policy-making process.⁵

Central to understanding how agenda-setting takes place and shapes our capacity to assess the legitimacy of health agendas is understanding how power is constructed and claimed by global health actors, including the advocacy coalitions through which they operate. Shiffman, for instance, draws our attention to three types of “power” in global health.⁶ ‘Compulsive’ power is easily seen, such as bilateral donors tying health aid to trade. Less visible are other types of power, including those based on epistemic or normative concerns rather than material interests. An example of this type of power is ‘structural’: in the context of a relationship between actors structural power enlarges the capacities of some while reducing those of others. Another is ‘productive’ power, such as how issues are deliberately framed and presented to shape the thinking and behaviours of others.⁶

Understanding how participants in the field of global health — and in particular, the area of sexual, reproductive, maternal, newborn, child and adolescent health — express their power to influence political attention is the subject of this paper. Nearly 100 new private-public ‘global health initiatives’ have been created over the past 15 years, bringing new financing, technical support, innovation, and advocacy capacity to global health.⁷ These private-public initiatives have also brought new challenges to health governance, as a wide range of non-state actors assumed key positions of influence over a growing set of resources.^{8,9} In response to this changing landscape of actors, there have been calls for stronger global health governance, especially in light of the cross-border nature of the issues and the need for greater solidarity and accountability among actors to address health problems and their social and economic determinants.¹⁰⁻¹²

While examples of compulsory and structural power are reasonably apparent in global health,⁶ productive power

may be less visible, and therefore of particular interest in understanding the norms and behaviours of global networks. This paper focuses on the case of the *Global Strategy for Women’s and Children’s Health (2010-2015)* document, developed by policy actors from across a broad range of sexual, reproductive, maternal, newborn, and child health alliances. Launched in 2010 as a five-year plan by United Nations (UN) Secretary-General Ban Ki-moon, the *Global Strategy* catalysed unprecedented political support in meeting the challenge of meeting the health Millennium Development Goals (MDGs), especially MDG 4 and MDG 5¹³.

The *Global Strategy* is presented here as the outcome of negotiations among competing advocacy coalitions, each motivated by a set of core policy beliefs. To assess the *Global Strategy*, this paper adopts key concepts from Sabatier and Jenkins-Smith’s Advocacy Coalition Framework (ACF),^{14,15} which focuses on explaining how policy change takes place when there is conflict concerning goals and technical approaches among different actor-groups. Coalition behaviours based on core beliefs is a key concept of this approach, including how such beliefs shift over time through policy learnings.

However, since the main objective of this paper is examining how productive power is used by global health networks in influencing policy, the ACF is treated only as a lens through which competitive coalition behaviours are viewed and interpreted rather than as an explanatory theory. The reason for this alternative interpretation is that the ACF is customarily applied to pluralistic political systems within nation-states rather than complex transnational governance landscapes.

Sabatier and Jenkins-Smith define an advocacy coalition as a set of “actors from a variety of public and private institutions at all levels of government who share a set of basic beliefs (policy goals plus causal and other perceptions) and who seek to manipulate the rules, budgets and personnel of governmental institutions in order to achieve these goals over time.”¹⁴ In the global case examined by this paper, coalitions are understood less as geographically bounded and operating with formal political systems, but rather as loose collections of alliances made up of committed individual and institutional policy actors with dense inter-organisational and interpersonal ties working across borders to influence policy. This more informal concept of advocacy coalitions aligns with Della Porta and Diani, who identify these as informal networks of collective action with clear common goals, but not necessarily backed by formal identity links.¹⁶ Therefore, the ‘maternal, newborn, and child health (MNCH) coalition’ is understood to be made up of a large number of alliances operating at different scales (from sub-national to global), united by a primary concern to reduce maternal and/or child mortality in line with the focus of the MDG on health as a means of poverty reduction.¹⁷ Alliance members include non-governmental organizations (NGOs), health professional associations, academic institutions, private and public donors and government institutions. Similarly, the ‘sexual and reproductive health and rights (SRHR) coalition’ unites a vast number of such private-public alliances concerned primarily with advancing the health and rights of women, including by securing such entitlements as contraception and safe abortion

services. This rights-based focus is expressed through shared goals emerging from the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995. It is important to be clear that neither coalition exists as a formally constituted and governed entity; each is a composite of a large number of different alliances and partners operating at different scale, sharing similar beliefs and advocacy approaches. Further, in practice, there is substantial overlap in policy beliefs between coalitions – many MNCH coalition members would not define themselves in opposition to the SHRH coalition, and vice versa, given the naturally co-dependent relationship between women's and children's health. As described by some ACF scholars and apt in this case is the concept of coalitions consisting of solid core beliefs "with fuzzy edges."¹⁸ Further, within coalitions, there is substantial disparity of beliefs on secondary aspects, notably within the MNCH coalition, with longstanding tensions between those primarily concerned with maternal health rather than newborn health or child health, or vice versa; despite overarching core beliefs about the importance of reducing preventable mortality and the value of taking an integrated approach to maternal and child health.

The Advocacy Coalition Framework and Global Health Networks

In developing the ACF, Sabatier and Jenkins-Smith questioned the depiction of policy-making as a sequence of seamless top-down sub-processes or *stages*, flowing forward from agenda setting to policy formulation, policy implementation, and policy evaluation and reformulation, and dominated largely by the actions of government leaders.¹⁵ In response, they developed a hypothetical framework that sought to reconcile top-down and bottom-up views, explaining how the interaction of different actor-groups at different levels (eg, scientists and technical experts, media, civil society, etc, together with government) could move the policy process through the competitive behaviours of coordinated action groups, or coalitions, formed through shared beliefs and values. Such behaviours include the deliberate "framing" of ideas and beliefs shared within the coalition to portray issues in persuasive way,¹⁹ as well as the opportunistic use of 'policy windows' as they open up in order to secure coalition dominance.²⁰

Belief systems are defined by Jenkins-Smith and Sabatier as *sets of value priorities and causal assumptions about how to realise them*.²¹ While actors are assumed to be instrumentally rational – ie, using all possible resources to pursue their goals – the framework draws more on cognitive and social psychology than economics in highlighting the biases and constraints of individuals in perceiving the world and processing that information.¹⁵

Sabatier and Jenkins-Smith propose a set of nine linked hypotheses addressing three main themes.¹⁵ The first theme concerns the nature of advocacy coalitions: that there are shared normative and causal beliefs that act as the 'glue' holding together members of advocacy coalitions, ie, formal or informal networks through which actors build resources and strategies to influence policy, competing with other such coalitions for dominance. The second theme addresses

how policy change occurs, including the notion of external events (*shocks*) as necessary but insufficient triggers for policy change. The third theme relates to the contribution of *policy-oriented learning* across coalitions, including conditions under which change occurs and the contribution of quantitative evidence in relation to quantifiable problems, and especially when professional forums exist for technical consensus-building across different coalitions.^{15,21} Both the ACF and Shiffman's concept of hidden 'productive power' revolve around the concept of the deliberate use of ideas and beliefs as structuring forces for political gain, and so are treated in a complementary fashion in this paper.

In Sabatier and Jenkins-Smith's view, belief systems operate on three levels: *deep core beliefs* (normative beliefs widely shared in the world and not specific to individual policy subsystems, such as the nature of good versus evil); *policy core beliefs* (normative beliefs and causal perceptions specific to particular coalitions, such as shared ideas about the severity and causes of a particular problem); and *secondary beliefs* (a large set of narrower beliefs about the seriousness of the problem or the relative importance of various causal factors).²¹ Although deep core beliefs are nearly impossible to change since they are rooted in one's fundamental perceptions about the nature of the world, Sabatier and Jenkins-Smith believe that policy core beliefs can shift gradually over longer periods of time (a decade or more) provoking major policy change, while secondary beliefs can shift more quickly, creating minor policy shifts in response to certain events or shocks (Figure).¹⁵

Context matters, therefore, in Sabatier and Jenkins-Smith's view of policy-making.¹⁵ Context provides *relatively stable parameters* that shape the resources and constraints of the *policy sub-system*²², as well as more dynamic event-based variables, such as changes in government, economic outlook, public opinion, or policy decisions of other policy sub-systems, that directly shape secondary beliefs and minor policy changes.

How Do Global Networks Interact?

While Sabatier and Jenkins-Smith understand the term "sub-system" to refer to *the substantive and geographic scope of institutions that structure interaction*,²² this paper applies a global lens to the concept, moving beyond the restriction of physical 'territories' to focus on global health policy sub-systems and their political behaviours. While the ACF has been most often applied to domestic political systems, the global setting of this case, with multiple 'fuzzy-edged' coalitions and multiple geographic scales, demands a more flexible use of the framework.

To begin, we borrow from Keck and Sikkink's concept of *transnational advocacy networks* to depict the global reproductive, maternal, newborn, child and adolescent health policy sub-system as one characterised by *voluntary, reciprocal and horizontal patterns of communication and exchange*.¹ In using the term "transnational advocacy networks," Keck and Sikkink focus rather restrictively²³ on networks of *non-state* actors seeking to influence the agendas of states, multilateral agencies and corporations through the use of collective information, ideas and strategies.¹ However, traditional ideas of dominance, embedded in "international health"

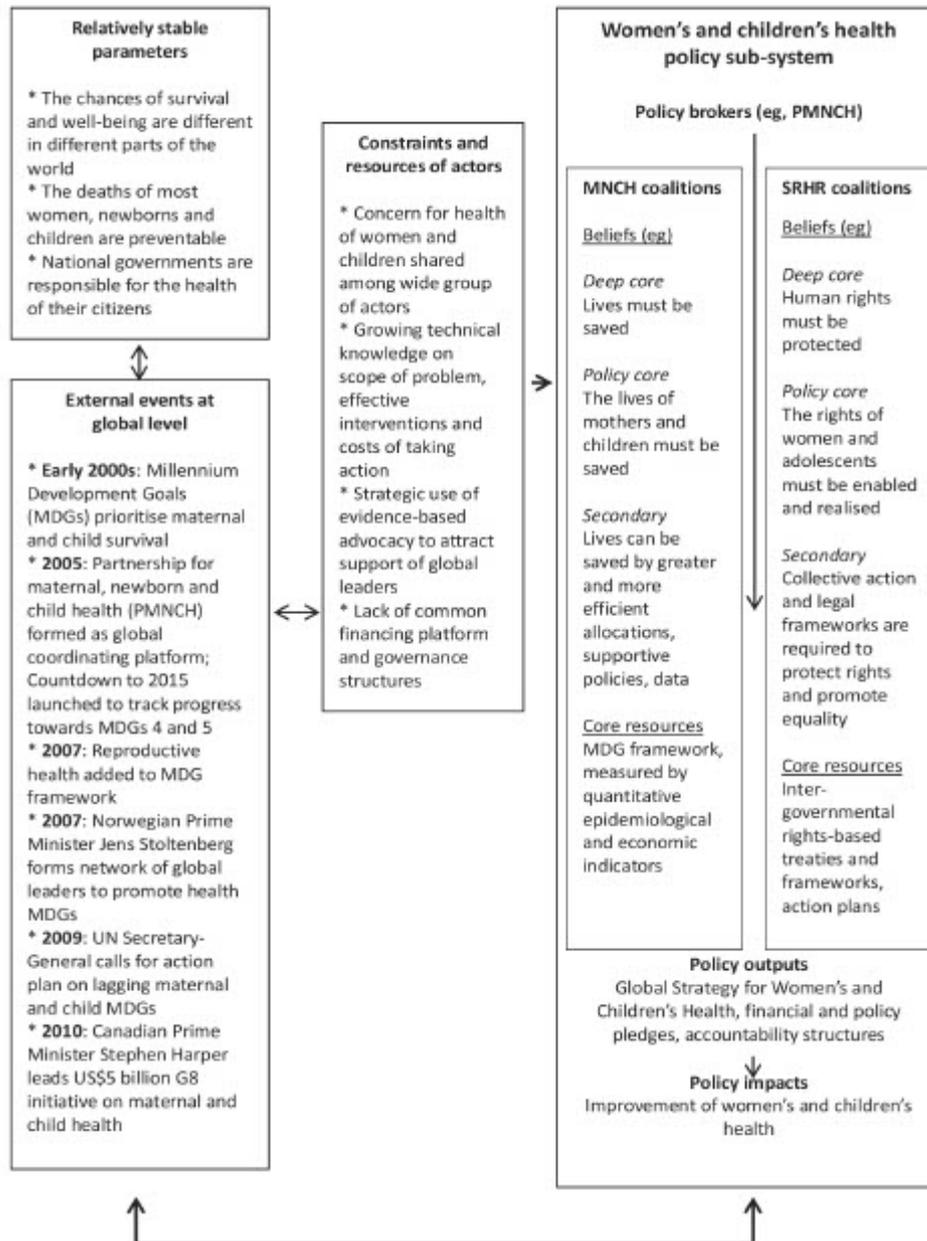


Figure. The Global Strategy for Women's and Children's Health Analysed Through Sabatier's Advocacy Coalition Framework.

and bilateral development aid to low-income countries, are challenged by the rise of “global health” in the past 15 years, with its constituency-based partnerships and networks of public and private actors, including low-income countries themselves.²⁴ This more participatory if complex concept of health, in which many actor-networks assert differing forms of influence at different levels, challenges traditional ideas of who holds power over whom and how, raising questions of governance and accountability.²¹

Accordingly, this paper describes a scenario in which a global health policy sub-system, composed of thousands of both state and non-state actors, governments, NGOs, UN agencies, private businesses, health professionals, academics, the media, etc – divide into disparate coalitions that cohere

on the basis of what Keck and Sikkink call “shared ideas and values” within “transnational advocacy networks.”²¹ These informal “networks of collective action,” combined with Della Porta and Diani’s interpretation of the term ‘coalition’ – are based on relations of voluntary exchange and dense personal ties.¹⁶ For the MNCH coalition, a deep core belief is that the lives of mothers and children must be saved, and preventable mortality, therefore, reduced. This belief is often framed by the coalition as part of the effort to reach the 2015 poverty reduction targets specified by the MDGs in relation to maternal and child health. On the contrary, the SRHR coalition is primarily concerned with the realisation of human rights. The SRHR coalition believes this cannot happen legitimately through a quantitative target-based framework like the

MDGs, but by inter-governmental agreements and legislative instruments. Quantitative and “scientific” arguments based on economics and epidemiology, used effectively by the MNCH coalition to attract political attention, have been less frequently used by the SRHR coalition, whose argumentation revolves often around rights and entitlements.

All actors in this global community operate within an arena determined by *relatively stable parameters* (Figure).¹⁵ Sudden events or shifts in external conditions (eg, changes in socio-economic conditions, governance arrangements, or public opinion) can facilitate policy change, largely in relation to minor or secondary beliefs, rather than core beliefs. However, events themselves are seen by Sabatier and Jenkins-Smith as necessary but insufficient factors to explain policy change produced by such advocacy coalitions or sub-communities. What must also be taken into account is the effect of policy learnings by advocacy coalitions over time as they learn and grow, including shifts in scientific or technical knowledge.^{22,25} Competition and negotiation among coalitions, therefore, is an enduring part of the process of establishing dominance in the policy-making process, with each coalition seeking to translate its own beliefs into policy. Competition takes place on the grounds of the strategic framing of their beliefs (the “productive power” discussed by Shiffman),⁶ as well as the wider set of resources (material, legal, and epistemic) held by each coalition. Often, this competition requires the intervention of *policy brokers* to mediate conflicts and move the policy process forward.²⁵ Policy, therefore, is the outcome of a highly politicised process of ideological competition between multiple policy participants at different scales, influenced by events, scientific evidence and beliefs.

In examining the central questions posed by this paper – eg, how do global coalitions interact to produce policy, and how is productive power used in this process? – the ACF provides a useful lens through which the *Global Strategy* may be viewed. There are two main reasons why this is so. First, this case examines the causal links between beliefs, values, and behaviours; second, this case focuses on how scientific and technical evidence is used as bargaining power in this process and the role of policy brokers in negotiating consensus between coalitions.

With transnational advocacy networks creating greater links between global, regional, national and sub-national policy processes,¹ this study follows a small number of other studies^{23,26} in using key concepts of the ACF to examine global political dynamics, including those influenced by the agenda-setting power of the MDGs.^{27,28} As such, this study seeks to fill a gap in global health governance literature on the agenda-setting power of advocacy coalitions, particularly in relation to women’s, children’s and adolescents’ health, which has attracted substantial attention and resources during the MDG era (2000–2015).^{27,28}

Methods

This paper relies on surveys, interviews, document analysis, and participant-observation methods to analyse how policy is produced through coalition behaviours. A case study approach with qualitative methods such as in-depth interviews and participant-observation can yield important results when seeking to explain “how” and “why”

contemporary phenomena occur, such as the influence of advocacy coalitions in the global policy production process.²⁹ Descriptive statistics from survey data are added to this case to triangulate the observations and increase validity.

A primary data source for this paper is the transcripts of 24 semi-structured key-informant interviews conducted by the partnership for maternal, newborn, and child health (PMNCH) with commitment-makers (approximately one hour in length per interview) during April–June 2013. These interviews were designed to follow-up on written responses to a larger survey, described below, and respondents were chosen randomly within seven different constituency groups that had made commitments (ie, governments, donors/foundations, UN/multilateral, NGOs, health professional associations, private sector, and academic and training institutions). The author was permitted by the Partnership to insert specific questions of relevance³¹ for this research paper into the interview guide in order to probe perceptions and beliefs of the respondents about the construction of the *Global Strategy* and related commitments. The questions were meant to be the same for all key informants (40 in total, representing a third of the respondents who had submitted responses to the written survey); however, in practice, the questions on advocacy were listed at the end of the interview, and time did not always permit full and complete answers. Therefore, 24 transcripts were deemed useable for the purpose of this study, spread across constituency groups as follows: senior representatives of low- and middle-income governments (3 interviews); donor governments (7 interviews); foundations (3 interviews); global health partnerships (3 interviews); private business (5 interviews); and NGOs (3 interviews). The author was permitted to observe six of these 24 telephone interviews to understand if the questions generated any observable responses of interest for this research, eg, particular emphasis, inflections, hesitations, etc.

Sabatier and Jenkins-Smith’s ACF suggests that understanding the process of policy change requires a time perspective of a decade or more in order to see how actors respond to emerging knowledge and alter their strategies accordingly.¹⁵ To this end, this study draws on a decade of participant-observation of the global health community and the major advocacy coalitions related to women’s, children’s and adolescents’ health within it (2005 to present, during the author’s employment with PMNCH). This longitudinal perspective has enabled a detailed understanding of the external context in which the *Global Strategy* emerged (2005–2009), the interactions between actors and coalitions that led to the creation of this policy project (2009–2010), and the effects created by the *Global Strategy* since its 2010 launch. It has also enabled the qualitative identification of the disparate coalitions and their observed ‘fuzziness.’

These observations were triangulated with the results of two rounds of written survey responses by organisations that had made written commitments to support the implementation of the *Global Strategy* over the September 2010 to June 2013 period. This data set includes 168 responses in the first round (2012) from 220 possible “commitment-makers,” and 120 from a possible 268 in the second round (2013). These responses were solicited by PMNCH^{41,30,31}; secondary analysis was performed for the purposes of this paper.

Overall, this study prioritises qualitative methodologies of data analysis, including the selection of codes (key actors, issues, events, global frameworks, behaviours), which were refined in an iterative fashion as the data interpretation process developed in the course of the research. Content analysis of the various data sets was used to examine and triangulate the three data sets.³²

Given this ‘insider’ association with the *Global Strategy* project, bias is assumed in the observation, which this analysis of survey data and key informant interviews attempt to mitigate. As Walt et al suggest, “position can influence the issues that researchers focus on, and, therefore, the research agendas created and the research questions asked.”³³ While ‘insider’ status may facilitate access to data and the ability to ask more meaningful questions, it disallows the ability to approach research topics from a fresh perspective that can allow new insights.

An additional limitation of this study design is that written and oral data were collected only from those who have made a commitment to the *Global Strategy*, and, therefore, little is known about the reasons why some institutions do not collaborate in this policy project, and what they perceive as the benefits or limitations of that decision.

Case Study: The Global Strategy for Women’s and Children’s Health

The creation of the *Global Strategy for Women’s and Children’s Health* is considered to be a successful effort in influencing political priority for women’s and children’s health. This claim is based on the mobilisation of US\$60 million in financing from a broad range of donors; the creation of new national and global initiatives for lagging issues such as newborn health and family planning; and the creation of a shared accountability framework to monitor resources and results for women’s and children’s health.³⁴

The *Global Strategy*, developed in 2010, proceeded, in part, from evidence previously agreed by stakeholders through such processes as the High-Level Task Force for Innovative International Financing for Health Systems in 2009, annual reports from Countdown to 2015, and the development of the MNCH Consensus of 2009³⁵. The process also built on the recommendations of purpose-built working groups on accountability, innovation, financing, human rights, and others, as well as the inputs of more than 300 organisations from different epistemic and professional groups, such as reproductive, maternal, newborn, child and adolescent experts, as well as governments, private businesses, UN agencies, donors, NGOs, academic organisations, and health professional associations.

The speed with which the *Global Strategy* was built reflected the political opportunity of the second high-level meeting on the MDGs in September 2010. All member-states of the UN were invited and the meeting was designated as a launching pad for the *Strategy*. This launch was facilitated by the championship of UN Secretary-General Ban Ki-moon. At that time, the child and maternal health goals³⁶ were the furthest behind of the eight MDGs to be achieved by 2015, and Ban felt that acceleration could have a “multiplier effect on all the other MDGs, including poverty reduction, education, gender equality, HIV/AIDS, and environmental sustainability.”³⁶

The Secretary-General was supported in his leadership by a growing list of national leaders who had expressed concern with maternal and child health. Among them were Norwegian Prime Minister Jens Stoltenberg, who in 2007 established a “global network of leaders for the health MDGs”³⁷; UK Prime Minister Gordon Brown and his wife Sarah Brown also led a high-profile campaign for the reduction of maternal mortality; Canadian Prime Minister Stephen Harper, who dedicated his presidency of the G8 in 2010 to an initiative on maternal and child mortality; and Chilean President Michelle Bachelet, a medical doctor with paediatric training also contributed to this campaign through this leaders’ network.³⁸ Adding to this were instrumental investments in early childhood mortality made by the Bill and Melinda Gates Foundation—particularly in childhood vaccines and malaria.

The Secretary-General’s leadership behind the *Global Strategy* in 2010 galvanised attention from a wide range of stakeholder groups within the global reproductive, MNCH community. Never before had there been such high-level interest expressed for this set of issues; this created an important window of opportunity for coordinated advocacy.

Regional and global reproductive health advocacy networks such as the International Planned Parenthood Federation (IPPF), the Asian-Pacific Resource & Research Centre for Women (ARROW), European NGOs for Sexual and Reproductive Health and Rights, Population and Development (EuroNGOs), and Development Alternatives with Women for a New Era (DAWN) secured an important victory in 2007 with the addition of MDG 5b and the addition of reproductive health to the MDG framework. Many went on to be closely involved in the *Global Strategy* process, often collaborating with multilateral actors such as United Nations Population Fund (UNFPA) and the World Health Organization’s (WHO’s) Reproductive Health and Research in joint policy advocacy work. However, relatively few governments came forward as high profile champions of the reproductive health cause in the *Global Strategy* process, and some influential leaders in the *Global Strategy* process sidestepped discussion completely on key reproductive health issues, such as abortion. Such leaders included Canada’s Prime Minister Stephen Harper, leader of the 2010 G8 initiative, whose Conservative party faced parliamentary controversy over whether family planning was to be included in Canada’s response to its own G8 maternal health initiative.³⁹

For their part, maternal health networks operating within wider MNCH networks in the early MDG era, such as the Partnership for Safe Motherhood and Newborn Health, the International Federation of Gynecology and Obstetrics, and the International Confederation of Midwives, did not abandon core policy beliefs about the centrality of reproductive rights and gender equity to maternal health.⁴⁰ However, it is clear that their decision to participate in a joint MNCH campaign facilitated key shifts in network strategy, including declining use of traditional moral and rights-based arguments and greater use of evidence-based advocacy based on quantifiable economic and epidemiological data.^{41,42} This deliberate selection of rigorous evidence forms, echoing the dominant technical norms of the MDGs,⁴³⁻⁴⁵ can be construed as a strategic response to gain visibility and attention for maternal and child health issues, even though the MDGs themselves

have been criticised since their inception for insufficient attention to equity and redistributive justice required for transformative global change.^{28,46,47}

Reproductive health remains a cornerstone of the RMNCH “continuum of care” concept that fostered the creation of PMNCH in 2005 as a union of three separate partnerships on maternal health, newborn health, and child health.⁴⁸ However, brokers in the *Global Strategy* process – including representatives of the delicately balanced PMNCH board, representing a wide range of disparate interests – did not seek to emphasise issues, such as abortion rights and sexual education of young people, that could cause rifts among stakeholders and create delay in achieving consensus (personal observation). Following the normative concerns of the MDGs themselves, discourse on rights in the final text of the *Global Strategy* was secondary to that of a more managerial nature, presenting RMNCH largely as a technical issue that could be solved with through more financial resources, greater efficiencies, data, and targeted policy choices.²⁸

Successful technical consensus-building among stakeholders and the political championship of the Secretary-General, the G8, Bill Gates and others created a strong positive wave for the *Global Strategy* leading up to its September 2010 launch. Although the *Strategy* was developed outside of the usual UN intergovernmental channels, the document was given formal political backing through its inclusion in the official communiqué issued by UN member-states in relation to the high-level meeting on the MDGs.⁴⁹ A measure of this support was seen in the September 2010 launch of *Global Strategy* itself, attended by a wide array of heads of state, UN, corporate and civic leaders, and accompanied by financial and policy commitments from about 70 stakeholders estimated at US\$40 billion.⁵⁰

After 2010, the influence of the *Global Strategy* was felt in a number of ways. Commitments from individual stakeholders expanded from 70 to more than 400 by 2015, including nearly 100 national governments.⁵¹ An accountability framework was established to monitor resources and results of the *Global Strategy*, including through annual reports issued by an “Independent Expert Review Group” made up of senior academic, media, parliamentary and civil society leaders.^{52,53} More than a half-dozen global initiatives were developed between 2011 and 2015 to focus attention on issues raised by the *Global Strategy*, such as innovation, family planning, child survival, commodities, newborn health, maternal mortality, and harmonised health financing.^{52,53}

The rapid creation of a web of global health initiatives with separate governance arrangements, resources, and outputs have intensified the debate about leadership and accountability within the global RMNCH community, mirroring the debate in global health more generally.⁵²⁻⁵⁴ While this complexity can be viewed positively as an outgrowth of enthusiasm and participation by a widening pool of stakeholders, it can also be seen a visible product of the tensions and pressures within the global RMNCH community. Various coalitions responded to the success of the *Global Strategy* as an opportunity to reassert individual core policy beliefs and revise their specific advocacy strategies in that light.

Results and Discussion

What does the example of the construction of the *Global Strategy* tell us about how global policy networks use their power to produce policy outputs and impact?

Survey and interview data collected at the midway point of the 2010-2015 *Global Strategy* project (ie, in 2012 and 2013) reveal the differing beliefs and perceptions of coalitions about the *Global Strategy* and its utility as an agenda-setting and policy formulation effort, as well as reflections on negotiations and competition between coalitions within the global RMNCH community. This ‘midpoint’ perspective is important in order to isolate attention to the process and effects of the 2010-2015 *Global Strategy*; the views expressed in surveys and interviews at this time do not yet appear to be weighted with consideration of the post-2015 Sustainable Development Goals (SDGs), which supersede the MDGs and mark a necessary point of transition for the *Global Strategy* and Every Woman Every Child.^{7,34}

Recalling Sabatier and Jenkins-Smith’s delineation of three major sets of ‘hypotheses,’ or drivers, for policy change – the competing beliefs and behaviours of advocacy coalitions, the role of external shocks in policy change, and the impact of new scientific knowledge on policy learning – the following section organises data collected from the 2012-2013 surveys and interviews in relation to these categories. Following the approach of others who have used the ACF as an informal guide to interpreting the behaviours of policy coalitions, not all of Sabatier and Jenkins-Smith’s nine hypotheses are addressed in this paper.¹⁸ This paper focuses on those hypotheses most relevant to the case.

Our findings are set within a context of considerable consensus among actors about the value of the *Global Strategy* as a normative statement of priorities and joint action plan. For example, nearly all (22 of 24) respondents who participated in the 2013 in-depth interviews reported in this paper agreed the campaign had delivered added value, and provided a wide set of reasons to illustrate their beliefs concerning the *Global Strategy* and the processes that created it. These included greater political visibility for RMNCH because of the UN Secretary-General’s personal leadership; the perception of broad technical consensus represented by the *Global Strategy*; the visibility of commitments made by others in supporting the *Global Strategy*; the catalytic value in creating innovative private-public partnerships to support the *Strategy*; and the emphasis on accountability through monitoring and reporting mechanisms associated with the *Global Strategy*, such as the Independent Expert Review Group.

These results underscore the results of the 2012 written survey of *Global Strategy* commitments.³⁰ In that study, 78% of respondents (n = 168) indicated that advocacy was a focal area of their pledge. This exceeded several other possible focus areas, including monitoring and evaluation (70%), research (63%), innovation (54%), and financing (45%). However, a similar study in 2013 used a keyword search to identify content areas of the commitments, and found that only 46% of commitments (ie, 135 of 293) contained evidence of advocacy content.³¹

This apparent discrepancy suggests that, at an overarching level, many saw the *Global Strategy* and commitment-making

as an advocacy process in its own right, whether or not their own commitment focused on identifiable advocacy activities. This point was articulated by most of the respondents involved in the 2013 key informant interviews reported in this paper, with 70% (17 of 24) referring, unprompted, to greater public momentum for RMNCH and/or the MDGs as a result of the *Global Strategy*.

Advocacy Coalitions: The Role of Shared Beliefs in Coalition Behaviours

“Actors within an advocacy coalition will show substantial consensus on issues pertaining to the policy core, although less so on secondary aspects.”¹⁵

Many respondents (13 of 24) taking part in the 2013 oral interviews started from the normative idea that the global RMNCH policy community consists of multiple “camps,” which the *Global Strategy* project has pushed closer together. These camps are understood in this paper as belonging to one of two main coalitions – the MNCH coalition and the SRHR coalition – defined on the basis of whether their major goal is one related to the survival theme of the MDGs or to a human rights-based belief in SRHR. The delineation of these two coalitions is based on participant-observation and interaction with coalition members in a wide range of meetings and conferences over the past decade, as well as document analysis of key reports, scholarly articles, and public statements.

“The Global Strategy has been important in facilitating cooperation among likeminded stakeholders, improving communication, decreasing transaction costs. It has created a common platform on which many different sectors can engage” (i19).

This idea was expressed by respondents in relation to both internal behaviours within their own organisations, as well as externally:

“It helped us make the case internally for increasing (our) commitment” (i18);

“The Global Strategy is something that has helped us over time as more agencies have bought into it. It’s driven attention and expanded the global architecture. [When working with others], we can now refer to a unified strategy, which has been helpful in attracting attention for our goals” (i18);

“We would have undertaken a lot of our work anyhow on MDGs 4 and 5, but shaping this work as a Global Strategy commitment has allowed us to connect more easily with others who are doing similar work and to build on those partnerships” (i17, 2013).

For some, however, the *Global Strategy* process exposed pre-existing conflict between coalitions, leading to unexpected consequences. Several of the oral respondents, for instance, noted that the normative concerns of the *Global Strategy* were those of maternal and child survival more than SRHR. Evidence for this claim includes the perceived imbalance in the text of the *Global Strategy* in relation to such issues. This included, on the one hand, perceived neglect to adolescent health and human rights, and on the other, a dominant focus on biomedical interventions and quantitative measurements. Family planning, for instance, was recognised in the text through the inclusion of two specific goals – preventing 33 million unwanted pregnancies and enabling 43 million new

users of family planning by 2015.⁵⁵ However, without a strong rights- and equity-based framework in the *Strategy*, these goals were seen by many to lack context and emphasis.

“We felt the Global Strategy was not as ‘family-planning friendly’ as it could have been – that it was very focused on maternal health, and that narrative wasn’t going to resonate with the reproductive health community. But we saw an opportunity to build on the momentum that the Global Strategy had set in motion, to start our own family planning campaign, which led directly to FP2020. The Global Strategy was the spark that ignited our imagination” (i1, 2013);

“The voices of young women and girls do not come very clearly in the Global Strategy. A lot of interventions described in the Global Strategy are technical in nature, focusing on health systems and services, which doesn’t address root causes of health, including education, empowerment and community leadership needs. So in shaping our commitment, we wanted to emphasise these issues” (i7).

The construction of the *Global Strategy*, therefore, became an arena in which coalitions competed and aligned to challenge dominant norms. While some made commitments to adolescent health and SRHR issues in order to flag up key gaps, as seen in the example above, others sought to leverage the *Global Strategy* much more directly, creating momentum for overlooked issues through high profile events such as the London Family Planning Summit in 2012, championed by the UK government, the Bill & Melinda Gates Foundation, UNFPA and others. The London summit led in turn to the “FP 2020” partnership in 2013, which seeks to implement the commitments of the London Summit. As a result of these events and growing donor support for family planning, 40% of all commitments to the *Global Strategy* by June 2013 included family planning.³¹ Such shifts represented a major challenge to the “MNCH” status quo, putting pressure on the identity and membership of this global policy community to embrace a broader identity, inclusive of sexual and reproductive health, and including adolescents alongside mothers and children.

“The Global Strategy was a great step forward, as it helped shift the discourse from focusing only on maternal health and mothers to women’s health. This presented a great opportunity for many stakeholders to join the movement around SRHR, and to reframe their existing commitments in this light” (i9).

Policy Change: The Role of External Shifts

“The policy core attributes of an... action programs are unlikely to be changed in the absence of significant perturbations external to the sub-system, ie, changes in socio-economic conditions, public opinion, system-wide governing coalitions, or policy outputs from other sub-systems.”¹⁵

The impetus for the creation of the *Global Strategy* itself was the introduction of the MDG framework and the concern by leaders such as Secretary-General Ban Ki-moon that inadequate progress in reducing preventable maternal and child deaths was impeding progress towards the 2015 goals. At that time they realised it would require a dedicated global effort to turn the situation around.

The successful struggle for visibility and resources by the

global reproductive health and rights network, seen in the examples above, was facilitated by an incipient shift in political attention to the broader social, environmental and economic determinants of health and well-being, represented by the emerging post-2015 SDGs. From the time of the Rio + 20 conference in June 2012, which launched the process of negotiating the post-2015 successor goals, a new emphasis has been established on the intrinsic relationship between health and other components of development, including education, gender equity, water and sanitation, agriculture and nutrition.⁵⁶

This reconceptualisation of health as a determinant, outcome and indicator of sustainable development has enlarged the arena for participation by a wide range of health actors.⁵⁷ This includes the women's health community, which sought to 're-politicise' SRHR issues in the MDG era by rejecting the narrow technical focus of the MDGs on maternal mortality, and embracing debate on the inter-connectedness of health issues and the distribution of power and resources.²⁸

The growing power of the reproductive health community can be measured by the growing number of commitments to the *Global Strategy*. Conversely, it is also clear from the experience of the 2010-2015 *Global Strategy* that the production of such consensus-based policy documents may reflect short-term tactical opportunities, such as seizing attention at a high-level meeting on the MDGs, rather than reflecting genuine shifts in core policy beliefs through compromise and negotiation.

Annual progress reports on the commitments, for example, continue to report at least a partial mismatch between the *Global Strategy's* "priority" countries and interventions, and those actually prioritised by commitment-makers.^{30,31}

An example of this is the high number of commitments made by stakeholders to India and South Africa (31 and 15 commitments, respectively, as of June 2012), although neither country was named on the *Global Strategy's* list of 49 priority countries.³⁰ Similarly, countries such as Somalia, whose child and maternal mortality rates were high with poor progress, received just seven commitments in 2012.

This finding is also echoed in the interviews for this paper, with less than a third of oral respondents (7 of 24) reporting that the *Global Strategy* had influenced their policy priorities in any meaningful way. This includes six of seven senior government representatives interviewed: "*The Global Strategy only validates our own policy and programming approach*" (i15).

This may be especially so for commitment-makers with the greatest access to power and resources, including the private sector. Representatives of private sector commitment-makers were especially explicit about their tactical use of the commitment process, with only three of five reporting that the *Global Strategy* was instrumental to guiding their investments, and then only when that guidance cohered with existing business strategies, including strengthening market position.

"*The focus on PPPs (private-public partnerships) in the Global Strategy helped us to think that others understand our business ideas and are mobilising support for them*" (i14);

"*The Global Strategy has provided a kind of framework for our investment areas. There are six or seven areas in the Global Strategy, and we selected two of them*" (i23);

"*We saw the Global Strategy as an opportunity to position ourselves as a global leader in providing healthcare, as well as to help us focus on our existing niches and how to integrate these into the public sector, working with public stakeholders*" (i18). This research finds, therefore, that external stimuli can have an important effect on the behaviours of advocacy coalitions, such as cooperating with each other to produce an effective policy response when opportunities arise. However, such behaviours are largely tactical in nature and do not necessarily reflect sustainable shifts in core policy beliefs.

Policy Learning: The Role of Scientific Evidence and Policy Brokers

"(a) *Policy-oriented learning across belief systems is most likely when there is an intermediate level of informed conflict between... coalitions*¹⁸;

(b) *Policy-learning across belief systems is most likely when there exists a forum that is prestigious enough to force professionals from different coalitions to participate, and is dominated by professional norms.*¹⁵

Sabatier and Jenkins-Smith's framework identifies a second major avenue for changes in policy beliefs among coalitions. This is through the adoption of new technical evidence and "policy learning" acquired with experience and time. The preceding informant quote about how the *Global Strategy* shifted the discourse "*from focusing only on maternal health and mothers to women's health*" illustrates the existence of policy learning between the MNCH and SHRH coalitions that occurred during the course of collaboration in the production of the document. At the same time, the overall lack of a rights-based framework to the *Global Strategy* illustrates the existence of compromise and the limits to such shifts in secondary beliefs.

The productive power of the MNCH community, wielded through its scientific and quantitative assessments of progress in mortality reduction, aligns well with the technical orientation of the MDGs.⁵⁸ This evidence often takes the form of empirical data generated by scientists such as epidemiologists and economists. The Countdown to 2015 network, led by highly regarded academics such as Cesar Victora, Jennifer Bryce, and Zulfiqar Bhutta, was particularly influential in this regard, publishing a broad range of data products that set the pace for MNCH measurement during the MDG era. Concepts of 'progress,' therefore, often follow these quantitative forms, promoting shared concepts and setting terms of debate about how change happens. The 2013 publication of a *Global Investment Framework for Women's and Children's Health*, for instance, presented economic evidence to strengthen the concept of health as an investment that generates social benefits and capital returns.⁵⁹

At the same time, prioritisation of quantitative evidence can exclude, for instance, more normative and political measures of change, vital to understanding complex social phenomena involving structural barriers, such as inequities based on gender, class, race or geography.⁴³ Differing ideas about how progress is measured is evident within the global RMNCH community, with reproductive health coalitions calling for a more explicit recognition of the political nature of change, the links between health and its determinants, and the role of collective action in realising rights.²⁸ As such, "policy

learnings” means different things to different stakeholders, as do the concepts of progress, accountability and governance. For some, accountability is measured through independent performance-based scorecards; for others, it is a process of mutual dialogue between stakeholders at all levels: for others, rights and entitlements are secured and measured through legal frameworks and conventions.

Respondents participating in the 2013 oral interviews displayed a wide range of beliefs in how progress and learning are best measured, including through comparison with other networks and in relation to global governance norms (or the lack thereof):

“Having heard about the Global Strategy at the 2010 UN General Assembly to review progress on the MDGs in New York, we decided to contribute to the goals of the Global Strategy alongside other countries. The motivation was to compare our progress” (i16).

The UN Secretary-General’s Office, together with the PMNCH, were positioned in the *Global Strategy* development process as neutral “brokers,” facilitating consensus between different networks – including those representing “normative” MDG 4 and 5 interests and those representing SRHR. Yet the absence of clear governance principles and rules around the implementation of the *Global Strategy* facilitated the proliferation of global initiatives, often described in the 2013 oral interviews as a matter of concern because of their rapid development and potential for confusion (i24, i15).

In this sense, the ongoing debate about governance and accountability in the global RMNCH community – who, how, and using which indicators – mirrors that of the wider global health community, where the behaviours and beliefs of networks play a significant role in policy-making.

Conclusion

The case of the 2010–2015 *Global Strategy for Women’s and Children’s Health* is analysed in this paper to explore how global policy networks – rising in number and influence in the global health arena – seek and achieve power over policy and resources. This portrait of the hidden role of politics within policy-making processes illustrates how global advocacy coalitions, bound by shared core beliefs and behaviours, but diverging secondary beliefs, compete and collaborate with each other in a strategic effort to influence policy agendas. This study, therefore, concludes with three observations based on the case presented. First, competing coalitions with different policy beliefs, norms and strategies can collaborate productively with each other for policy influence if incentives and conditions are sufficient to facilitate this collaboration. In this case, the MDGs offered a time-bound opportunity for networks to come together to build a joint *Global Strategy* and common advocacy platform to attract political attention and resources for the benefit of all networks.

Second, while such collaborations may be framed as examples of successful, “consensus-based” efforts,⁶⁰ they do not necessarily imply fundamental shifts in policy beliefs among disparate networks, and can instead represent a short-term tactical response to unexpected events and opportunities, such as the offer of the UN Secretary-General to champion the cause of women’s and children’s health. The depiction of the *Global Strategy* as a ‘consensus’ project, despite significant

underlying differences in beliefs between the MNCH coalition and the SRHR coalition, was an effective response to a time-bound opportunity, since it projected a positive and confident image of a “global RMNCH community” united in its knowledge, norms, and behaviours – an attractive picture to would-be investors and champions, no matter which side of the MNCH-SRHR divide.

Third, this paper finds that the ACF successfully predicts the slow evolution of network core beliefs. However, minor or secondary views – such as those expressed by “evidence-based” frames to gain political attention – can and do change in response to shared experience, new evidence, and opportunity/events. The 2015 development of an updated *Global Strategy* for the 2016–2030 period,⁶¹ for instance, puts far greater focus on human rights and social and economic determinants of health compared with the 2010 *Global Strategy*. This increased focus reflects the difference between the more utilitarian MDGs and more rights-based SDGs. The new document also reflects changes over time of the MNCH and SRHR coalitions. The MNCH coalition appears to have come to terms with the inherent merits and ‘messiness’ of a harder to measure rights-based approach to health, while the SRHR coalition has seen that scientific discourse and quantifiable indicators can attract investment and political attention that in turn can enable advancements of its own rights-based agenda.

On the whole, the *Global Strategy* case suggests that, under the right circumstances, even competing ideas and beliefs held by different policy networks can blend effectively into a shared policy product that benefits all actors, at least temporarily while windows of opportunity remain open.

As Shiffman observes, power struggles are inextricably part of the global health landscape, including in relation to the important role of networks in governance reform.⁶² Scientific evidence is vital to advancing progress, but normative questions of resource allocation and equitable provision of public goods require political and social debate that empirical methods alone cannot address.

In this sense, this study of power relations among networks suggests that there is a highly productive role for politics in global public health. Far from seeing policy-making at the global level as a neutral process to be guided by principles and science, and protected from politics, this paper concludes that contention and debate is indeed vital to progress, lending greater legitimacy, accountability and transparency to the policy process.

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Authors’ contributions

LM is the sole author of this article, responsible for study design, research, analysis, and drafting.

Ethical issues

Ethical approval for this study was granted by the London School of Hygiene and Tropical Medicine, London, UK as part of the author’s doctoral research project. The analysis of this paper belongs to the author alone; findings were not

reviewed or endorsed by partnership for maternal, newborn, and child health (PMNCH).

Competing interests

LM was a staff member of the partnership for maternal, newborn, and child health (PMNCH) during the research and writing of this article, which was undertaken to fulfil, in part, the requirements of a doctoral dissertation at the London School of Hygiene and Tropical Medicine, London, UK. The findings and interpretation in this paper do not represent those of the PMNCH, and are attributable only to LM.

Endnotes

[1] MDG 4 calls for reducing under-five child mortality by two-thirds by 2015; MDG 5 calls for reducing maternal mortality by three-quarters by 2015 and achieving universal access to reproductive health.

[2] Sabatier and Jenkins-Smith¹⁵ define a policy sub-system as "consisting of those actors from a variety of public and private institutions who are actively concerned with a policy problem or issue, and who regularly seek to influence public policy in that domain."

[3] Q8: "What was the added value of making this commitment in association with the *Global Strategy*? Would you have made this commitment if the *Global Strategy* did not exist? Why/why not? Did the *Global Strategy* influence your focus on particular interventions/services in your commitment?"

[4] PMNCH (<http://www.pmnch.org/>), a global alliance of more than 700 member organizations, played a facilitating role in the development of the *Global Strategy* in 2010. PMNCH continues to advocate for Every Woman Every Child and to track progress of commitments.

[5] http://www.who.int/pmnch/knowledge/publications/2009_mnchconsensus/en/.

[6] MDG 4 sought to reduce under-five child mortality globally by two-thirds by 2015 against a 1990 baseline; MDG 5 sought to reduce the maternal mortality ratio by three-quarters on a global level during the same time period, as well as achieve universal access to reproductive health by 2015. The reproductive health goal was added in 2007 after successful advocacy by sexual and reproductive health and rights networks.²⁶

[7] An updated version of the *Global Strategy (Survive, Thrive, Transform: The Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030)* launched in September 2015 alongside the new Sustainable Development Goals.

[8] Sabatier and Weible assume that within policy sub-systems, actors are aggregated into "two to five" advocacy coalitions or "informal networks,"²² composed of specialists from both governmental and private organisations. These actors share a set of normative and causal beliefs and engage in a "non-trivial degree of coordinated action over time."¹⁹ This coordination can be relatively weak (eg, monitoring activities of allies) or strong in nature (eg, developing a common implementation plan).

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Chapter 6

Development and expression of actor-power: Mass media campaigns

6.1 Introduction

This chapter, intended for submission to the Journal of Health Communications, responds to the third research question of this thesis: “How do networks use media campaigns for issue visibility and for augmenting network power at different scales?” This paper builds from findings in chapters 4 and 5 that power lies in how network actors frame and produce their ideas, and investigates these power relations through the lens of communication campaigns. This paper looks at a mass media campaign to examine how the global women’s and children’s health network sought to use the media to express ideas at scale. There is inevitable repetition given that the chapter has been written as a paper to be submitted for publication.

This case focuses on the 2007-2009 Deliver Now for Women + Children campaign, the first large-scale campaign produced by the global women’s and children’s health network in the MDG era, and predecessor to the larger Every Woman Every Child campaign, discussed in chapters 4 and 5. The Deliver Now campaign was active in Latin America, Africa and Asia, and was coordinated by the Partnership for Maternal, Newborn & Child Health (PMNCH). India was an important Deliver Now campaign site because of its large contribution to the global burden of maternal and child deaths, which had become a key concern of India’s newly elected centre-left government in the mid-2000s.

In the MDG era, community-based health policy planning was a cornerstone of health policy in India, which focused on equalising progress in lagging states with high maternal and child death indicators, such as Orissa. At the same time in the 2000s, there was a rapid increase in media access at the household level, reflecting shifts in market liberalisation, private investment, and technology in India, starting

in the 1990s. This improved media access in Orissa, and enabled conditions for the planning of a Deliver Now India media campaign in Orissa, which is the focus of this paper.

The Shiffman and Smith framework (2007) pays scant attention to media as a strategic resource for actor power. Yet media-based messages and campaigns are frequently used by advocacy networks to expand the reach of network policy ideas and frames, increase credibility of network claims, and stimulate public demand for policy action. Global health networks may seek to align with media organisations to achieve these goals, extending network capacities.

This paper expands the Shiffman and Smith framework by using a social ecology approach from health communications study (“People and Places Framework for Public Health Influence”) to conceptualise media campaigns as a link between policy actors and policy environments.

The author of this paper was closely involved with Deliver Now India campaign design and monitoring as a staff member of PMNCH. As discussed in chapter 3, qualitative methods included document review, semi-structured interviews, and participant observation. Global-level document review drew on the document analysis process undertaken in chapters 4 and 5 on global health networks, with additional resources specific to communication campaigns and health policy environments in India and Orissa. These resources included messaging frameworks, TV spots and scripts commissioned by the India-based producers of the Deliver Now India campaign; news articles from the Delhi- and Bhubaneswar-based media about the campaign launch; Government of Orissa planning documents related to the Deliver Now campaign; and Government of India reports and policy statements related to women’s and children’s health, among others.

Knowledge of India and Orissa’s health policy and media environment was enabled by the author’s prior professional work in India. During 1999-2003, the author was based in New Delhi as project manager of the BBC World Service Trust’s India office. The BBC operated health media campaigns across India, including Orissa,

through a memorandum of understanding with India's Ministry of Health and Family Welfare and public broadcasting corporation, Prasar Bharati, parent of Doordarshan TV and All India Radio. During the time, the author facilitated the development of partnerships between the BBC and private TV and radio channels in Orissa. This enabled close knowledge of the public health and media environment in India, which was important to the development of PMNCH's Deliver Now India campaign in the following years.

During 2007-2009, the author acquired documents for case analysis, including e-mail exchanges relevant to Deliver Now India, through participant observation in association with her employment with PMNCH. Case involvement presented potential limitations to acquiring unbiased information and knowledge; this was addressed through triangulation of emerging qualitative observations with 18 semi-structured interviews with policy actors in Orissa in 2009. Most respondents were selected by snowball technique. Secondary analysis of campaign evaluation data added to emerging qualitative findings and suggested questions for future research; more details are available in chapter 3.

This case found that the global women's and children's health network used mass media campaigns to disseminate messages successfully to media audiences in India, with potential evidence of public demand for policy action. This may contribute to augmenting global network membership. However, negotiations between the global network, media organisations, and state-level policy actors altered network strategies in important ways, including by influencing campaign financing and messaging. Thus, through mass media campaigns, power operates in global networks at multiple scales and in multiple directions, not only from global to local, but also from local to global, offering potential for multi-scaled network resource exchange, growth, and accountability.

Cover sheet: Research paper 3

Section A – Student details

Student	Lori McDougall, LSH230644
Principal Supervisor	Gill Walt
Thesis Title	How do global health advocacy networks seek issue attention?

Section B – Paper already published

Where was the work published?	
When was the work published?	
If the work was published prior to registration for your research degree, give a brief rationale	
Have you retained the copyright?	
Was the work subjected to academic peer review?	

Section C – Prepared for publication, but not yet published

Where is the work intended to be published?	<i>Journal of Health Communications</i>
Please list the paper’s authors in the intended authorship order	Lori McDougall
Stage of publication	Not yet submitted

Section D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation	
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Student signature
Date: 15 January 2019



Supervisor signature
Date: 15 January 2019

6.2 Global health networks and the strategic use of mass media campaigns

Background: This paper explores how a mass media campaign was used by the global women's and children's health network in the MDG era to improve issue visibility and to augment network power at scale, using the case of the *Deliver Now India* TV campaign in the state of Orissa, commissioned by a global network institution in 2008-2009.

Methods: This paper applied a social ecology model from the field of health behavioural communications to conceptualise multi-level linkages between health actors and wider policy and cultural/media environments. Evidence was collected through document review, in-depth interviews with media and policy actors in India, participant observation, and survey data.

Results: This case found that the global women's and children's health network used a mass media campaign to seek influence over issue priority among targeted media audiences in India. Evaluation reports indicated the media campaign was successful in influencing knowledge and attitudes of individuals exposed, and may have stimulated public demand for policy action, with potential effects on network scale and growth. Negotiations during the campaign between the global network, media organisations, and state-level policy actors altered campaign strategies and frames in ways that influenced power relations.

Conclusions: Mass media campaigns can improve the capacity of network actors to influence policy environments, as well as catalyse interplay between differing scales of network actors, producing conditions for expanded network influence. Yet as an actor with independent power, incentives and agendas, media can also hinder such processes, disrupting network strategies and plans.

Key messages

- Media is capable of influencing health policy agendas through global-local network engagement;
- Global health advocacy networks seek partnerships with media for member-expansion and policy influence;
- Mass media campaigns can improve network power by improving visibility of network issues, messages and frames;
- Media organisations are purposive actors with their own agenda, incentives, and norms. Media may support network goals, but also challenge network strategies;
- The study of mass media campaigns can reveal how power operates in global health networks, from global to local levels, and from local to global.

Background

Global health advocacy networks and mass media

Private-public networks became an important influence on global health decision-making in the 2000-2015 UN Millennium Development Goal (MDG) era (Rushton and Williams 2011; Buse and Harmer 2007; Buse and Walt 2000).

In the MDG era, these networks, or “cross-national webs of individuals and organisations linked by a shared concern to address a particular health problem, global in scope” (Shiffman et al. 2015, p. i4), facilitated increased health financing, innovative approaches and technologies (Low-Beer 2012), and enabled civil society to raise overlooked issues in global health (Gómez 2018; Lee 2010). However, such networks also brought duplication, fragmentation and new forms of influence in the global health system (Ooms et al. 2018; Bruen et al. 2014), prompting debate on the legitimacy, mandate and uses of money and

power of these networks in contrast to traditional forms of multilateral health governance (Shiffman 2014).

The growth of private-public transnational networks in the last decades of the 20th century (Keck and Sikkink 1998) was enabled in part by the rise of the “network society” and strengthening links among state and non-state actors facilitated by the rise of digital information and communication technologies (Castells 1996). From the early 2000s, many transnational networks of organisations and individuals found a shared normative focus in advocating for the achievement of the MDGs (Low-Beer 2012; Rushton and Williams 2011). This included the development of the global women’s and children’s health network, which grew rapidly in size and scale during the MDG era (Smith and Shiffman 2016).

Global health advocacy networks use mass media campaigns²⁹ as tools for agenda-setting, including increasing public education for policy influence, disseminating messages at scale and with speed (Dorfman and Krasnow 2014; Clavier and de Leeuw 2013; Chapman 2004). In the 2000-2015 era of the UN Millennium Development Goals (MDGs), global health advocacy networks took advantage of the electronic communications revolution³⁰ to satisfy a key requirement of successful campaigning: the saturation of media messaging among targeted audiences (Rice and Atkin 2013; Wakefield, Loken and Hornik 2010).

²⁹ Rice and Atkin (2013, p. 3) define mass media, or public communication, campaigns as:

Purposive attempts to inform or influence behaviours in large audiences within a specified time period using an organized set of communication activities and featuring an array of mediated messages in multiple channels generally to produce non-commercial benefits to individuals and society.

³⁰ Internet users in developing countries increased 20-fold during the 2000-2015 MDG period, to approximately 2 billion in 2015. Access to traditional technologies such as TV also expanded in this period, with TV ownership in 2012 estimated at 72 per cent of households in developing countries and 35 percent in the least developed countries (International Telecommunication Union 2015a, 2015b).

The growing reach of mass media-based information in low- and middle-income countries from the 1990s and 2000s was enabled by economic, technological, and infrastructure advances (Straubhaar 2007; Singhal and Rogers 2001), creating an avenue for global health advocacy networks to improve health status and address health inequalities within and among low-income countries, and to achieve global goals.

This paper uses a case study of the *Deliver Now for Women + Children India* campaign, conducted in India's eastern coastal state of Orissa in 2008-2009³¹, to ask how global health networks used mass media campaigns for issue visibility in the MDG era, and how this process may have influenced efforts to augment network power.

Deliver Now India was an advocacy campaign (2007-2009), coordinated and financed by a large membership institution within the global women's and children's health network, the Partnership for Maternal, Newborn & Health (Partnership for Maternal, Newborn & Child Health 2007). PMNCH is hosted by the World Health Organization in Switzerland, and was established in 2005 to facilitate collective action among organisations and individuals concerned with achieving the global MDG targets, particularly MDGs 4 and 5³² (Storeng and Béhague 2016). *Deliver Now* was the first global campaign to be launched by PMNCH, which emerged in 2005 as a merger of three separate partnerships on maternal health, newborn health, and child survival, with members from donor agencies, NGOs, governments, academia, the UN, health professional groups, and others (McDougall 2016a).

Deliver Now India was part of the \$1 million *Deliver Now for Women + Children* global campaign (2007-2009), predecessor to the larger *Every Woman Every*

³¹ Orissa was renamed Odisha in 2011.

³² MDG 4 aimed to reduce child mortality, and set a target of reducing the global under-five child mortality rate by two-thirds by the end of 2015, measured against progress from 1990. MDG 5 called for improving maternal health, and set two targets of reducing the maternal mortality ratio by three-quarters (1990-2015) and achieving universal access to reproductive health.

Child campaign (see chapters 4 and 5). The *Deliver Now* campaign was based on media engagement, civil society advocacy, and political championship at head-of-state level within Latin America, Africa and Asia. India was an important national campaign site for *Deliver Now* because of India's large contribution to the global burden of maternal and child deaths. The Orissa campaign supported the Indian Ministry of Health and Family Welfare's National Rural Health Mission– a new policy approach to consolidating vertical programmes relating to women's and children's health, stimulating demand for service uptake, and decentralising health planning and monitoring through community-based structures and programmes.

This paper contributes to the study of communication campaigns as instruments of social and structural influence on public health policy, including at both individual and social levels. "Social ecology" approaches, focusing on the dynamic relation between personal and environmental factors, have been applied to the study of public health communication behaviours for the past 20 years (Sallis and Owen 2015; Glanz and Bishop 2010; Cohen, Scribner and Farley 2000)³³. The field of media advocacy studies, related to this, takes up the question of how media influences social perceptions and behaviours related to conditions and inequalities that shape individual and public health (Dorfman and Krasnow 2014). Yet media advocacy is often considered to stand in contrast to the field of behavioural change communications, which focuses more on persuading individuals to change their attitudes and behaviours rather than with the structural and societal conditions that influence those characteristics (Waisbord 2018, 2015).

³³ *In health communications literature, environmental and policy-level questions became more important from the late 1990s, accelerated by concerns about the effects of globalisation on media, health and development as well as greater attention to the social determinants of health (Waisbord 2015; Storey and Figueroa 2012; Gumucio Dagon and Tufte 2006). This included increased consideration of social and environmental contribution to the individual effects of direct message exposure from campaigns, including the distribution, magnitude and cost-efficiency of various communication approaches (Waisbord 2018; Wakefield, Loken and Hornik 2010).*

The study of global health advocacy networks and their use of communication campaigns can bridge this conceptual gap, by bringing attention to the iterative process of individual change and social change. For instance, global health network communication campaigns can contribute to the knowledge and attitudes of individuals and organisations to build demand for policy change, as well as expand network power and membership growth, including through exchange among members at differing scales, local to global. This is the subject of this paper.

Functions of mass media campaigns

A primary function of mass media campaigns is to disseminate health policy ideas at scale (Wallack 2002). Unlike other forms of networked communication, such as interpersonal (e.g., peer to peer) campaigns, mass media offers opportunity to reach audience members simultaneously and in multiple domains, from households, community opinion leaders to public and private health policymakers.

Media messages can be persuasive at scale because they enable social learning through persuasive media role models and champions (Bandura 1994). Media consumption may contribute to improving or denigrating policy structures, including through the production or suppression of social trust (Rojas, Shah and Friedland 2011; Livingstone and Markham 2008). Social trust may determine how media campaign health messages are absorbed and acted upon (Vishwanath, Randolph Steele and Finnegan 2006); and how media messages are disseminated indirectly, on a word-of-mouth basis within social networks to those without direct media access (Boulay, Storey and Sood 2002).

In these ways, global health networks may use mass media campaigns for many strategic purposes. Among others, these include:

- (1) To expand the reach of network policy ideas, improving the speed and scale at which networks can influence social norms and policy environments (Dorfman and Krasnow 2014; Rice and Atkin 2013);

- (2) To lend credibility to network discourse and “frames” – i.e., “patterns of cognition, interpretation, and presentation of selection, emphasis and exclusion by which symbol-makers routinely organise discourse” (Gitlin 2003, p. 7). Media endorsement and dissemination of network frames can amplify network messages and enhance credibility and issue attention. For example, media institutions can decide how much visibility to give to certain issues, and they can encourage individual journalists and editors to act as trusted champions for favoured issues;
- (3) To stimulate public demand for policy action (Gurman, Rubin and Roess 2012), supporting network growth through public information transmission, joint ideation, and civic and political ties based on shared ambitions for social change (Vishwanath, Randolph Steele and Finnegan 2006; Wallack 2000);
- (4) To build strategic partnerships with media organisations, using powerful champions to enhance capacity of global health advocacy networks to reach health decision-makers, attract new network members, and sustain the engagement of existing members.³⁴

Multi-stakeholder advocacy networks sponsor public health communication campaigns as important tools for policy influence. They also seek media attention for the policy products and events they create, including important conferences and meetings, scientific and technical reports, and public commentaries from powerful champions (Shiffman and Smith 2007).

³⁴ For example, in 2004, global health champions Bill Gates and Kofi Annan, supported by the US-based Kaiser Family Foundation, convened a meeting of 20 private and public media corporations from 13 countries to propose the development of a global media initiative on HIV/AIDS. Media participants pledged broadcast airtime and editorial coverage to raise public attention to the issue. The commitments amplified the existing efforts of UNAIDS, civil society and donor partners to disseminate agreed frames and messages about HIV/AIDS, and deepened the relationship of media and the HIV community. Two years after its launch, the UN announced more than 150 media companies covering 76 countries had joined the campaign (United Nations 2006).

Media campaigns sponsored by private-public networks differ from government-sponsored health campaigns in at least two ways:

Audience and messaging: Network campaigns apply pressure on governance systems to prioritise changes in favour of specific policy goals, backed by laws and regulations, programmes, and other institutional features that delimit or enable the production of health. They deploy frames and communication strategies that target changes to this environment, including building public pressure on governments for change (Wallack 2002). These frames and strategies may be directed at “upstream” or “downstream” policymaking processes, or both (Dorfman and Krasnow 2014). “Upstream” processes, such as budget allocation, regulation and legislation, rely on “downstream” factors, such as citizen demand and pressure enabled by knowledge, skills, motivation and attitudes (Dorfman and Krasnow 2014). Both “upstream” and “downstream” goals are important to improving public health. While it is less common for government to lead upstream agendas in media campaigning because of the difficulty of “advocating to” itself, there are exceptions: In the UK, for instance, the government campaigned for seatbelt use prior to introducing mandatory use to encourage citizen compliance (Walt 1994).

Participation: Network-sponsored media campaigns emerge from a heterogeneous set of actors and organisations from differing technical, epistemic, and geographic backgrounds, each bringing their own resources, ideas, and personal communication channels (Dorfman and Krasnow 2014). Agreeing on dominant campaign strategies and frames may be more contentious in a horizontal network organisation than in a government bureaucracy carrying out government policy. Network strategies offer scope to disseminate campaign messages through the mass media, as well as through interpersonal (non-media, peer to peer) channels among network members.

Media campaigns exercise influence through multiple pathways. Individuals may be exposed *directly* to messages that inform, model and guide their behaviours through media consumption; they can be exposed *indirectly* through social

persuasion by those who have seen/heard media messaging (van den Putte et al. 2011; Bandura 1997); and they can be influenced by “institutional diffusion”, or the ways in which health policy structures, including global health networks, are shaped by the process and effects of media campaigns (Popova 2016).

These diverse pathways are important to understanding how media campaigns can operate in multiple, mutually reinforcing ways to improve population health.

Conceptual framework

This paper is guided by Shiffman and Smith’s framework on the determinants of political priority in global health policy (2007). The framework, a well-tested and validated analytical tool (Walt and Gilson 2014), has been applied extensively over the past decade to agenda-setting studies in global health (Best et al. 2018; Prata and Summer 2015; Keeling 2012; Tomlinson and Lund 2012; Pelletier et al. 2011). Related studies examine how and why global health networks emerge, and under which conditions they are effective in influencing political priority (Shiffman et al. 2015).

The Shiffman and Smith framework establishes key categories and factors that interact to explain how global health networks may contribute to issue prioritisation. Their framework depicts prioritisation as a product of four categories of influence: actor-power (i.e., arising from policy community coherence, leaderships, guiding institutions and civil society mobilisation); policy ideas (produced by policy communities, or networks, as frames of meaning, communicated inside and outside the network); political contexts (including favourable policy “windows” for collective action); and issue characteristics (shaped by credible indicators, evidence of issue severity, and effective interventions).

In the arena of global health, advocacy networks operate transnationally, linking actors across borders through “voluntary, reciprocal and horizontal patterns of communication and exchange” (Keck and Sikkink 1998, p. 8). The purposive

behaviours of these horizontal networks, concerned primarily with normative interests, distinguish themselves from hierarchical structures, such as states and corporations, established in reflection of material interests, such as money or power (Kahler 2009).

In view of the frequent use of mass media campaigns by advocacy networks for influence and issue attention (Dorfman and Krasnow 2014), this paper introduces a complementary conceptual framework to explore policy-level effects of mass media campaigns. The “People and places framework for public health influence” (Maibach, Abrams and Marosits 2007) is based on social ecology concepts from the field of health behavioural communications. The framework assists in understanding multi-scale dimensions of mass media campaigns, and their effects on different levels and types of social structures (individuals, social networks, communities, societies).

Social ecology concepts direct attention to how mass media strategies may enhance actor-power, with effects on political context. The approach is described below.

Understanding health behaviours through a social ecology lens

Social ecological models of health behaviour depict public health as the product of multiple spheres of influence –personal, interpersonal, community, and public policy – interacting on an iterative and continual basis (Sallis and Owen 2015; Cohen, Scribner and Farley 2000; Stokols 1992). Healthy behaviours do not arise merely from the knowledge or attitudes that individuals hold, but also from their social relations, and the wider physical, cultural and policy environments that enable those relations and individual health capacities arising from them.

In respect to mass media, such campaigns exercise influence over personal ideas or attitudes, but also infuse social and policy environments, including global health networks themselves. Maibach, Abrams and Marosits reflect this interlinked concept in their “People and places framework for public health influence” (2007; figure 6.1).

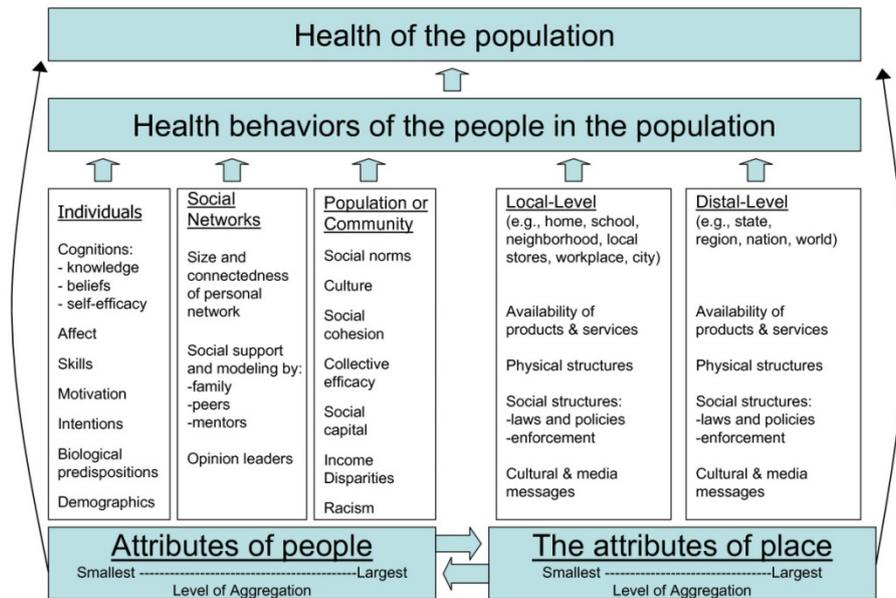


Figure 6.1: People and places framework for public health influence (Maibach, Abrams and Marosits 2007)

Maibach et al. envisage five “fields of influence” in their framework. The category of “people” are sub-divided by scale into (1) individuals, (2) social networks, and (3) populations, or communities. Underpinning these fields are individual characteristics such as cognition, affect, skills, and motivation; social network characteristics such as social support and persuasion; and population-level characteristics such as social trust, social capital, norms, and collective efficacy.

The category of “place” is sub-divided into two fields: (1) local-level structures such as homes and schools, and (2) distal-level structures, such as states, regions, and the world at large. Underpinning “place” are four types of factors: availability of health products and services; physical structures; social structures; and media and cultural messages.

Through the interaction of these social categories and environmental factors (i.e., the interaction of “people and places”), public health is produced. Mass media campaigns play an important role in this process because of their potential to unite each of the five “fields of influence” (Maibach, Abrams and Marosits 2007) through direct, indirect and institutional pathways as discussed.

In health communications scholarship, a “stages” model is often discussed, i.e., campaigns induce the acquisition of individual knowledge, followed by attitude shifts, then behavioural modifications, and finally social practice (Lerner 1958). While this “stages” model has been long critiqued (Dearing and Rogers 1996), as has Laswell’s “stages” heuristic of policymaking (see chapter 2.3), the concept of sequential steps in social communication and development continues to influence the practice and evaluation of mass media programmes (Waisbord 2018).

Methods for media campaign investigation are often underpinned by logic models that understand such campaigns as “dose-response” instruments – delivering standardised information to individuals to stimulate better health, including through improved self-efficacy (Popova 2016). Such concepts adopt a realist perspective on the power of information and messages, rather than the power of people to construct their circumstances through social knowledge and norms. Such models tend to underplay the influence of social and political conditions that structure the conditions for individual behaviour and choice, thus overplaying the power of mass media itself to induce social changes at scale (Abroms and Maibach 2008; Maibach, Abroms and Marosits 2007).

In contrast, social ecology models of health behaviour rely on sociological and psychological concepts of how social relations influence public health, as well as biological health (Bandura 2000, 1997, 1994). This enables a reconceptualisation of health media campaigns as vehicles for influencing *population* health, through the effects they exert simultaneously on multiple fields that shape public health, including individuals in dialogue with others in the context of social networks, communities, and institutional relations (Maibach, Abroms and Marosits 2007).

Social theorist Albert Bandura notes:

People do not operate as isolates. They work together to improve the quality of their lives. Their shared beliefs in their collective efficacy to accomplish social change play a key role in the policy and public health approaches to health promotion and disease prevention. (1994; pp. 159-160)

Unless people believe that they can produce desired effects and forestall undesired ones by their actions, they have little incentive to act. The growing interdependence of human functioning is placing a premium on the exercise of collective agency through shared beliefs in the power to produce effects by collective action. (2000; p.75)

Because media campaigns stimulate ideas and behaviours that reverberate within social networks and wider communities, they influence how people interact with their policy environments, including through social trust, dialogue, and collective action (Abroms and Maibach 2008). The “people and places” framework suggests a view of health communications as a fundamentally social process, requiring the application of conceptual frameworks and methods in which social relations, including power dynamics, are understood as a structuring characteristic of health status (Waisbord 2018).

Methods

Case selection

The starting point for this paper emerged from the author’s personal experience as a staff member of PMNCH during the MDG period, and of the BBC World Service Trust, based in New Delhi, during the early MDG period (1999-2003). During this time, the BBC operated health behavioural change campaigns in India that were produced through the development of public-private partnerships on issues like HIV/AIDS and leprosy. The research concern of this paper, how networks use mass media campaigns for issue visibility and network influence, was refined through review of theoretical and conceptual literature. This included frameworks on prioritisation processes in global health policymaking (Shiffman and Smith 2007), as well as frameworks on behavioural communications that conceptualised media campaigns as catalysts of social and environmental relations (Maibach, Abroms and Marosits framework 2007).

The case of the *Deliver Now India* mass media campaign was selected for study because its scale and strategic importance to the global women’s and children’s health network during a period of network growth in the MDG era. The *Deliver Now* campaign was conducted at global level, national level, sub-national level,

and district level, allowing rich scope for observing and analysing scaled interactions between network members. The campaign was also selected for practical reasons. As a member of the PMNCH secretariat, the author had close knowledge of the history, actors, and products of the *Deliver Now* global and India campaigns, and had made extensive contributions to campaign concept, design, implementation and evaluation during 2007-2009.

Data collection and analysis

Research methods for this paper were document review, semi-structured interviews, secondary analysis of a household survey, and participant observation. The “people and places” framework, which synthesises key concepts from social ecology health communications literature, was applied to collect and organise data in relation to “attributes of people” and “attributes of place” (i.e., policies, resources, institutions at “local” or state/national level and “distal” or global level).

Document review

Approximately 50 written and visual artefacts were reviewed in relation to the *Deliver Now India* campaign (e.g., national and state-level maternal and child health policy documents and reports, video versions of TV spots, edited and unedited media scripts, campaign press releases and news articles, authored commentaries by campaign leaders, campaign messaging frameworks, formative workshop reports, campaign evaluation reports). Nearly all documents were retrieved from publicly available sources, particularly the online archives of PMNCH, hosted by the World Health Organization.

Eight of the documents reviewed for this study are unpublished, including project progress reports, broadcast strategy documents, a baseline report, two internal evaluation reports (i.e., one for the social accountability campaign and one for the media campaign), and the *Deliver Now India* mass media campaign endline evaluation contrasting with baseline findings. Access and review of these documents were enabled by author’s participation in this case. Such documents enabled the development of a timeline related to the *Deliver Now India*

campaign; extraction of thematic information; and analysis of campaign discourses and narratives.

Semi-structured interviews

Case evidence was also collected from 18 face-to-face semi-structured interviews conducted by the author in English with informants representing state and district-level organisations in Bhubaneswar, Orissa, as well as with those representing global and national institutions. The interviews included questions about how various types of policy actors saw their role in relation to improving the implementation of women's and children's health policies in Orissa (see Annex C: Interview guide). Interviewees were selected mainly by snowball technique, starting with two individuals known to the author through prior case participation. Interview informants were purposively selected from different constituency groups working mainly at state or district level in Orissa to generate a cross-section of ideas and views of the *Deliver Now India* campaign. These groups included representatives of state government (4); state-level UN agencies (2); state-level technical cooperation agencies (2); state-level media (2); state-level NGOs (3); state-level researchers (1); district-level NGOs (1); national-level NGOs (1); and national representatives of foreign donor agencies (2). Interviews lasted 60-90 minutes in length, conducted in Bhubaneswar, Orissa, in June-July 2009.

A qualitative framework approach was undertaken to organise and structure the interview data (Miles, Huberman and Saldaña 2014; Gale et al. 2013). Interview notes were coded by hand by the author in relation to the five fields of influence and related factors in the Maibach, Abrams and Marosits framework. These included codes such as "social norms", social capital", "social structures", "cultural and media messages", "collective efficacy", etc. Similar codes were grouped into categories conforming to the "people-based attributes" or "places-based attributes" of the Maibach et al. framework. Data by category was charted into a matrix form, summarised from interview notes, including illustrative quotes from respondents. Connections between data categories were mapped to explore inter-relations between "people" and "place".

For instance, in analysing notes about the women's and children's health policy environment in India, data was categorised as "place" when relating to policies and networks, and "people" when referring to social trust and other normative aspects of policy actors, but links were required to be drawn across the two categories in view of Kahler's characterisation of "actor-based" networks (2009), a distinction supported by Shiffman and Smith's category of "actor power" with respect to global health networks (2007). Finally, review of categorised evidence made visible the similarities and divergences in data collected, forming the basis for findings reported.

Secondary analysis of household survey

For the purposes of this thesis, the author requested permission of the *Deliver Now India* evaluation team to include a sub-set of questions related to issues of collective action and attitudes about the health system (Annex A). The evaluation survey collected data from 1,100 young married women in six districts of Orissa in November-December 2009 to assess potential post-campaign changes in knowledge, attitudes and reported behaviours on maternal and child issues raised by the campaign.

The evaluation – survey design and primary data analysis – was undertaken by the senior epidemiological researchers from the London School of Hygiene and Tropical Medicine led by Professor Oona Campbell, and commissioned by Development Media International (Collumbien, Blackmore and Campbell 2010). Fieldwork was coordinated by HDI, a research consultancy agency in Bhubaneswar, Orissa, commissioned and supervised by the London School of Hygiene and Tropical Medicine. The author participated in discussions on survey objectives and design; provided specific survey questions of interest to this paper; and designed the presentation of results together with Professor Campbell, who was a member of the author's doctoral advisory committee (table 6.1). The author did not participate primary analysis, except for the specific survey question added for the purpose of this paper.

The role of the survey data in this study is to enrich qualitative findings and to point to future questions for investigation about the conditions under which networks may replicate and gain in strength at community levels through mass media campaign saturation effects.

Participant observation

During the 2007-2009 *Deliver Now* campaign process, the author held alternating roles that enabled direct observation of this case, including as a full-time Geneva-based PMNCH staff member involved with the *Deliver Now* campaign design and contracting processes; part-time consultant in Canada supporting campaign implementation; and full-time research student in London. Documentation of observations include a personal archive of notebooks, meeting reports, and e-mails relating to campaign activities during 2007 to 2010.

Review of archival material added to timeline construction and analysis of discourse within the global health network, as well as triangulation of data collected during document review and in-depth interviews. This material was particularly important for substantiating campaign sequences and events when drafting this paper, as several years had passed since *Deliver Now India* took place. Citations from these notes (“personal correspondence”) appear in this paper when not available through public sources. Care is taken to avoid citations that reveal individual identity.

Given the author’s close involvement with this case over several years, self-reflection is particularly important for reasons of case validation and ethics. Network actors closely involved in this case, including those in London, New Delhi and Orissa, were informed of the author’s research intentions for this paper. Similarly, global network actors involved with this case, i.e., managers from PMNCH and its host agency, WHO, were supportive of the author’s intent. Interview respondents were informed at the outset of interviews about the author’s professional role at PMNCH as well as research intentions. The author’s

parallel status as a student researcher at LSHTM is included in her online biography on www.pmnch.org for reasons of transparency and information.³⁵

Close observation permitted knowledge and insight about *Deliver Now* campaign actor motivations, frame development, and coalition-building processes, including normative tensions and competitive dynamics. This enabled ease of access to key documents and interviews that enriched case study. It may also have produced bounded insights about processes and effects of the network and its campaign (Adler and Adler 1987) that restricted consideration of alternative evidence that may have altered case interpretation and study conclusions. For this reason, the in-depth interviews described above were necessary to triangulate research methods and strengthen the basis for case observations and findings.

Case findings

The following section describes case findings, structured in relation to key factors of analysis of the “People and Places” framework.

Attributes of “place”

In the “People and Places” framework, both physical and non-physical factors are considered elements of “place”, operating at both distal and local levels. Non-physical structures are considered by Maibach et al. to include two factors: (1) *social structures*, such as policies and laws; and (2) *cultural/media messaging*.

This sub-section presents case findings on non-physical factors, i.e., the *global and national/state health policy environment* for women’s and children’s health, as well as *global and national/state media attributes* associated with the *Deliver Now* campaign. Physical characteristics of “place”, such as physical structures (e.g., health clinics) and the availability of products and services (e.g., medicines),

³⁵ *The author’s annual work plans at PMNCH since 2009 have also described the subject and context of formal doctoral studies. The World Health Organization, as the administrative body of PMNCH, granted the author periods of paid and unpaid leave in 2016 and 2018-19 for doctoral study, including the production of this paper.*

are highly relevant to the production of women's and children's health, and to the interests of global health networks. However, this case prioritises examination of social and cultural aspects of place to focus discussion and findings.

Global health policy environment

At distal level, or global level, the policy environment for the *Deliver Now India* campaign emerged from the Millennium Development Goals, and specifically from the *Global Campaign for the Health MDGs*, a political advocacy effort to accelerate progress for MDG framework targets, particularly MDGs 4 and 5 on reducing under-five child mortality and maternal mortality (McDougall 2016b). The *Global Campaign for the Health MDGs* was convened in 2007 by Norwegian Prime Minister Jens Stoltenberg as a multi-part effort to accelerate progress against the global goals (Murray, Frenk and Evans 2007). Stoltenberg recruited heads of state from Asia, Africa and Latin American to join this effort for MDG progress, and to bring public attention to the prevention of maternal and child mortality. Members of Stoltenberg's "Network of Global Leaders" included the leaders of Brazil, Indonesia, India, Chile, the UK, Pakistan and Mozambique (Norad 2007).

The *Deliver Now* campaign was the advocacy and communications arm of the global campaign. The campaign sought primarily to generate civic demand for change and to stimulate political accountability for results:

To keep momentum both in the North and the South a dedicated advocacy and communications drive is being developed: "Deliver Now for Women + Children". Coordinated by the Partnership for Maternal, Newborn & Child Health – a global network of more than 180 organizations– the advocacy drive will strengthen civic activism to increase demand for maternal and child health services, hold political leaders accountable and committed to deliver investment and expansion of maternal and child health services, strengthen the capacity of the media, and enable scaling up of health services to reduce maternal, newborn and child mortality. The drive will promote solutions in line with the principles of the Global Campaign. (Norad 2007, p. 28)

In India, the *Deliver Now* campaign included a social accountability campaign, which operated in parallel to the mass media campaign (Partnership for Maternal, Newborn and Child Health 2007). The social accountability campaign was coordinated by a civil society partnership, the White Ribbon Alliance for Safe Motherhood.³⁶ The media campaign was coordinated by Development Media International, a London-based media charity.

During the 2007-2009 lifespan of *Deliver Now*, national and regional advocacy and communication campaigns were launched by leaders of several countries, including by Tanzanian president J.M. Kikwete in April 2008; a state-level Minister of Health and Family Welfare in India in April 2008; and by Chilean president Michelle Bachelet in September 2008 (PMNCH 2008).

Global financing for the *Deliver Now* campaign came primarily from the northern sponsors of the *Global Campaign* – Norad and the UK's Department for International Development (DFID), with technical assistance from UN agencies such as UNFPA and private foundations such as the Bill & Melinda Gates Foundation. The coordinator of the *Deliver Now* campaign was UNFPA's reproductive health lead, chair of the PMNCH advocacy working group. A campaign design team, with representatives of these organisations, met regularly in 2007. They were guided by a technical scoping and mapping exercise led by a DFID-supported consultancy agency to assess priorities, viability and interest among potential partner countries (Grellier 2007; Partnership for Maternal, Newborn and Child Health 2007).³⁷

³⁶ *The White Ribbon-led social accountability campaign in Orissa is the subject of chapter 7. This demand-side campaign focused on community monitoring and feedback activities to stimulate government accountability and improvements in the delivery of maternal and child health services. Activities included district-level public hearings, community-led checklists for facility monitoring, media advocacy, and community education on rights and entitlements.*

³⁷ *One of the advisors of the Deliver Now campaign was American political scientist Jeremy Shiffman. Shiffman's political prioritisation framework, developed with Stephanie Smith, guides this paper (Shiffman and Smith 2007; Grellier 2007; Partnership for Maternal, Newborn and Child Health 2007).*

National/state health policy environment

At local, or national/state level, *Deliver Now* intersected with the policy interests of the Government of India. In 2004, Sonia Gandhi's centre-left Congress Party had formed a majority government with allied parties and began implementing an ambitious set of social welfare reforms. The decentralisation of health services, ongoing in India since the 1990s, was accelerated with the advent of India's National Rural Health Mission (NRHM) in 2005, a federal umbrella with state-level directorates that consolidated vertical programmes and placed control of plans, budgets and monitoring in the hands of district- and community-based structures (Narwal 2015). Improving women's and children's health in lagging states, and improving overall health progress, was a key focus for the Indian government, and was consistent with PMNCH's focus on the global goals.

Orissa, with a population of approximately 42 million and nearly 10% of India's tribal population (Government of India 2011a), benefitted from increased budgets and high-level political attention for women's and children's health at the federal level. Although the maternal mortality rate in Orissa had fallen from 424 to 303 deaths per 100,000 live births during 1999-2006, this was still more than twice India's 2015 MDG 5 goal of 140 (Registrar General of India 2009, 2006, 2001).

With rising budgets and policy interest for women's and children's health in India, the Government of Orissa was open to PMNCH's proposition to develop a *Deliver Now India* state-level mass media campaign, based on targeted TV and radio messaging to improve household level knowledge and behaviours on maternal and child health (Partnership for Maternal, Newborn and Child Health 2007). The *Deliver Now India* campaign included a mass media campaign to increase public information and pro-health behaviours in Orissa, where civil society groups such as the White Ribbon Alliance for Safe Motherhood had campaigned successfully on these issues in recent years (Papp, Gogoi and Campbell 2013).

Because of PMNCH budget limitations, Orissa was the only state within India to be approached by PMNCH and the global *Deliver Now* campaign for a community-level media campaign, although media advocacy activities were ongoing at a central level in Tanzania and other *Deliver Now* campaign sites (Partnership for Maternal, Newborn and Child Health 2007).

National/state media messaging environment

In 2008-2009, at the time of the *Deliver Now* campaign, the media environment in India had been undergoing rapid transformation. In 1990, just a decade before the MDGs began, the only TV organisation authorised to operate in India was public service broadcaster Doordarshan (DD), charged with producing news, cultural, and entertainment programming as a tool for national integration and social development; DD terrestrial stations covered 90% of the country (Sinha and Asthana 2004). Although India's population was about 900 million in 1991, there were only 21 million TV sets in the country (Singhal and Rogers 2001), representing significant pent-up demand for TV access.

India's economic liberalisation in the early 1990s transformed the media landscape. Star TV, the first regional satellite service in Asia, established an early foothold in India's expanding English-speaking middle-class, offering foreign and then Bollywood film and TV entertainment and 24-hour news content. Star, purchased by Rupert Murdoch in 1992, was followed in India by many other private cable and satellite channels aiming to bypass the dominance of state-led TV (Page and Crawley 2001). Although relatively few in India could afford subscription fees, TV ownership in India tripled to 65 million sets by the end of the 1990s (Singhal and Rogers 2001).

Rising competition for viewers and advertising pushed public broadcasting in India toward commercialisation of content and business structures, pressured by the need to retain its vernacular reach across India's diverse market and public service editorial content. Advertising revenue became increasingly important to DD's operating budgets; audience license fees had been abolished in 1985 (Sinha and Asthana 2004).

As programming choice in the late 1990s and early 2000s expanded across the country, including cultural and 24-hour news programming, TV viewership followed suit, even in economically poorer and remote districts. In Orissa, TV ownership among rural households doubled from 9.2% to 19.4% during 2001 to 2011 (Government of India 2011b). The first private cable news organisation in Orissa, OTV, was established in 1997, converting to satellite in 2006 and expanding to devotional, music, and entertainment programming in local languages and dialects (OTV 2018).

As many former state employees and young workers found employment in India's urban media centres, the quality of news reporting at state- and district-level seemed to suffer (i1, i4). One district-level civil society respondent complained that local news media was slow to investigate government claims or to challenge state discourse:

They only talk about numbers [i.e., the rise in institutional deliveries] – they don't talk about quality. That's one of the biggest grouses against NRHM ... District-level media is not enough engaged. (i3)

Although several interview respondents for this paper spoke approvingly of the important role of mass media in raising attention to important social issues like women's and children's health (i1, i4), the independent power of local media was variable and subject to influence, both from the state and from new private media corporations, often seen as propagating consumerist, neoliberal norms (Johnson 2006; Crabtree and Malhotra 2000). From this perspective, media campaigns such as *Deliver Now India* can be understood as tools for raising the visibility of public issues and stimulating political attention, but also as assets vulnerable to capture and control.

Interaction of health policy and media messaging environments

The *Deliver Now India* media campaign aimed to stimulate household-level and community-level improvements in health knowledge and behaviours, and to widen the reach of the district-level White Ribbon social accountability campaign (see chapter 7) by broadcasting at an all-state level.

PMNCH was supported financially by the Government of Norway to recruit a media agency to design and manage the *Deliver Now India* campaign in Orissa. British media charity DMI, led by a former senior executive from the BBC World Service Trust, had previously collaborated with India's health ministry, public and private sector broadcasters.

DMI's plans included the creative development of "repeatable" TV and radio formats to sustain audience interest; brokering partnerships with national and foreign technical experts to form message and audience priorities, messages, and frames; developing business arrangements with national media partners to reduce airtime costs and promote cost-efficiency; and developing partnerships with paid research experts for formative investigation, pretesting and campaign evaluation. This process involved a wide set of relationships with government and non-government policy actors at both state and federal level in India, UN technical experts, research partners, and the PMNCH secretariat in Geneva, as sponsors of the campaign.

Campaign partners agreed that no more than five main health "problems" should be selected for the spots, all of which must be high priority by the Government of Orissa. Problems needed to be attached to "solutions" that media audiences could feasibly act upon themselves. After extensive debate, the five problems were agreed as post-partum haemorrhage, malaria in pregnancy, newborn hypothermia, newborn malnutrition, and early childhood diarrhoea (Collumbien, Blackmore and Campbell 2010). Creative formats were based on "entertainment-education" approaches (Rice and Atkin 2013), weaving technical messages into entertainment formats, such as those based on comedy or fantasy³⁸.

³⁸ A common approach practiced by DMI was informed by Bandura's concept of self-efficacy and collective efficacy (2000, 1997), in which certain characters act as role models for others, encouraging the transfer of positive health behaviours from the TV screen to the household and to social networks. These role models were often individuals who defied tradition and courted social disapproval, such as Sabita, a young mother who credited public health workers with informing her that her "leaky" infant daughter was fed liquids during bouts of diarrhoea. Creative elements of surprise, gentle humour and/or fantasy were introduced to discourage social and political tensions that might otherwise arise from individual defiance and opposition to norms. For instance, in a TV spot promoting the use of bed

Yet successful media campaigns depend upon airtime saturation and high repetition (Wakefield, Loken and Hornik 2010). In an era of rising media power in India, PMNCH's modest campaign budget of USD500,000 could not sustain peak-time repetition of campaign materials on costly private and public TV channels, even in a secondary media market like Orissa. DMI pursued DD executives in New Delhi to obtain free airtime for the *Deliver Now* campaign, as DD had done for the BBC-sponsored health campaigns just a few years earlier (*participant observation*). However, the era of *pro bono* had changed, DD insisted that airtime contributions would need to be fully monetised, and that any partnership would need to demonstrate audience impact of the campaign deliverables – critical for sustaining DD's commercial sponsorship and advertising revenues in a competitive market.

The DMI team was forced to reconsider its campaign production and broadcast plans with DD. If DMI needed to fill airtime gaps from existing project funds, saturation would be threatened and campaign impact reduced. A solution was proposed by NRHM's Orissa directorate. Government health managers had built confidence in the *Deliver Now* campaign because of repeated interactions during campaign planning meetings with DMI, and now proposed direct investment in the global campaign.

Government officers held out three conditions for doing so: The global *Deliver Now* branding should be deleted and replaced with NRHM branding; Oriya-language radio spots be translated into local dialects; and that 60-second TV spots be replaced with 30-second versions to improve cost-efficiency for paid airtime. DMI and PMNCH agreed to the conditions without hesitation because the Government of Orissa's leadership would enable greater broadcasting intensity and grant increased recognition and credibility for the campaign. The partnership also offered the possibility of closer links between India and global-level network members, augmenting network power. Also, messaging saturation

nets, a smart young girl paraded unexpected knowledge to disarm family elders who promoted misconceptions about malaria transmission.

could enable the possibility of social diffusion effects, so that even non-media viewers would access campaign messages through word-of-mouth-effect within social networks.

Plans were thus revised to establish a multi-phase campaign period extending through 2009 and into 2010 under the direction of the government. A senior government official from Orissa framed this decision as a highly pragmatic “trade” of resources between global and local partners, to which Orissa could contribute local expertise and knowledge:

We have many resources, but what we are missing is quality products. We would like to continue broadcasting after your project finishes, but it is too costly to broadcast 60 second spots; 30 seconds would be much better (e-mail correspondence from the author’s personal archive)

At the February 2009 media launch of the *Deliver Now* campaign, the Orissa government projected the campaign as one developed and led by Orissa and India, with global resources leveraging Indian health policy objectives. The global campaign branding was displayed at the launch and in the press materials, but was not otherwise referred to in the speeches at the event. At the launch, Orissa’s principal health secretary framed *Deliver Now* not as a global campaign, but as a local campaign for serving local needs:

Our topmost priority in Orissa is to bring down the maternal mortality rate and the infant mortality rate, and the Deliver Now campaign will assist us in doing the same. (Business Standard 2009)

With this reframing, Orissa now took charge of airtime plans, revising dates and broadcast formats, moderated by their understanding of local TV habits. Government actors now sent directives to DMI and PMNCH urging faster production:

We would certainly like to reiterate that DMI should expedite the processes for producing the media spots and submit to us at the earliest, enabling us to provide our feedback on the content. (e-mail correspondence from the author’s personal archives)

A government representative in Orissa interviewed for this case after the above e-mail was sent (i6), confirmed that the health ministry had dedicated nearly all of NRHM Orissa’s annual health broadcasting budget on that campaign, and that

further investments would be made to convert campaign messaging into non-broadcast theatrical formats, including village puppet shows and song and drama performances, as well as through training programmes for community health workers and medical officers (i6). As a result, global-level investment in the *Deliver Now* campaign became far less than that of the Orissa government (*personal correspondence*).

In summary, environmental factors of rising and decentralised health budgets in India; increased policy attention to women's and children's health at both national and state level; and the expanding reach of the mass media into the districts and states of India interacted with global structures, resources, and an increasingly active global women's and children's health network to create conditions for issue attention.

Attributes of “people”

In the “people and places” framework, “people” live and interact in various ways to create their own health outcomes in relation to the “places” in which they are situated. They live: (1) as *individuals*, whose personal attributes include cognition, skills, motivation and intentions; (2) as members of *social networks*, the attributes of which include social support and behavioural modelling; and (3) as members of a *population/community*, the attributes of which include social norms, collective efficacy, and social capital. The following sub-section discusses results of the *Deliver Now India* media campaign in relation to these categories.

Individuals

The LSHTM evaluation of the *Deliver Now* media campaign in Orissa was conducted through a household survey among 1,100 young married women in Orissa in November-December 2009³⁹, and found evidence of pre/post campaign

³⁹ *The baseline evaluation, completed before the start of the broadcast campaign in May 2009, was based on a before-after cross-sectional design, with survey questions based on indicators included in India's National Family Health Survey, modified to measure knowledge, beliefs and behavioural intentions featured in the Deliver Now media campaign. Survey responses were collected on a random sampling basis from three regions of Orissa: coastal, western, and southern. Two districts were*

changes in health knowledge and behaviours (Collumbien, Blackmore and Campbell 2010). This included significant increases in knowledge about the importance of keeping babies warm and dry after birth (51% pre-campaign to 74% post-campaign); greater risks of malaria among pregnant women compared to other women (58% to 77%); and the importance of increased breastfeeding when infants have diarrhoea (51% to 71%). Significant increases in behavioural intentions included sleeping under an insecticide-treated bed net to prevent malaria during the next pregnancy (10% to 28%), and to feed children as per appetite during the next bout of diarrhoea (14% to 27%). The study concluded that the campaign was well-liked, well-understood, and reached its target audience effectively.

Social networks

The LSHTM evaluation also showed changes from the January-February 2009 baseline study to endline among respondents who reported no direct exposure to the TV campaign. For example, in response to the statement, “Babies should be bathed after birth”, agreement among non-viewers fell from baseline to endline in five of the six districts sampled, with significance reported in two of the five districts ($p < 0.05$ and $p < 0.01$) after controlling for potentially confounding factors such as higher age and education levels of the respondent. The LSHTM study concluded that, since there were no other large-scale health education interventions at the time of the media campaign, *Deliver Now* may have transferred information to non-viewers through social “diffusion”, with non-viewers acquiring information from viewers (Collumbien, Blackmore and Campbell 2010).

The author of this thesis designed a sub-set of questions in the LSHTM evaluation for this paper to identify potential social network effects of the campaign. Findings, reported in table 6.1, show nearly 70% of those who recalled all five campaign spots (67.6%; $n=250$) said they had talked to others about the TV

selected at random in each of the three regions; two blocks were selected within each district; within each block, four villages were selected at random. Within the resulting 48 villages, researchers aimed to secure 27 eligible participants per village, of whom 85% had access to TV and 15% had limited or no access to TV, defined as at least once-weekly access to TV.

campaign spots. Among those who did talk to others (not shown in table), it was to friends and neighbours (40.4%), then family members such as husbands, mothers-in-law, and sisters-in-law (36.5%), and to a lesser degree, local health workers (5.3%).

Populations/communities

Table 6.1 also compares outcomes by level of campaign exposure. Those exposed to the full range of campaign spots (i.e., five of five) expressed attitudes and behaviours suggestive of “collective efficacy” compared with those who had seen fewer spots. For example, only 38.6% of those who had seen four or fewer spots said they had spoken to others about the campaign. High exposure appeared to influence attitudes toward services (i.e., 95% of those exposed to all five spots said the quality of their delivery care was “good” compared with 83.3% of those who had seen none). Those most exposed to the campaign expressed greater willingness to attend a public hearing on health services (70.3% of those exposed to five spots compared with 52.5% of those exposed to none).

It is important to note, however, that data was not analysed to establish statistically valid correlations between campaign exposure and attitudes/behavioural intentions, and is presented in table 6.1 for speculative purposes to assist development of future research questions relating to campaigns and social networks.

In the survey, surprisingly few women complained about poor quality of maternal and newborn health care, even though reports of facility overcrowding, corruption, and disrespectful care were very common in the qualitative interviews conducted for this study (i1, i3, i4, i11, i16). For example, nearly all (93%) of respondents exposed to all five spots said they had “no bad experiences” with their maternity care compared with 81% of those exposed to no campaign spots.

	Attitude/behaviour outcomes among TV viewers (n=1100)	Respondents who had seen 5 TV spots	Respondents who had seen 1-4 TV spots	Respondents who had seen 0 TV spots
1	Have you talked to anyone about any of the TV spots that you saw?			
	Yes	67.6% (n=250)	38.6% (n=251)	0% (n=0)
	No	32.4% (n=120)	61.4% (n=399)	0% (n=0)
	Missing	0	0	100% (n=80)
2	On the whole, do you feel the quality of care offered during your delivery was:			
	Good	95.0% (n=208)	85.5% (n=324)	83.3% (n=35)
	Medium	4.6% (n=10)	13.5% (n=51)	16.7% (n=7)
	Poor	0.4% (n=1)	1.0% (n=4)	0% (n=0)
	N/A (not recently delivered)	n=151	n=271	n=38
3	Did you complain about any bad experiences you had with services received for pregnancy or birth?			
	Yes	1.8% (n=4)	1.1% (n=4)	0% (n=0)
	No	5.0% (n=11)	16.1% (n=61)	19.0% (n=8)
	“No bad experiences”	93.2% (n=204)	82.8% (n=314)	81.0% (n=34)
	N/A (not recently delivered)	n=151	n=271	n=38
4	If a public hearing was organised near your village, would you attend such a meeting if it concerned health services for children or health services for pregnant women?			
	Yes	70.3% (n=260)	55.8% (n=363)	52.5% (n=42)
	No	29.7% (n=110)	44.2% (n=287)	45% (n=36)
	Missing	0	0	2.5% (n=2)
5	Would you attend such a meeting if it concerned education?			
	Yes	74.1% (n=274)	57.4% (n=372)	52.4% (n=43)
	No	25.9% (n=96)	42.6% (n=276)	43.9% (n=36)
	Missing	0	0	3.7% (n=3)

Table 6.1: Mass media campaign outcomes related to collective efficacy

Source: Data, LSHTM for Development Media International; survey questions and table presentation by author.

One interpretation of this could be that respondents wished to please the interviewer by responding positively, or that “government-friendly” framing of the messages positively influenced viewer attitudes about quality of delivery care. For example, the TV spots depicted government health workers as competent and trustworthy in their knowledge, attitudes and skills. This may have encouraged viewers to consider their own health system experiences in a positive light.

Most of those interviewed said they recalled the campaign messages (Collumbien, Blackmore and Campbell 2010). The campaign evaluation suggested that this may have been due to the social framing and content of the *Deliver Now* TV spots. For instance, each of the five *Deliver Now* TV spots featured informed and capable female characters playing leadership roles in dialogue with their families and communities. These role models may have encouraged viewers to associate female-led social dialogue with positive health outcomes. Maternal and child health public hearings might therefore have been understood by female campaign viewers as an effective venue for social accountability and health system reform, worthy of their time and participation.

Also, the *Deliver Now* TV spots blended messages on health, education, gender empowerment, youth participation, social inclusion and other determinants of health. This integrated approach may have also captured viewer attention, especially when the TV spots directly challenged traditional beliefs and hierarchies, not necessarily witnessed in real life.

These descriptive statistics may point to a possible correlation between campaign exposure and collective efficacy attitudes at a population level – an attribute of Maibach et al.’s “people-based” concept. However, this has not been assessed by statistical methods, and would also require complementary qualitative research. Table 6.1 is presented in this paper to enrich qualitative findings and to assist in forming future research questions on collective efficacy, i.e., how mass-media based frames may motivate both individual and social-level

change, and how global health networks may benefit from local-level participation to increase network scale and resources.

Discussion: Linking people and place through media campaigns

The *Deliver Now India* case illustrates how mass media campaigns unite multiple fields in a continuous loop of mutual influence – individuals, social networks, and populations in relation to local and distal policy environments. These linkages can be beneficial to the strategic and normative interests of global health networks because they enhance conditions for issue visibility and network replication at multiple levels, increasing network power.

At community-level in Orissa, campaign influence occurred *directly*, in relation to individual behaviours (i.e., survey respondents reported higher personal health knowledge and behavioural intentions after the campaign compared with before the campaign). In relation to social networks and communities, influence also occurred *indirectly* (i.e., citizens exposed to the campaign demonstrated behaviours linked to collective efficacy, measured by indicators such as reported willingness to speak to others about the campaign, willingness to participate in public hearings on health and education, and positive attitudes toward health systems and services.)

Influence also occurred environmentally through a process of *institutional diffusion*. This occurred at state level when Orissa's health department took advantage of the opportunity of the *Deliver Now* campaign to scale up its public education and broadcast efforts to advance women's and children's health policy objectives and improve state reputation. It also took place at distal level, when the Orissa campaign contributed to increasing the scale and influence of global efforts for maternal and child health.

This case study points to a reciprocal process too, adding to the Maibach et al. framework: Global networks may benefit from local network replication to expand power and influence. National and sub-national policy structures,

drawing on resources from global campaigns, may improve engagement with the communities they serve via enhanced health education and media outreach. Social networks and communities may benefit from intensified broadcast outreach with enhanced interest in collective action. Finally, individuals may benefit from increased health knowledge and motivation from campaign exposure to participate in community health activism.

The financial vulnerability of the Orissa *Deliver Now* campaign may have invited unforeseen influence from partners who held such resources. It is not clear if dominance by the Orissa health ministry dissuaded other stakeholders from joining the campaign and lending their own resources. Those resources may have altered the shape or course of the campaign, i.e., by widening debate on messaging or campaign strategy. For example, a study of the *Soul City* health media and social justice project from South Africa suggests that multiple partners engaged in common media campaigns can create impact and longevity through resource pooling, while also holding each other to account (Usdin et al. 2005)⁴⁰.

In the case of *Deliver Now India*, state dominance was manifested in secondary messaging in TV spots that encouraged viewers to trust and value the public health system in Orissa. There was a conflict between the positive views expressed in this setting versus comments made in other settings, including public hearings (see chapter 7), on the poor quality of public health facilities or the experience of care received. The way how *Deliver Now India* diffused messages with positive narratives may have influenced views. The diarrhoea TV spot, for instance, modelled a rural young couple seeking, and finding, excellent support from their local health clinic. This and other depictions may have contributed to building trust of people in the health system.

⁴⁰ Soul City, founded in 1992, is a non-profit foundation operating popular TV drama serials, radio programmes, reality shows, social media, community clubs, and print-based projects, linked numerous national and regional community groups and media organisations across South Africa and the region (Usdin et al. 2005).

In this sense, the mass media campaign may have enhanced state power to a degree. The government of Orissa identified a timely opportunity to use its financial resources to assume control of the *Deliver Now* campaign, rebranding the campaign spots and extending the broadcasting schedule, but also using its local knowledge to capitalise on favourable viewing moments.

In the absence of competition for campaign control by other powerful actors – illustrated in this case by the refusal of India’s public TV broadcaster Doordarshan to join the campaign – Orissa’s NRHM gained important policy space to exercise influence over the globally designed campaign. The campaign appears to have been successful in encouraging health system demand and generating social trust in government public health services. As a public relations campaign for federal health policy and the Orissa health system, *Deliver Now* appears to have succeeded, unchecked by the participation of other media and policy partners in campaign execution.

However, as a rights-based campaign aimed at strengthening civic activism, accountability and media capacity development (Norad 2007), the results are mixed. Campaign evaluation data suggests that community access to evidence-based health information had improved, and collective efficacy effects may have been present, establishing conditions for advocacy network replication. However, in view of survey results (table 6.1) on high satisfaction levels for government health services, the highly positive campaign media frames may have discouraged dissenting views and community-level debate. This is not possible to assess in the absence of qualitative data on community perceptions on the role of mass media campaigns, but could inform the development of future research questions on the topic of global network replication.

Such findings point towards the importance of considering how “people”-based power relations structure the “place” in which they are located. Studies on community-based health monitoring structures in India, for instance, suggest that power differentials among health actors (e.g., citizens and state providers/administrators), structured further by gender and caste differences,

undermine the capacity of such structures to produce citizen-led development (Gaitonde et al. 2017; Scott et al. 2017).

Survey findings may also be understood in part through the complaint by the civil society representative in Orissa that district media is under-engaged, and that the government downplays public dialogue on quality improvement (“*They only talk about numbers – they don’t talk about quality*”). This might have been mitigated if more and varied media actors had been involved with the campaign. Longer-format programming might have resulted in more nuanced and integrated health messaging, rather than a programme of TV spots, with just 30 or 60 seconds to make their point.

Interviews with Orissa government actors indicated satisfaction with their ownership of the campaign (i6, i7, i8), framing their investment in airtime and logo placement as an example of savvy entrepreneurship. By leveraging the skills and capacities of the global network, Orissa could address local gaps and progress toward their policy aim of greater community demand for health services (“*We have many resources, but what we are missing is quality products*”).

Viewed through the “people and places” framework, the Orissa media campaign stimulated a process of iterative debate and mutual influence among individual actors and wider policy environments at both local and distal levels. As the framework suggests, and illustrated by the survey results in this paper, media campaigns can influence individual attitudes/behavioural intentions toward wider policy structures. Media campaigns can also facilitate the influence of communities on policy environments, if members of social networks speak to each other about what they see on TV, and link this experience to participating in accountability processes, such as public hearings on maternity health services, as suggested in these findings.

Thus, it can be understood from this case that mass media campaigns can support a dynamic *continuum* of such effects, from (i) changes in individual health knowledge to (ii) social network behaviours (*people*) to (iii) wider

structural/environmental effects (*place*). This illustrates that the continual interaction of actors and structures is instrumental to shaping public health behaviours, and to Shiffman and Smith's idea that such interactions influence global health agendas.

Media, as both a structure and actor, played an important role in this case. As a structured channel for disseminating messages, media was influential to conveying information and stimulating "collective efficacy" attitudes and behaviours. Yet as a prospective network partner, media organisations can choose to enable or deny support to network objectives, as seen in DD's refusal to partner with the *Deliver Now India* campaign, forcing the global network to seek campaign financing elsewhere. DD's own increasing commercial interests in a privatising media environment suggests that, while media actors may alter network plans and power arrangements, they are also subject to wider environmental constraints in these choices.

Thus, it can be understood from this case that mass media campaigns influence issue visibility and global health network power in several ways, including:

1. Campaigns stimulate network discussion and the creation of shared meaning among network members, contributing to structural cohesion and potential replication. At a global level, PMNCH strengthened relations with the Government of Orissa through co-sponsorship of the *Deliver Now India* campaign. At a community level, the young mother in Orissa who watched the TV spots, spoke to her friends and family about what she remembered, and attended a public hearing on maternal health is a potential node within a wider informal advocacy network, linking social networks to community response, upon which global level networks depend for power and network growth;
2. Media campaigns are used as platforms to disseminate shared ideas by network members. This can put pressure on policy systems at multiple levels – from sub-national to global – to respond to network "asks". This view

challenges governments and donors to broaden their perspective from supply-side inputs, like staffing, commodities, and financing, to consider social and political processes that shape how such inputs will be demanded and used.

Conclusions

This paper analysed the case of the *Deliver Now India* mass media campaign to question how transnational advocacy actors use strategic communication campaigns to position their messages and improve network scale.

Findings in this case reflect the particularities of a highly interested and active policy environment for women's and children's health during the MDG period. Yet they may be of general value because media institutions often play dual roles: They can be structures for disseminating network messages, but also intentional actors in health policy processes, with their own incentives and norms. Thus, the India case study may have implications for both global and other national health advocacy networks that seek to expand their influence through mass media.

This paper found that networks use mass media campaigns to not only increase policy issue visibility, but facilitate the interaction of actors and networks with policy environments at various levels – from districts, to states, to national and global level. These processes are enabled not only by media as channels for influence, but by the strategic choices made by media actors to support, or withhold support, to network-sponsored media campaigns.

In terms of social ecology theory, this study confirmed that these concepts bring attention to far-reaching communication resources and tools (e.g., mass media campaigns) that can improve the capacity of global health network actors to influence policy environments at scale, introducing a spatial dimension to the understanding of global health policy networks, formed in relation to both local-level policy environments and distal-level (e.g., global) policy environments.

Beyond concepts of social ecology, this study found empirically that mass media campaigns contribute to developing and expressing actor power. What began as a globally sponsored *Deliver Now* campaign was localised in Orissa through the social and political participation of individual viewers at district-level, and by government actors at state level who used the campaign to promote their policy goals, wresting control from media actors at national and global level. Local policy structures can benefit from drawing on global resources while global networks benefit from reaching greater scale through the local networks.

From a policy perspective, the implication of this study is that investing in media campaigns may be an effective strategy for networks to attract issue attention and influence behaviours at a policy level, and potentially at a social level. Mass media may assist networks by increasing issue visibility and improving the speed and scale at which networks can attract new members. In a liberal-democratic market environment, media actors can also exert influence over network strategies and power arrangements by contributing – or withholding their resources, as per their own incentives.

This enlarges the understanding of mass media public campaigns as more than passive structures for disseminating network messages to large audiences, but as catalysts for the social exchange of ideas that can stimulate public demand for health system performance and accountability. Media actors are not mere stenographers of global health, disseminating network messages to distant audiences. Guided by their own ideas and priorities, media organisations are powerful actors that can enhance or disrupt advocacy networks in response to their own incentives and disincentives.

Future study on global health networks may consider the question of how global networks are enabled, or constrained, in efforts to expand membership at community level, and the role that mass media may play in this process, particularly through online communication – a factor that was not considered in this study because of the MDG period in which it was set, when internet access had not yet spread widely in Orissa.

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Chapter 7

Development and expression of actor-power: Interpersonal communication campaigns

7.1 Introduction

This chapter (prepared as a paper for publication), responds to the fourth and final research question of this thesis, “How do networks use interpersonal communication campaigns to increase network growth and power to gain issue attention at local and national levels?” This study builds on findings about the spatial and scalar effects of mass media campaigns in chapter 6, and enquires about the characteristics of a different type of communications campaign, based on participatory dialogue and social relations, also sponsored by the global women’s and children’s health network.

The Deliver Now India social accountability campaign in 2008-2009 was coordinated by the White Ribbon for Safe Motherhood civil society network in the state of Orissa, India. The campaign centred on “public hearings” in 12 districts, held among community members, health workers, administrators and policymakers to raise social awareness of maternal health entitlements, and to address grievances about health system gaps. Local media reported on public hearing outcomes to encourage state accountability for reform.

The power of global health networks to achieve issue attention is produced, in part, through civil society mobilisation (Shiffman and Smith 2007). In this paper, the Deliver Now India social accountability campaign offers a window into that process, and is analysed as an arena of social relations that enables and constrains network actor-power. The paper considers the varying kinds of resources that network actors contributed to the Deliver Now India campaign (e.g., financial, technical, reputational), as well as the institutional structures, both local and global, that shaped the campaign and its outcomes. Bourdieu’s ideas about

differing forms of “capital” (social, economic and cultural) assist in the analysis of network power in relation to wider social, political and economic structures.

This study is based on qualitative methods, including document review, in-depth semi-structured interviews with national and sub-national governance actors, and participant observation of campaign design and implementation processes. Document analysis enabled process-tracing of the global Deliver Now for Women + Children campaign (2007-2009), which spawned the national campaign described in this paper. Additional written and visual campaign materials were analysed, including transcripts of public hearings, photographs, news articles, seating plans, monitoring reports on facility quality, baseline research, project evaluations, news articles, and policy texts, among others.

Documents were identified, in part, through participant observation by the author as a secretariat member of the Partnership for Maternal, Newborn & Child Health, which contracted the White Ribbon Alliance to produce the Deliver Now campaign in India. This enabled identification of respondents at the national and sub-national level, as well as the development of interview questions for 18 semi-structured interviews undertaken in Orissa in 2009 on aspects of issue attention and network power, including local, state and national policy environments; barriers and facilitators of civil society accountability efforts in Orissa and India; and the relationship between local, national and global advocacy campaigns.

This case found the positive effects of the Deliver Now India social accountability campaign depended upon the exchange of sub-national and global resources, produced by networks for normative purposes (i.e., for improving political attention to women’s and children’s health), as well as material purposes (i.e., to improve network financing, reputation, and influencing power). This process relied upon acquisition and use of differing forms of capital; among these, social capital was particularly important for mobilising civil society network members and sustaining social trust. In this way, interpersonal communication campaigns were found to be important to the production and use of network power at both global and local levels.

Cover sheet: Research paper 4

Section A – Student details

Student	Lori McDougall, LSH230644
Principal Supervisor	Gill Walt
Thesis Title	How do global health advocacy networks seek issue attention?

Section B – Paper already published

Where was the work published?	
When was the work published?	
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	
Have you retained the copyright for the work?	
Was the work subjected to academic peer review?	

Section C – Prepared for publication, but not yet published

Where is the work intended to be published?	<i>Social Science and Medicine</i>
Please list the paper's authors in the intended authorship order	Lori McDougall
Stage of publication	Not yet submitted

Section D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper.	
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Student signature
Date: 15 January 2019



Supervisor signature
Date: 15 January 2019

7.2 “Answer us before you give any speeches”: Interpersonal communications and network power

Background: This paper explores how interpersonal communication campaigns were used by the global women’s and children’s health network in the MDG era to improve issue visibility and to augment network power at scale. This paper presents the case of the *Deliver Now India* social accountability campaign in the state of Orissa, coordinated in 2008-2009 by the civil society-led White Ribbon Alliance for Safe Motherhood India with the financial support of the global Partnership for Maternal, Child and Newborn Health.

Methods: Case development is guided by Bourdieu’s theory of social relations, and the contribution of different and unequal social, economic and cultural forms of “capital” to actor power in particular “fields”. Data was collected through 18 semi-structured interviews of district-, state- and national-level policy actors; participant observation of campaign design and implementation; and analysis of written and visual artefacts, including transcripts of public hearings, news articles, community-led monitoring reports of health system functions and quality of care, and policy texts.

Results: The global woman’s and children’s health network in the MDG era used interpersonal communication campaigns as a strategic approach to improve social mobilisation. In the case of the Orissa campaign, social capital between community level network members and the local population, as well as the exchange of other forms of capital, enabled the larger network to acquire campaign resources, reputational power and legitimacy. Generation of power occurred at multiple levels, including through resource exchange processes among global and sub-national levels of the network.

Conclusions: Interpersonal communication campaigns have potential to increase issue attention and network power at local and other levels. They can improve the legitimacy of global networks, facilitate civil society mobilisation

and influence network coherence. Network actor-power depends on how skilfully actors deploy and exchange their capital, but also on how they are habituated to behave in relation to their environment and circumstances. The research suggests that risks to social trust, cohesion, and reputation may occur when networks fail to secure capital, to use it effectively, and/or when networks are inured to ways of thinking and acting that jeopardise their interests.

Key messages

- Interpersonal communication campaigns are an effective strategy for global health networks to influence issue attention at local and other levels;
- Advocacy networks increase network power at scale through the organisation of interpersonal campaigns and resource exchange processes among different network levels – from global to sub-national networks, and vice versa;
- The strategic use of different forms of “capital” – cultural, economic and social – influences the capacity of networks to cohere and mobilise attention;
- Risks to social trust, cohesion, and reputation may occur when networks fail to secure capital and to use it effectively, posing potential limits to network growth and influence.

Introduction

Global health advocacy networks and communication campaigns

Public-private global health networks, or “cross-national webs of individuals and organisations linked by a shared concern to address a particular health problem, global in scope” (Shiffman et al. 2015, p. i4), have proliferated since the 1990s. Such networks, including civil society, government, the UN, private business and other members, have brought new agendas and resources to global health (DeLaet and DeLaet 2016; Rushton and Williams 2012). They have also become

crucial for understanding how and why priorities and decisions are made in global health today; through their study, more can also be understood about the differing ways in which power is developed and exercised in global health (Shiffman 2018; Sriram et al. 2018; Ruckert and Labonté 2014).

In the 2000s, many such networks focused their attention on advancing the health-related targets of the Millennium Development Goal (MDG) framework, established by the United Nations (UN) during 2000-2015 to reduce global poverty⁴¹ (United Nations 2018). This included civil society actors within the global women's and children's health network, as well as related institutions such as the Partnership for Maternal, Newborn & Child Health (PMNCH), hosted by the World Health Organization (WHO) in Geneva (McDougall 2016; Smith and Shiffman 2016; Storeng and Béhague 2016).

Such actor-networks used the MDG framework as a “centrepiece” for advocacy campaigns (Fukuda-Parr and Hulme 2017; p. 73), producing knowledge summaries, evidence reports, mass media and interpersonal communication campaigns to mobilise political support for globally agreed goals (Smith and Shiffman 2016; Díaz-Martínez and Gibbons 2014).

Building on findings in chapters 5 and 6 about the influence of networked campaigns, this paper explores how interpersonal communication campaigns were used by the global women's and children's health network in the MDG era to seek issue attention through processes of community dialogue and social trust. It related these questions to the case of the *Deliver Now India* social

⁴¹ MDG 4 aimed to reduce child mortality, and set a target of reducing the global under-five child mortality rate by two-thirds by the end of 2015, measured against progress from 1990. MDG 5 called for improving maternal health, and set targets of reducing the maternal mortality ratio (MMR) by three-quarters (1990-2015) and achieving universal access to reproductive health. Indicators to track improvements in reproductive health included contraceptive prevalence rate; adolescent birth rate; antenatal care coverage, and unmet need for family planning. Other MDGs were dedicated to eradicating income poverty and hunger (MDG 1), achieving universal primary education (MDG 2), improving gender equality and women's empowerment (MDG 3), combatting HIV/AIDS, malaria and other diseases (MDG 6), ensuring environmental sustainability (MDG 7), and developing a global partnership for development (MDG 8) (United Nations 2018).

accountability campaign, coordinated in 2008-2009 by the civil society-led White Ribbon Alliance for Safe Motherhood India, an NGO member of PMNCH.

Understanding campaigns as an arena of social relations among diverse health policy actors, this case explores characteristics and effects of this campaign, complementing understanding of the *Deliver Now India* mass media campaign (cf. chapter 6) as a product and expression of network power.

The White Ribbon Alliance India coordinated plans among civil society members of its state-level branch in Orissa to use the *Deliver Now India* campaign to undertake community monitoring and awareness-raising work about women's and children's health care. These activities included "public hearings" organised in 12 district capitals in Orissa among citizens, health workers, health administrators, elected officials, and the media to discuss community experiences of state health services (Partnership for Maternal, Newborn & Child Health 2007a). The *Deliver Now India* social accountability campaign (henceforth called "*Deliver Now India*") operated in association with the *Deliver Now India* mass media campaign discussed in chapter 6; both were affiliated with the global *Deliver Now for Women + Children* campaign sponsored by PMNCH as its first major advocacy campaign of the MDG era, designed to raise civic demand for maternal and child health services and to hold political leaders to account (Norad 2007).

Interpersonal communication campaigns

This paper draws on literature from the field of health communication to understand *Deliver Now India* as an "interpersonal communication campaign". Unlike mass media health campaigns, in which standardised messages are transmitted and repeated, interpersonal campaigns are based on the "*process of message transaction between people to create and sustain shared meaning*" (West and Turner 2006; p. 8).

This literature also assisted in situating interpersonal communication campaigns within the field of "Communication for Development" (C4D), a term commonly

used to describe communication processes for fostering societal change (Lennie and Tachie 2013). C4D has evolved considerably since its origins in the post-World War II era, when it described mass media-based efforts to diffuse innovative ideas and technologies across social systems (Rogers 1962). In recent decades, C4D has come to represent more participatory forms of learning and exchange, including through the ideas of Brazilian educationalist Paulo Freire (1970), who advocated for community-based dialogue and collective analysis in resisting socio-political oppression (Gumucio Dagron and Tufte 2006). In this way, C4D is now understood as a two-way dialogue process in which communities speak out, express their aspirations and concerns, and engage in decisions that relate to their health and personal development (United Nations 1996). Interpersonal communication campaigns thus have dual meaning: They are intimate sites for discussion and the creation of meaning among people (Hargie 2017), as well as contributing mechanisms to wider political movements for justice and rights (Castells 2015; Tilly and Wood 2009).

In public health, interpersonal communication campaigns are commonly instigated by civil society groups and public health authorities to encourage positive health outcomes (Berlin Ray and Donohew 2013; Glanz, Rimer and Vishwanath 2011). Examples of campaign activities include peer counselling, women's groups, community drama, and workshops, usually conducted on a small group basis (Rice and Atkin 2013). Activities rely on dialogue, social modelling and trust-building for behavioural effects, rather than transmission of top-down information at population level to inculcate behavioural change (Waisbord 2018; Servaes 2008). Public hearings, for instance, were a cornerstone of the *Deliver Now India* interpersonal communications campaign, based on citizen-led dialogue to develop joint strategies to address common conditions and struggles with district health systems.

Conceptual and theoretical approach

Civil society mobilisation is an explanatory factor of “actor-power” in the Shiffman and Smith framework on the determinants of political priority for global health initiatives (2007). How civil society actors communicate and

mobilise to achieve issue attention influences how global health networks acquire and exercise power. Such processes may rely upon network development of social capital, and other forms of capital, to acquire influence for both normative and material purposes. This paper relies on Bourdieu's theory of social relations (1986, 1977) to explore this idea in relation to interpersonal communication campaigns.

Social relations theory

Following Bourdieu, the "field" of global health is not a neutral venue of equal opportunity and perfect competition among different health advocacy networks pressing forward their respective claims for political attention. Rather, global health is a field shaped by the powerful behaviours and circumstances of those who play upon it, each player enabled and constrained in their actions by unique and unequal allocations of "capital": economic, cultural and social.

Capital – whether economic, social or cultural – reflects the social histories and predispositions (what Bourdieu terms as "*habitus*") of each actor, as well as the and the strategic choices that actors make. Differing forms of capital, structured by *habitus*, renders "*the games of society – not least, the economic game – something other than simple games of chance offering at every moment the possibility of a miracle*" (Bourdieu 1986, p. 46).

For the study of network power, social capital seems particularly important. Unlike economic capital, such as money or property, or the symbolic power conferred by cultural capital, such as social pedigrees or educational titles, social capital, by its capacity to magnify reciprocal social ties among actors, can enhance network replication at scale. Defined by Bourdieu, social capital is the "*aggregate of the actual or potential resources which are linked to possession of a durable network of relationships of more or less institutionalised relationships of mutual acquaintance*" (1986; p 51).

Social capital in the form of group membership provides each member with "*a credential which entitles them to credit*" (p. 51), providing the basis for

liquidating this credit under certain circumstances and converting it to economic capital (e.g., using social connections to access financing) or to cultural capital (e.g., using social ties to enhance reputation or social standing).

A Bourdesian view attributes actor-power to individual, historical and socially engrained ways of seeing, thinking and behaving (i.e., *habitus*). This influences how network actors acquire and use resources (or “capitals”) to aid their struggle. In other words, actors succeed not only because their policy solutions are worthy and political conditions are favourable, but also because their capital – in the form of ideas, strategies, tools, and behaviours – determine how effectively their claims are heard.

Bourdieu’s theory of social practice applied to the field of global health paints a picture of an ever-shifting arena of power relations among actors competing for influence. Far from understanding power as the product of immovable structures or forces, impervious to human effort or agency, Bourdieu understands political power as a product of the continuous and mutually influential interaction of structural forces and human choices/behaviours.

Thus, while global health networks may possess differing resources that can help or hinder their bid for issue attention, it also matters how networks choose to “play the game”; these choices are determined in turn by their own histories, habits, and learned behaviours (Shiffman 2015). In this sense, interpersonal communication campaigns can be understood as an expression of agency by civil society networks seeking priority for women’s and children’s health, but also a determinant of normative and material resources from which global health power emerges. In summary, to Bourdieu, social relations are patterns of *“interaction between agents, who are differently disposed and unequally resourced, within the bounds of specific networks that have a game-like structure”* (Crossley 2002).

Actor-networks, for instance, are capable of bending rules to their advantage through their *habitus* as well as their strategic assets (i.e., their “capitals” –

economic, cultural or social), acquired by dint of their predispositions. Power can be seen by comparing differing amounts and forms of capital held by different networks. Inequality among them is inherent, since we do not live in a “*world without inertia, without accumulation, without heredity or acquired properties, in which every moment is independent of the previous one*” (Bourdieu 1986, p. 46).

Social capital theory

Among different forms of capital, social capital merits special attention in this paper because it is an important component of interpersonal communication (Vishwanath, Randolph Steele and Finnegan 2006). Related to public health, other social theorists, such as Coleman (1988) and Putnam (1995) have generated attention to the influence of social capital on well-being. Putnam’s concept of social capital, “*the features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives*” (1995, pp. 664-665), brings attention to the relationship of individuals to networked forms of organisation, since it is *through* participation in such networks, with their norms of obligation and reciprocity, that individuals gain access to information and social support mechanisms that improve their well-being.

Ideas about social capital have been well-explored in public health (Lin, Burt and Cook 2017; Szreter and Woolcock 2004). Social capital has been used to examine the political and social determinants of public health, as well as the relationship between socioeconomic inequality and health outcomes (Wilkinson 1996). Social capital is understood as an important support factor for individual health, reducing risks associated with personal stress, isolation, and lack of information (Kawachi and Berkman 2003; Cattell 2001). Social capital can also enhance social inclusion, as well as magnify social exclusion, due to the influence of wider structural and contextual factors in networks based on geography, education, social class or race (Portes 1998).

In the context of health advocacy networks, social capital in form of social connections, shared norms and trust may *contribute to* network coherence,

power and replication, as well as *result from* network power, manifesting as expansion of network membership at scale, and giving rise to new opportunities for social interaction. Yet capitals are subject to fluctuation. For example, loss of economic capital (e.g., loss of network campaign resources) may threaten network social capital by reducing the interest and commitment of network members to collaborate in joint campaigns, and thus limiting network capacity to attract new members through these campaigns. Also, loss of social and/or economic capital may threaten network reputation and prestige (i.e., cultural capital). Fluctuations in capital flows may also occur for structural reasons, e.g., when external/environmental conditions force certain shifts in network leadership arrangements that affect social trust or reputation.

Interpersonal communication campaigns can contribute to capital production in various ways. As an *input* to social capital, interpersonal campaigns can perform essential network functions, including:

- Facilitating information flow among current and prospective network members (Rice and Atkin 2013);
- Defining and defending network boundaries, supporting the production of collective identity (Melucci 2005; Polletta and Jasper 2001);
- Constructing symbolic “frames” of meaning that shape network messages and persuade others about problems, causes, and preferred policies and investments (Benford and Snow 2000).

Social capital, as an output of interpersonal communication campaigns, can benefit networks in various ways, including by:

- reinforcing network integration and coherence (Rojas, Shah and Friedland 2011);
- determining how messages shared by other forms of network campaigns – such as mass media campaigns – can be understood and acted upon (Vishwanath, Randolph Steele and Finnegan 2006), including indirectly through word-of-mouth among those lacking direct media access (Boulay, Storey and Sood 2002); cf. findings in chapter 6.

This paper uses these ideas of capital to understand how advocacy network relations may exert influence at various scales of operation. By studying the networks, norms and trust that enabled participants in the *Deliver Now India* campaign in Orissa to act together, this paper seeks to improve understanding of how global health networks may develop and use interpersonal campaigns for influence.

Methods

Research methods for this paper are based on document analysis, semi-structured interviews, and participant observation of campaign design and implementation processes in India and Orissa, as well as at the global level.

The starting point for this paper was the author's personal experience as a staff member of PMNCH during the MDG period, during which time the *Deliver Now India* campaign was conceptualised and implemented (Partnership for Maternal, Newborn & Child Health 2007a).

Case selection

The *Deliver Now India* campaign can be understood as a bounded arena of interpersonal communications, in which social relations of trust and conflict may be magnified for examination (Keck and Sikkink 1998). The *Deliver Now India* case was selected for this study because of it was an important campaign in the global women's and children's health network during a period of network growth in the MDG era.

Also, as discussed in chapter 6, the *Deliver Now India* case was selected for practical reasons. First, as a member of the PMNCH secretariat, the author had close knowledge of the history, actors, and products of the *Deliver Now* global and India campaigns, making extensive contributions to campaign concept, design, implementation and evaluation during 2007-2009. Second, the *Deliver Now* campaign was conducted at global level, national level, state level, and district level, allowing rich scope for observing and analysing scaled interactions between network members. These national and global policy environments

allow global health network actors to be understood in relation to political context, including local ones.

Document analysis

Building from a general understanding of the global women's and children's health network (chapter 4), approximately 50 written and visual documents related to the *Deliver Now India* campaign were reviewed for this paper (e.g., transcripts and seating plans from public hearings conducted at district level in Orissa in 2008 and 2009; photos; White Ribbon Alliance project reports and formal evaluations; PMNCH web articles, videos and press releases about the campaign and global-level citizen dialogue events; media articles and reports from the campaign launch; reports from inception and dissemination workshops; and community-led health facility reports). This analysis assisted in understanding why and how the *Deliver Now India* campaign was conceived, funded, implemented and assessed, and in which national and sub-national policy contexts during which periods of time.

More than 40 of these documents (including media reports, public hearing transcripts, and project descriptions) were retrieved from publicly available sources, including Government of India websites and the PMNCH website. Eight unpublished documents (i.e., project reports, including baseline, progress and endline evaluation reports, guidelines on conducting public hearings) were retrieved from the author's personal files.

Semi-structured interviews

Document analysis helped to form questions and to guide initial respondent selection for 18 semi-structured interviews conducted by the author in Orissa's capital city of Bhubaneswar in June-July 2009. Interviews included questions about how various types of policy actors saw their role in relation to improving the implementation of women's and children's health policies in Orissa; the role of public hearings and civil society networks in government service delivery in Orissa, and in India; barriers and facilitators of civil society accountability efforts

in Orissa and India; and the relationship between local, national and global advocacy campaigns (see Annex C: Interview guide).

Interview informants were purposively selected from different constituency groups working mainly at state or district level in Orissa to generate a cross-section of ideas and views of the *Deliver Now India* campaign. Apart from the initially selected interviewees, most respondents were identified through snowball technique. The interview informants included representatives of state government (4); state-level UN agencies (2); state-level technical cooperation agencies (2); state-level media (2); state-level NGOs (3); state-level researchers (1); district-level NGOs (1); national-level NGOs (1); and national representatives of foreign donor agencies (2). Informants are identified in this paper by category of professional employment (e.g., government representative, civil society representative, media representative, etc.), unless remarks have been made in a public forum and shared with media. Informants are differentiated in their reported remarks as i1, i2, i3, etc.

The face-to-face semi-structured, open-ended interviews lasted 60-90 minutes and were conducted in English. Notes were handwritten and then typed up as transcripts for analysis.

Participant observation

Evidence for this paper was also collected through a process of participant observation. During the 2007-2009 *Deliver Now* campaign period, the author was a full-time Geneva-based PMNCH staff member involved with initial campaign design and contracting processes in 2007 and a part-time consultant in Canada supporting campaign implementation in 2008. Documentation of observations include a personal archive of notebooks, meeting reports, and e-mails relating to campaign activities during 2007 to 2009.

These notes and e-mails were important to substantiate recall of campaign events; anonymised citations (including “personal observation”) appear when data is not available through public sources. For reasons of ethics and

transparency, all network actors closely involved in this case, including those in New Delhi and Orissa, were informed of the author's personal research intentions. Similarly, global network actors involved with this case, i.e., managers from PMNCH and its host agency, WHO, were informed and supportive. The author's status as a student researcher at the London School of Hygiene and Tropical Medicine (LSHTM) from 2009 onward is included in her online biography on www.pmnch.org (PMNCH 2018).

Close understanding of the *Deliver Now* programme objectives enabled the author to analyse data for meanings that may have been hidden to a researcher who lacked such knowledge. On the other hand, it is likely that data collection and analysis processes were affected by pre-existing personal and cognitive biases of the author about the campaign: A researcher with no previous ties to *Deliver Now India* may have collected or interpreted data in a less bounded way, possibly producing different conclusions.

Data analysis

Qualitative framework analysis (Miles, Huberman and Saldaña 2014) was applied to structure and synthesise data. Data points were structured into a set of codes established iteratively and deductively, then grouped into eight key concepts and then linked to the analytical framework for this paper. The eight concepts were: social capital, civil society mobilisation, resource exchange, framing, collective action, health behaviours, network cohesion, and issue attention. Data points were inserted into the framework and marked by category labels to highlight similarities and divergences. Labels assisted in constructing major themes and sub-themes discussed in this paper.

Context and case description

Before describing the details of the *Deliver Now India* case, this section will describe the health policy environment in Orissa and in India, including civil society mobilisation.

Maternal and child health policy environment

The advent of *Deliver Now India* reflected increasing attention to maternal and child health in India in the 2000s, as well as a sharp focus on maternal and child health in the global MDG framework through MDGs 4 and 5 (Partnership for Maternal, Newborn & Child Health 2007a).

In 2005, India's newly elected centre-left coalition government sought to move away from target-oriented vertical programs to an integrated, rights-based approach to reproductive, maternal, newborn and child health (Vora et al. 2009; Shiffman and Ved 2007). It launched the second phase of the Reproductive and Child Health Programme (RCH II), delivered through the National Rural Health Mission (NRHM), a new national health umbrella to improve provision and access to quality health services, particularly among women and children in poorer and marginalised areas of India.

NRHM, launched in 2005 by Prime Minister Manmohan Singh, was part of a comprehensive package of social welfare reforms to increase national public spending on health in India, particularly for the benefit of the rural poor (Narwal 2015). NRHM was a channel for the delivery of increased and decentralised financing to state- and district-level, including for the recruitment and training of community-based health workers; citizen-led programme management and monitoring of new public health standards; and community engagement in intersectoral planning (Government of India 2005).

Orissa was an important state for the equity-focused NRHM programme. With a population of 42 million (Government of India 2011a), Orissa's maternal mortality ratio was 258 deaths per 100,000 live births in 2007-2009, against 212 for India nationally (Registrar General of India 2011). In general, the status of women in Orissa was low: India's 2005-2006 National Family Health Survey III (NFHS-3) found that 58% of married women did not usually participate in household decision-making, and nearly 40% had experienced domestic violence. Health indicators for women were similarly challenging: 68% of pregnant women in the same survey were anaemic, and the institutional birth rate was

less than 40% (International Institute for Population Sciences and Macro International 2007).

Orissa accounts for nearly 10% of India's "Scheduled Tribe"⁴² population, and 23% of the rural population in Orissa is classified as Scheduled Tribe (Government of India 2011a); most live in rural and remote areas of the state, and face significantly higher levels of poverty, unemployment, and lower access to health services compared with non-indigenous people in Orissa (Tripathy et al. 2010). For instance, a national report in 2012 suggested that a baby born to a Scheduled Tribe family in India had a 14% higher risk of dying in the neonatal period, and a 45% risk in the post-neonatal period, compared with other social groups (National Institute of Medical Statistics, Indian Council of Medical Research and UNICEF India 2012).

Yet, during the period of this case study, the population of Orissa was undergoing rapid social development. Between 2001 and 2011, literacy among rural women in Orissa increased from 47% to 61% (Government of India 2011b). In some of the districts where the *Deliver Now India* public hearings were organised by the White Ribbon Alliance, literacy among rural women doubled, or nearly so, during 2001 to 2011, including in the economically and socially disadvantaged districts of Koraput (16% to 32%), Nuapada (24% to 44%), and Kandhamal (33% to 50%) (Government of India 2011b). In relation to health, under-five child mortality rates in Orissa fell from 91 deaths per 1,000 live births in 2005-2006 to 48 in 2015-2016, mirroring wider national and global reduction trends. Institutional births in a public facility in Orissa more than doubled during this time, from 29% to 76% (International Institute for Population Sciences 2016).

⁴² *Scheduled Tribe (ST)* is a classification applied by the Government of India to people of indigenous backgrounds, who are recognised by India's constitution for administrative and social welfare purposes. The 2001 Government of India census enumerated 62 tribes in Orissa, with a total ST population in Orissa of 8.2 million, equal to 22% of the total population of the state. The female literacy rate among ST members in Orissa in 2001 was 23%; nearly all (95%) of ST members in Orissa in 2001 lived in rural areas (Registrar General of India 2001).

Rising trends in women's and children's health in Orissa in the MDG era are attributed, in part, to state-level implementation of RCH II and other programmes under the NRHM banner (Thomas et al. 2015). This included upgrading referral units at block level to provide Emergency Obstetric Care (EmOC); scaling up 24x7 primary health centres; and expanding community support systems for primary care, including maternity services, by training new health volunteers, the so-called "Accredited Social Health Activists" or ASHAs (Department of Health and Family Welfare Orissa 2008).

Importantly, NRHM's new demand-side financing program, *Janani Suraksha Yojana* (JSY; "Maternity Protection Scheme"), offered cash payments to women who sought professional maternity care. Compensation differed according to criteria, including place of residence, poverty status, and service required. In Orissa, classified by NRHM as a "low-performing state" in regard to maternal and infant health, every rural woman who met the conditions could claim Rs. 1,400, with an additional Rs. 600 for the ASHA who accompanied her to the facility (Government of India 2006). This was a significant financial incentive in a state with monthly per capita income of Rs. 1,200 in 2005-2006 and an estimated 40% then living below the poverty line (Rout 2010).

Thomas et al. (2015) reported that institutional delivery rates among Scheduled Tribe women in Orissa rose from 12% in 2005-2006 to nearly 70% in 2011, and that equity gaps also reduced for other maternal and child health services during this time, including in relation to antenatal and postnatal care, and immunisation.

However, in the early days of JSY, when the *Deliver Now India* campaign took place, pro-equity effects were weaker than in later years of the programme: Vellakkal et al. (2016) found larger pro-equity effects in uptake of institutional delivery and antenatal care in 2011-12 than in 2007-2008), with no evidence of positive effects on antenatal care in the earlier years of JSY. The programme encountered early implementation challenges, as was officially recognised in 2007:

Services have not kept pace with demand ... and monitoring and grievance redressal systems are not in place ... JSY, the largest single intervention under the NRHM/RCH II umbrella, is equal [in budget allocation] to nearly all the national programmes put together and has shown phenomenal growth, but now needs major consolidation to fully attain its objectives. (National Rural Health Mission 2007)

Also, there were specific JSY implementation problems, including late disbursement of cash payments (61% in Orissa) and the necessity of beneficiaries to have to pay for transport expenses to the facility themselves (91% in Orissa) (National Rural Health Mission 2007). Furthermore, Rout (2010), citing data from 2005-2006, reported that nearly 60% of auxiliary nurse-midwives (ANMs) at this time did not reside in the same village as their health sub-centre and only half of Primary Health Centres (PHCs) had four or more beds. Government reports suggested that 80% of the increase in services during the first five years of the JSY programme was fulfilled by less than 20% of government facilities (Government of India 2015).

Furthermore, JSY and NRHM were implemented in an era in which India's social development policy aimed to strengthen community-based monitoring processes, mandated by the 73rd and 74th amendments to the Constitution of India (Laskar and Garg 2010). For instance, NRHM operated its community-based monitoring programme through a set of health planning and monitoring committees, populated by health system representatives; local self-government representatives (*panchayati raj institutions*); and civil society organisations (CSOs). Committees were formed at the level of the PHC, involving the participation of Village Health Nutrition and Sanitation Committees (VHNSCs).

Village committees fed into higher-level health planning and monitoring committees, at block (sub-district) level, district-level, and state-level. Committee members were tasked with developing local-level assessment tools of health service functioning, including report cards on citizen satisfaction, patient interviews, and focus group discussions. CSOs shared citizen report card results at public dialogue meetings ("*Jan Samvad*") at PHC and block levels, attended by health system officials to discuss problem resolution (National Rural Health

Mission, Centre for Health and Social Justice, Population Foundation of India 2010).

These public hearings represented one of many legal and constitutionally mandated channels for citizen consultation and participation in post-colonial India (Shah 2004). They contributed to the aims of NRHM, enabling the state to assess health system performance through the feedback of local communities. From the perspective of citizens, however, such channels have often been deemed ineffective for practical purposes, burdened by structural impediments to participation (Kothari 1986), such as lack of legal standing by citizens within official oversight bodies; lack of structured access by citizens to official information, including spending information; and meagre opportunities to confront legislative bodies directly with dissenting views (Goetz and Jenkins 2001).

Civic trust in public health services is influenced not only by the quality of interpersonal communications and relations among individual patients and providers, but by how those relations are structured by the wider systems and contexts in which they are embedded (Rowe and Calnan 2006). In India, the expansion of economic liberalism and the continued rise of social inequalities since the 1990s were met with a raft of state-sponsored pro-equity approaches, such as NRHM, backed by legal rights and measures. However, as Roalkvam (2014) points out, such health entitlements depend not only on legally guaranteed rights, but on the social conditions that enable how those rights can be claimed.

In an ethnographic study in a tribal area of Orissa, Mishra (2014) found that trust relations developed among women and local community health workers were undermined by the narrow, indicator-focused approach to NRHM monitoring, which privileged hierarchical collection of statistical evidence related to a limited set of concerns, including institutional delivery, immunisation rates, and nutrition referrals. Qualitative feedback by health workers that could improve system performance, including ideas for the integration of traditional medicine

practices with the formal health system, was relegated to the margins of monthly review meetings, and often suppressed by health workers themselves for fear of being seen by officials to support medical “quackery”.

This finding supports studies in other settings in India that document the constricting influence of embedded public health system hierarchies and practices on community trust (Scott and Shankar 2010; Sheikh and George 2010), despite the redistributive aspirations of NRHM and its heightened attention to community engagement and monitoring.

Civic advocacy for improved accountability

For the past several decades, trade liberalisation and the intermingling of global, local, state and non-state actors have characterised public health in India (Jeffrey 2018). Global-local interaction has produced new forms of power, both overt and covert, exercised by national and global elites (Kapilashrami and Baru 2018). Civil society groups have assumed prominent roles in challenging and implementing official public health policy in India, assuming multiple, often conflicting, roles in service delivery, citizen advocacy, and public-private facilitation (Chandoke 2018; Scott et al. 2017).

Yet, the broader post-independence struggle of civil society in India to make democracy “live up to its ideals” (Tandon and Mohanty 2002, p. 19) has increasingly included civil society resistance to the abdication of government responsibility for health, and growing commercialisation and privatisation (Kapilashrami and Baru 2018).

In the 1990s and 2000s, social accountability for health was a growing theme among many civil society groups in India, including those operating as part of global transnational advocacy networks with close links to government, such as *Jan Swasthya Abhiyan* (JSA)⁴³, the Indian chapter of the global rights-based

⁴³ Formed in 2001, Jan Swasthya Abhiyan is a civil society coalition made up of 21 national networks and organisations in India, coordinated through state-level chapters. More than 1,000 organisations participate in the work of the coalition, including raising awareness on adverse effects of globalisation

People's Health Movement. JSA, which had long opposed the growing commercialisation of health care in India, had worked extensively with the federal Ministry of Health and Family Welfare and state-level counterparts in coordinating consultations on the development of NRHM and RCH II (Gaitonde et al. 2017).

While India's federal government suffered no lack of political attention to women's and children's health in the MDG era, nor constitutionally mandated mechanisms for accountability, bottlenecks and gaps were myriad when it came to state and district-level policy implementation, absorption capacity of decentralised funding flows, health system and administrative capacity, and protective mechanisms to ensure citizen rights to health. These gaps at state- and district-level have driven much civic activism, media and scholarship in the past 10-15 years, producing rising attention to health accountability in India, particularly at state and district levels where health policy and budgeting mainly takes place (Hamal et al. 2018; Subha Sri, Sarojini and Khanna 2012; Human Rights Watch 2009).

Thus, issue-based civil society networks, such as the White Ribbon Alliance for Safe Motherhood India, were heavily involved in advocating for improved policy implementation of safe motherhood and newborn health programmes, emphasising women's right to information and community mobilisation (Papp, Gogoi and Campbell 2013; Shiffman and Ved 2007). White Ribbon India represented a voluntary national network of 1,500 member-organisations and individuals (Motihar and Gogoi 2009). It had five state chapters, including one in Orissa, that were coordinated by a national secretariat in New Delhi. White Ribbon is also an example of a transnational, multi-scaled civil society health network connected with a private-public global health network: White Ribbon India was one of 15 national chapters affiliated with the global White Ribbon Alliance, based in Washington, D.C. Both White Ribbon India and the global

and promoting decentralised health planning and community participation in India. These organisations include non-governmental organisations (NGOs), women's groups, service delivery networks, and trade unions (Jan Swasthya Abhiyan 2018).

White Ribbon Alliance are also members of the Partnership for Maternal, Newborn & Child Health (PMNCH).

As has been noted, White Ribbon India organised the *Deliver Now India* campaign in Orissa. In doing so, it built upon a network of community-based member-organisations at the district and sub-district levels that had previously activated a successful community-based programme of *adalats* (“people’s courts”) for safe motherhood in 2006-07, supported by UNICEF and the UK’s Department for International Development in 22 districts of Orissa (UNICEF and State Commission for Women Orissa 2007). The *adalats* facilitated public dialogue on grievances, and potential forms of redressal, related to public maternity services.

Prior to this, many such community organisations in Orissa had been engaged in struggles with the state for a long time, and more recently some also with private businesses, over forest, mineral and land rights. Such trends were accelerated by trade liberalisation, foreign investment and rising domestic consumption of aluminium, steel, iron and other resources (Pandey 2017; Kumar 2014).

Women’s rights movements, furthermore, often overlapping with tribal rights movements in Orissa, focused attention in the 1990s and 2000s on labour and land rights, but also on domestic violence and alcoholism, and related deprivations, such as child malnutrition. Such struggles were organised through traditional channels like unions, but also through women’s self-help groups and other community-based groups (Padhi 2017; Padhi and Pradhan 2013).

India has been the site for extensive study on social movements dedicated to issues such as caste and tribal rights, women’s status, and labour, land and natural-resource rights (Shiva 2015; Oommen 2010; Guha 2009; Morrison and Agarwal 1988). Until recently, relatively little has been written on civic struggle related to public health in India and in Orissa. However, in the past 10 years, an extensive body of literature has developed on health accountability and health system bottlenecks in India (still with limited focus on Orissa), framed by the 2005 advent of the NRHM and its women’s and children’s health focus.

Recent studies, for instance, have focused on capacity gaps in maternal health policy implementation at state and district level (Sanneving et al. 2013); structural and performative challenges faced by state-sponsored health committees associated with NRHM (Scott et al. 2017; Srivastava et al. 2015); citizen perspectives on maternal and reproductive rights and entitlements (Bhattacharyya et al. 2015; Dasgupta 2011; Jeffrey and Jeffrey 2010); and the role of litigation in ensuring reproductive rights (Kaur 2012).

One of the few qualitative health system studies on maternal health in Orissa (Mahapatro 2015) focused on the important role of traditional attitudes/practices and household power relations in relation to maternal health risks, finding these to be cultural and political barriers to care-seeking, and unaddressed by normative technical focus of government schemes such as JSY.

In their recent review of literature on accountability and maternal health inequities in India, Hamal et al. (2018) found that the lack of functioning accountability mechanisms in India contributes conclusively to health system problems– e.g., poor health worker performance, weak implementation of public health standards, discriminatory policies, lack of representative politics. Yet the literature also finds that poor accountability is a systemic problem, not only centred on the individual capacities and attitudes of frontline health workers and weakened health systems they work in, but to factors that lie outside the domain of the health sector, such as education, infrastructure, water and sanitation, and gender equity, from district level to national level.

The Deliver Now India campaign

As noted before, *Deliver Now India* was coordinated and financed by PMNCH as part of the global *Deliver Now for Women + Children* advocacy campaign funded through a grant from the UK's Department for International Development (DFID) from 2007-2009 (Partnership for Maternal, Newborn & Child Health 2007a). It represented the first major global campaign launched by PMNCH since its emergence in 2005, and was an important forerunning campaign to the larger *Every Woman Every Child* campaign, accompanying the launch of the *Global*

Strategy for Women's and Children's Health in 2010 (Partnership for Maternal, Newborn & Child Health 2007a; United Nations Population Fund 2007; see chapters 5 and 6).

The campaign in Orissa was part of a set of national advocacy campaigns sponsored by the global PMNCH network in India and other regions. During 2007-2008, *Deliver Now* campaigns were also launched in Africa (Tanzania), Latin America (Chile), and in North America (United States) under the wider umbrella of the *Global Campaign for the Health MDGs* (Murray, Frenk and Evans, 2007).

The Orissa campaign aimed to raise the political visibility of maternal and child health issues in a key Indian state, promote citizen awareness of health entitlements, improve health-seeking behaviours, and stimulate social accountability efforts to improve supply-side delivery of services. *Deliver Now India* operated at both the national and sub-national level in 2008-2009, i.e., focusing on the state of Orissa, which in parallel during 2007-2009, functioned as one of nine pilot states selected by the Government of India to implement community-based monitoring mechanisms to support NRHM (see above) and related programmes (Laskar and Garg 2010).

Deliver Now India focused on public hearings involving the participation of approximately 15,000 women in Orissa during 2008-2009 (USAID 2010). These hearings sought to address deficiencies of official channels of popular consultation and participation through citizen-led evidence collection and direct representation to participating officials and parliamentarians. They drew upon familiar parliamentary and legalistic traditions in India, while at the same time, opening civic space for dissent and resistance (Papp, Gogoi and Campbell 2013). As such, White Ribbon's public hearings in Orissa were independent from NRHM's official community monitoring efforts.

However, the campaign built upon awareness of entitlements for maternal and child health generated by NRHM's large-scale government programmes. In doing

so, it mobilised White Ribbon's regional and district network of community-based organisations to act as local campaign coordinators (White Ribbon Alliance for Safe Motherhood 2007). Some were based in the most economically disadvantaged parts of Orissa, including remote tribal areas in the south and east of Orissa, where women's rights and health status were particularly low, and where traditions of resistance and social action had long taken root on tribal, women's, land and natural-resource rights (see above).

In designing and implementing *Deliver Now India* in 2007-09, White Ribbon members extended the work of the *adalat* project to cover the remaining districts that had not been covered yet, including intensifying efforts in other districts where needed. To do so, White Ribbon Alliance India selected 12 districts of Orissa for focused efforts and mobilised three sets of actors (White Ribbon Alliance for Safe Motherhood 2007), i.e.:

- *community members*, to advocate for their rights to improved maternal and child health services;
- *national and state-level political leaders*, to exert pressure on district-level colleagues to implement government commitments to health;
- *media and other opinion leaders*, to act as public watchdogs to ensure allocated public funds were spent properly on effective interventions to improve maternal and child health.

Public hearings were conducted in 12 district headquarters of Orissa during June 2008 to March 2009. Each event, preceded by a public rally, was attended by 1,000-1,500 women, health officials, elected officers, service providers, the media and others, with meetings lasting approximately two hours to address health system and policy grievances (White Ribbon Alliance 2008b; Partnership for Maternal, Newborn & Child Health 2007).

In parallel to the public hearings, White Ribbon implemented other national- and state-level interpersonal communication activities to support *Deliver Now India*, including advocacy planning meetings and media capacity-building and

orientation workshops. At the end of the campaign, in June 2009, a dissemination workshop was organised in New Delhi and in Bhubaneswar with national- and state-level policy makers and media, sharing citizen-led findings about health facility quality, gathered by checklist processes and other forms of qualitative feedback (USAID 2010; White Ribbon Alliance for Safe Motherhood 2007).

To measure outcomes against the project's own objectives and targets, White Ribbon's national secretariat hired a New Delhi-based market research firm to measure changes in pre- and post-campaign knowledge about public maternity care entitlements in four of the 12 districts that hosted public hearings (n=480). This data was complemented by pre-post campaign comparisons of health facility functioning in all 12 *Deliver Now* districts.

Data collected from 204 health sub-centres and 102 primary health centres in the 12 districts indicated pre-post campaign differences in provision of equipment, such as blood pressure instruments (45% to 60%) and scales (48% to 57%); an increase in ANM visits to new mothers and babies (15% to 25%); and promotion of referral transport for routine delivery and emergency obstetric care (56% to 63%). A similar data-gathering exercise among community members using "entitlement" checklists showed a rise in awareness of maternity care entitlements (64% to 88%) (GfK Mode, reported by USAID 2010). Such data and other outcome information of the public hearings were uploaded on the PMNCH website for global dissemination (PMNCH 2008).

Furthermore, the public hearings encouraged government officials to make pledges at these meetings (USAID 2010), including to initiate:

- formal investigations of allegations made in relation to bribery and unauthorised health worker absences;
- construction and/or upgrading of health facilities in disuse or disrepair;
- creation of referral transport to improve access to second-level care;
- establishment of formal grievance and redress mechanisms;
- development of community-based committees to track implementation of pledges.

This research process did not extend beyond the lifespan of the 2008-2009 *Deliver Now India* campaign. Therefore, it is not possible to know how/if specific pledges were followed up and what the effects of campaign participation were on women themselves.

However, insights may be gained from Papp, Gogoi and Campbell's 2013 study on community-based social accountability activities conducted by the White Ribbon Alliance in Orissa. Through their interviews with community participants, the authors found that pro-social "mindsets" of policymakers, providers and clients contributed to community accountability processes in important ways. Collective beliefs – e.g., that maternal health is worthy of attention, and that access to high quality, respectful maternal health services is a human right – lent confidence to the public hearing process, and contributed to follow-up, alongside the provision of public programmes and media monitoring to strengthen community monitoring processes. Public hearings, they concluded, contributed to shifting mindsets by reframing health as an important collective struggle, rather than an individual experience.

Findings

Unlike the *Deliver Now India* evaluation reports, this study is not primarily concerned with impact on health infrastructure and policy implementation, but rather with the contribution of interpersonal communication campaigns to network power and issue attention. To examine these effects, this section is divided into parts on (1) global-local relationships; (2) local mobilisation; (3) government-network relations; and (4) civil-society network reach.

(1) Global-local relationships

The *Deliver Now India* campaign involved the mobilisation and exchange of resources, particularly between PMNCH and White Ribbon. The PMNCH global network relied upon the local credibility of White Ribbon with the Government of India to quickly and easily establish *Deliver Now India* as an important national campaign. It also relied on the credibility of White Ribbon in

demonstrating to donors that it could address grassroots needs through its campaigns.

For example, PMNCH sought to demonstrate this by inviting White Ribbon to a high-level side event with heads of government, donors and the UN at the UN General Assembly in 2007 (personal observation). There, the India coordinator of White Ribbon spoke about the upcoming plans of the *Deliver Now India* campaign to reach women denied of quality maternity care (Partnership for Maternal, Newborn & Child Health 2007c). The intervention underlined the reciprocity of the global-local exchange: White Ribbon could use the global stage to share messages about its mission and itself; PMNCH could use White Ribbon to demonstrate its own claim to legitimacy, by partnering effectively with networks far away from the elite confines of the UN and global meetings.

For White Ribbon India, the supply of assets from the PMNCH global network involved not only campaign financing, but also the transfer of technical expertise on maternal and child health from the World Health Organization (as PMNCH's host organisation), as well as global campaign branding and messaging. Further, the global network endorsement of White Ribbon's work to other PMNCH partners in India (including the Government of India) supported White Ribbon's reputation and position as a national advocacy leader (White Ribbon Alliance for Safe Motherhood 2008a).

Indeed, several respondents, including media observers and those not part of White Ribbon itself (i4, i9, i11), cited funding from UNICEF and the UK Government as a turning point in White Ribbon's organisational development and influence with key players in Orissa, including the state government. They further observed that White Ribbon's growing reputation from these earlier projects enabled the network to convert its growing reputation into financing from other donors.

Other respondents, however, commented on potential risks to White Ribbon's sustainable growth in Orissa because of perceived reliance on foreign financing

to sustain its advocacy work. If funding declined, so did district member engagement and interest.

“It is a challenge to keep partners on board [without money]”, said a White Ribbon partner from a UN agency based in Orissa (i15), who recounted past network efforts to raise core funding to sustain its work, including unsuccessful approaches to the corporate sector in India. “Grassroots NGOs are demotivated by lack of funds to meet campaigning needs” and this adds to their disappointment about seeing few improvements in service delivery at district level: “Women are demoralised”, observed a government officer in Orissa (i16).

If fluctuating funding can strain network cohesion, especially in the context of networks that rely on social trust and engagement to produce interpersonal campaigns, it may also limit network positioning and growth. Some respondents felt that the need for money dictated a short-term project approach that hampered White Ribbon’s capacity to broaden network skills over the long term, including in areas of knowledge translation, monitoring and evaluation, and policy development. “You need social mobilisation, but you also need technical expertise to make policy differences in quality of care” (i15).

Other respondents in Orissa (i13, i17), including those representing donor and UN agencies, focused on the adverse effects of vertical financing in limiting the capacity of White Ribbon to form partnerships outside of the maternal and child health community. This was a limiting factor to innovation and cross-sectoral partnerships to address the social determinants of maternal and newborn health. Said one such respondent:

“White Ribbon is made up largely of ‘mother NGOs’, rather than NGOs that integrate their work across different sectors. They tend to see maternal health as a vertical issue. This is because their money is coming in this fashion” (i17).

Although vulnerable to shifts in economic capital, White Ribbon appears to have had considerable success in using its growing public profile, global connections,

and evident ties with government leaders, the media, and other influencers to develop social and cultural capital.

In doing so, White Ribbon appeared successful in achieving a degree of autonomy from PMNCH, evident in differences between the two networks in message framing. For instance, the global press release from PMNCH for the launch of the campaign in September 2007 echoed the technical/managerial framing of the MDGs, underlining the normative supply-side logic of global resources delivered through local organisations for political effect:

Currently, 20 percent of the world's births are in India but 25 percent of the world's child deaths and 20 percent of the world's maternal deaths occur there as well. Deliver Now will work with local organisations to implement a program to build political will to ensure delivery of services and raise awareness in the Indian state of Orissa (Partnership for Maternal, Newborn & Child Health 2007b)

White Ribbon subtly revised this messaging to include more rights-based framing when it issued its own press release to a national audience in India six months later:

With more than half a million women dying in pregnancy and childbirth, of whom over 70,000 are in India, Deliver Now is a much-needed call for greater political commitment, increased investment in health services and support for communities to demand better access to quality health care. (White Ribbon for Safe Motherhood India 2008a; emphasis added)

Deliver Now India was not only created through resource exchange processes between PMNCH and White Ribbon, but also by each actor's structural environment and predisposition. For instance, several interview respondents remarked that White Ribbon India's activities of organising rallies, public hearings, political champions, and media campaigns were supported by an appreciative government, which itself was paying greater attention to community-based monitoring of maternal and newborn health under the NRHM programme (i1, i13, i17). These activities were also shaped by the "culture" of the White Ribbon Alliance in India itself, which belonged to the global White

Ribbon network, headquartered in Washington, D.C., reputed for generating public demand for rights and services, empowering community representatives to mediate between the citizens and the health system, and highlighting lived experience of maternity care (Papp, Gogoi and Campbell 2013; Shiffman and Ved 2007). This media-friendly human rights-based approach differed, for instance, from other civil society groups predisposed to quieter, highly detailed “technical advocacy” approaches prioritising biomedical and managerial frames used in reports, workshops and other interpersonal approaches (personal observation).

Similarly, as a relatively “young” global network launched only in 2005, PMNCH was steeped in a culture to outreach to new members (personal observation). White Ribbon’s network in India included 80 national organisational members and nearly 1,500 state-level members working through five state branches (Motihar and Gogoi 2009). Generally, PMNCH also stood to benefit strategically from strengthening links with an increasingly powerful country such as India.

Tightening links with national civil society networks through normative projects like *Deliver Now India* enabled PMNCH to replicate at speed with relatively few costs, as well as enhancing its perceived legitimacy to “speak for others” who bear social injustices. This added to the competitive position of PMNCH in establishing itself with donors and champions as an investment-worthy global platform in an increasingly crowded field of global health initiatives.

(2) Local mobilisation

The replication of PMNCH messages at the local level was aided by the White Ribbon network, which had strong connections with community-based organisations and long-standing experience to organise public hearings. White Ribbon’s guidelines advised network leaders to arrange preparatory meetings with key actors and to conduct information-gathering processes prior to the hearings; to prepare the meeting venue and public rallies to be held on the day of the hearing to attract public attention; to network with district officials and local women’s groups to encourage participation; to play an active role during and after the hearings to amplify citizen claims and to negotiate policy proposals; and

to disseminate outcomes, including by inviting media representatives to attend the hearings (White Ribbon Alliance 2008b).

Drawing on the experience of the safe motherhood *adalats*, the White Ribbon guidelines also prescribed the community partners how to communicate the importance and sobriety of a public “hearing” and arrange seating plans accordingly, while ensuring opportunity for informal, eye-to-eye contact between women, health workers and government officials to facilitate interpersonal communication and encourage mutual trust and respect (White Ribbon Alliance for Safe Motherhood India 2008b).

For instance, theatre-style rows of women, community health workers and village council representatives were to sit opposite a dais composed of local health workers, district-level health officials and other senior administrative authorities. The event chair, often the district’s senior-most administrator (“District Magistrate/Collector”), was supposed to sit at one end of the dais, with community speakers at the other. On the floor, specific constituencies were assigned specific seating areas, as per their function and role at the event, including local journalists invited to report on the outcomes of the hearing and to track whether commitments made were fulfilled (figure 7.1).

The formal seating plan for the public hearings – both fixed and hierarchical – reflects longstanding social norms. Powerful local officials retain their traditional roles as meeting chairs and panel members. The legal symbolism of terms like “respondents”, “hearing”, and “testimony” underlines the plaintiff’s right to be heard. If petty corruption, disrespect and abuse are so common as not to be seen, public hearings were designed to make the common appear uncommon and covert forms of power highly visible.

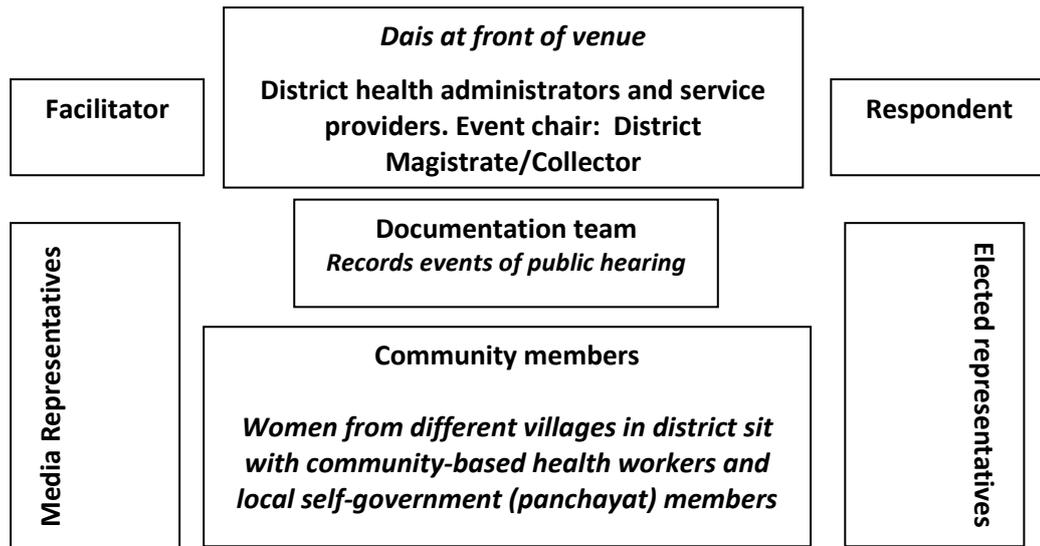


Figure 7.1: Seating plan for *Deliver Now India* public hearings in Orissa (White Ribbon for Safe Motherhood India 2008b)

Interviewees, including those from within the White Ribbon partnership, confirmed that public hearings were a high-profile part of *Deliver Now India*, requiring considerable effort, expense and skill to organise effectively (i5), although White Ribbon in Orissa deployed a wide range of other social accountability tools, including community monitoring of health facilities, scorecards, entitlement checklists, media engagement, etc.

Network members also underlined how White Ribbon in Orissa had built community trust over the years through its interpersonal communications campaigning, including by introducing a new style of political advocacy and social accountability work for maternal and newborn health based on interpersonal communications, community participation and mobilisation. PMNCH clearly benefitted from White Ribbon’s experience of interpersonal communications in the local context of Orissa, its access to community-based organisations and established trust relations with local society.

By contrast, some government and UN officers observed that most civil society actors in Orissa were focused only on delivering services to communities on reproductive and child health at the time when *Deliver Now India* was implemented in the mid-2000s (i16, i17). One White Ribbon member said:

“Before White Ribbon came along, no one was doing political mobilisation – advocacy was not on the agenda” (i15). Another commented: “White Ribbon has created energy and visibility. Partners needed a grassroots network to put certain agendas in the mind of government” (i13). “They have managed to create coordinated and cohesive relations between the state secretariat and the district coordinators. And they have the confidence of the government too” (i16).

(3) Government-network relations

At the June 2009 dissemination workshop and press conference to mark the end of the *Deliver Now India* public hearing campaign in Orissa, the national and state-level White Ribbon networks were the subject of admiring statements by state cabinet ministers, media, and development partners as they took the dais to speak:

The White Ribbon Alliance has taken a pioneering role in monitoring the maternal and child health programmes across the state through its alliance actors (Ghadei 2009)

My door is always open to you [White Ribbon] for redressing our infant and maternal health situation. I look to you to provide a “blueprint” for action in our common mission of reducing maternal mortality (Acharya 2009)

Even so, it was unclear why a civil society network – with its own internal strains, incapacities, and dependence on foreign funding – should be entrusted to “provide a blueprint” for a government – or indeed, why a government should like to promote an impression of dependence. Indeed, even senior government officials in Orissa spoke cautiously about tensions when “outside” social justice actors collaborate with “inside” actors such as governments (i8). One health bureaucrat in Orissa attributed harmonious relations with White Ribbon to the fact that the network rendered useful services to government by trading on their social ties. Revealing his relief that government had found a solution to managing the “messy” business of social relations, he said:

It is better that White Ribbon handles our maternal death audit project, because when Government handled it, people were not giving information properly. They (White Ribbon) are known people, so our local health staff is cooperating in sharing data. Our local staff were afraid to share when people from the district hospital tried to collect the data from them. ... They are not competitors, they are working with us. (i8)

Yet, as a partner of *both* communities and governments in interpersonal communication campaigns, White Ribbon traded on its social capital to reveal community grievances, raising potential risks to its relations with both: With government, in exposing bureaucrats and politicians to public ire, and with citizens, whom it may be unable to protect from social censure or official sanction when grievances are aired. An example of risk is evident in this comment from a powerful elected official in Orissa, who expressed barely concealed delight at what he had learned recently by attending a *Deliver Now* public hearing:

I was surprised to see the level of corruption in the doctor brought before me. The fellow was positively trembling! (i7)

Several respondents in this study noted that the price demanded of advocates who sit at the table with government is often one of silence, if not complicity, on topics of dissension. Favours and resources, however, may be doled out by the state and other powerful patrons to “tame” community struggles and maintain the status quo in the interests of ruling elites (McAdam 1982).

Some respondents commented on possible risks to White Ribbon of subordination, reinforced by financial need amidst the backdrop of health privatisation in Orissa, in which hiring NGOs and other private actors are often hired on lucrative contracts for service delivery: “There’s too much kow-towing to government and there is a risk of being co-opted” (i17).

Advocacy networks such as White Ribbon operate in a shifting space for civil society in India. Given India’s colonial legacy of top-heavy bureaucratisation and dominance of local governance institutions by rural elites, civil society groups

struggle to secure space to raise questions about state legitimacy, state ability to implement policies, and democratic participation (Tandon and Mohanty 2002).

The mediating role of the White Ribbon network in this process is illustrated in the following excerpt (figure 7.2) from the June 2008 public hearing in Bolangir district, attended by nearly 1,300 women, the District Collector (chief administrator), Chief District Medical Officer (CDMO), and other government officials (White Ribbon 2008c). The full transcript appears in Annex B.⁴⁴

⁴⁴ *Transcript available at:*
www.who.int/pmnch/activities/deliver_now_transcript_hearing_25june2008.pdf?ua=1

Woman in gold-red sari

When a maternal death occurs, our family is ruined. You, the Collector and CDMO, never feel the sorrow and panic that our families feel. You are meant to provide us with a quality service, but we are not getting it. So, whom do we hold accountable for maternal deaths?

First government official

We need to create awareness, empower women to demand their entitlements, take care of the nutritional needs of pregnant women, advise them to seek institutional care ... (cuts off)

Woman in gold-red sari

Answer us before you give any speeches. Can you identify one woman in this huge gathering who has given birth safely in a hospital without bribing a doctor?

White Ribbon leader

This is a problem we have found in all the districts. Women put the same question. You should demand your rights without giving bribes. If women are deprived, they should meet the Chief Medical Officer and submit a grievance in writing, and if possible, send a copy to the White Ribbon Alliance, so that we can follow up the case.

Woman in yellow sari

In every delivery, we only get the JSY incentive money after we have paid a bribe of Rs. 200. If we do not give them any money, they make things very difficult for us. The health department puts pressure on us to pay bribes. We are illiterate. We give thumb impressions. Even though you say there is a provision for free medicine in the hospital, we are not getting free medicine. We have to buy it from an outside store.

Second government official

Since the DSWO (District Social Welfare Officer) is not present, the question cannot be answered.

Figure 7.2: Example of community dialogue during a public hearing in Bolangir district, Orissa, June 2008

The perfunctory replies above by the two government officials at the *Deliver Now* public hearing illustrate a fundamental risk of social dialogue during the public hearing process – that underlying power structures and logic patterns that perpetuate inequalities are exposed but remain unaddressed, inculcating social cynicism and distrust. Community distrust may be directed to the state, but also to those who collaborate with it.

Even so, others who have conducted research on the White Ribbon public hearings (e.g., Papp, Gogoi and Campbell 2013) report that, in focus group discussions and one-on-one interviews with village participants, many community members saw the public hearings as a valuable space to come together and reframe their experiences of poor quality maternity care as a collective – rather than individual – problem. This research also supports the idea that, for some women, participating in a public hearing is an act of individual liberation and an expression of an emotional desire for social justice in the face of state indifference (Goodwin, Jasper and Polletta 2004).

The struggle of the White Ribbon Alliance in India to generate a collective consciousness around maternal and newborn health is shaped by the resources, structures and political opportunities at hand. Several respondents in this study, including those from donor and UN agencies, observed internal structural barriers and strategic issues that may undermine White Ribbon's ability to demand state responsiveness, both as an "inside" partner and an "outside" agitator:

They are poor at acknowledging their own weaknesses, including the lack of forum to address communication issues with regional reps – there is no board for White Ribbon in Orissa, for instance. This risks the disengagement of partners. (i13)

Quality of care is becoming our biggest issue, but to deal with this, you need technical credibility to influence policy – this is more important than external pressure right now. (i15)

White Ribbon faced considerable tensions in wearing two hats, one as government partner and collaborator, and the other as social critic. This dilemma often showed itself in relation to external communications and to the media, where public statements on the record are important to network reputation and issue-framing.

Network members at both national and state level worried about getting the media-state relationship right, and feared misrepresented by journalists:

We need to balance the carrot and stick approach. The government didn't speak to us for two months after we had a question raised in parliament. (i2)

Communicating through the media is very, very, very important to what we do, but it's tricky to manage. It can put a chill on our relationship with government if they think you have set up a journalist for a negative story – the Indian media loves bashing government. (i1)

Government officials support the public hearings – the district collector and the chief district medical officer take part, they agree to mobilise the police, the ambulances; they ask health workers to spread the messages. Our bigger problem has been with the media – they thought this was a political thing and wondered how much money was changing hands. We needed to persuade them to come and cover this as a proper news story. (i3)

Furthermore, civil society advocacy networks risk internal tensions in playing a dual “insider-outsider” role. They may be rewarded by governments for doing so, and offered a “seat at the table” in recognition of their service. Yet their capacity to achieve policy advocacy goals is not only a matter of their own agency, but how the structures around them enabled or constrained such agency.

For example, at the June 2009 *Deliver Now India* dissemination meeting, ministers in Orissa shared frank comments on their own struggles to achieve policy results:

The problem is that the political and bureaucratic classes can't work together. We must address this communication gap – the lack of convergence, the clashing egos ... In the past seven years, there has been

more than enough money – we can't use it all. Crores of rupees are lying unspent. There is no lack of money or policies in place. There is a lack of political will. We need more demand from civil society (Acharya 2009)

We have provided money in the budget; our main issue is implementation. We are seriously lacking political will in this state, including me. Look at Sri Lanka and see what they've done. Do we have less manpower? Do we have less money? (Ghadei 2009)

Every day, I have a new priority. Today, it's safe motherhood, tomorrow I'm going to a meeting of HIV/AIDs people and I might say something different. (Samal 2009)

Thus, the capacity of networks to achieve and sustain attention to their issues through interpersonal communications campaigns depends not merely on the degree of economic, cultural and social capital they possess, but also the wider policy environment. Clearly, improving issue-attention to women's and children's health also depends on strengthening health systems more broadly, as these district-based White Ribbon network members observed:

There can be as many as four or five chief medical officers in a district in a single year. The post is plagued by constant retirements. By the time he understands the situation, he is gone. (i4)

Challenging the corruption and non-attendance of doctors in districts is very difficult – they are an untouchable vote bank for political leaders. Doctors won't stay in the districts because they go for better-paid private work in the cities. ANMs [Auxiliary Nurse Midwives] don't have secure accommodation. People opt for district hospitals rather than local facilities because they perceive better service is there. (i3)

Linking the social, economic and political determinants of poor maternal health – here, expressed in terms of health system challenges – was regarded by several respondents as an important focus for White Ribbon going forward (i15, i16, i17).

(4) Civil society network reach

Many civil society networks, such as White Ribbon, are not only local but also global; resources and exchange relationships exist both upwards and downwards, spreading risks and opportunities for network growth and

coherence across wide geographies and multiple sites of power in global health (Kapilashrami and Baru 2018).

For example, *Deliver Now India* ended formally in 2009, but evidence and messaging on quality, equity and dignity from public hearings in Orissa have since infused global-level messaging (Kinney, Boldosser-Boesch and McCallon 2016) and triggered social accountability global events during the remainder of the MDG period.

Such events included public hearings in other countries and at the global level, produced by White Ribbon with other NGO partners from the PMNCH alliance, as well as consultations to inform the follow-up to the 2010 *Global Strategy* for the new post-2015 Sustainable Development Goal (SDG) era:

To date, over 100 Citizens' Hearings took place in over 20 countries, and recommendations from these events are being shared with ministers of health, ministers of foreign affairs, and other political leaders. The outcomes of the Hearings have also been submitted as feedback into the process for the updated Global Strategy for Women's and Children's Health and have been used to set the agenda for the Global Citizens' Hearing that was held at the World Health Assembly in May 2015. (White Ribbon Alliance 2017a)

From 2015, White Ribbon built upon its longstanding relationship with PMNCH on social accountability to organise an annual event on the side of the World Health Assembly (WHA) in Geneva: The "Global Citizen's Dialogue" event invites community representatives to travel to Switzerland to share their experiences at WHA, engaging with national health ministers and other senior global health leaders (World Health Organization 2015a).

Furthermore, outcomes of *Deliver Now India* and subsequent campaigns were reported online, and formalised in reports submitted to accountability mechanisms. This included the final report in 2015 of the independent Expert Review Group on Women's and Children's Health (World Health Organization 2015b) – an influential global accountability body operating during the final years of the Millennium Development Goals (2012-2015), which contributed to

the rights-based framing of the *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*, launched by the UN and partners to implement the SDGs (Kuruville et al. 2016).

To sum up, *Deliver Now India* not only extended the reach of the PMNCH-led global maternal and child health advocacy network to rural Orissa, thus expanding its power and legitimacy, but the campaign also helped White Ribbon Alliance India to influence policy ideas at the global level about the women's right to quality of care, and to build its own reputation and resources at the global level while doing so.

Discussion

The strategic provision of campaign resources through the *Deliver Now India* campaign by the global PMNCH-led network for its local-level replication and power, and by the local and national-level White Ribbon network for financing, global-level reputation and member retention, may at first glance be interpreted as rational mutual resource mobilisation. In resource mobilisation theories, rational actors are believed to seek out resources from others that they might otherwise lack in the process of trade and exchange (Oberschall 1973).

Yet capital resources may not be equal, and exchange processes cannot be produced without reference to the historically conditioned social structures in which they are practised. Bourdieu's social relations perspective therefore provides a better interpretation of the interaction between the global multi-constituency network for maternal and child health advocacy and the civil society network of White Ribbon.

One interpretation of this case is that, by providing economic and cultural capital to White Ribbon in Orissa, the still-emerging PMNCH network sought to gain access to White Ribbon's extensive network of partners at state and district level, to replicate its membership, improve its global reputation, and secure resources from donors. As a still-emerging partnership in 2007, reputational standing and financial capital were highly important to PMNCH.

White Ribbon's acquisition and exercise of global network capital, in turn, was habituated by the civil society network's own history and social position within the bounds of the field in which it was located. This included White Ribbon's position as a national branch of a global voluntary network, known for its media communications, champions, high profile public events, and interpersonal communication campaigns, such as those involving public hearings.

In this sense, the public hearings in Orissa were neither a game of roulette, "*offering at every moment the possibility of a miracle*" (Bourdieu 1986, p. 241), but a venue shaped by embedded assumptions about the prerogative of those with power, such as policymakers and doctors, and the limitations of those without. In confronting health systems in Orissa, White Ribbon used public hearings as a challenge to political indifference, breaking down social barriers to create "shared meaning" (West and Turner 2006) through mediated interactions among citizens, health workers, bureaucrats and politicians. For state officials, participating in public hearing offered a glimpse into the unguarded performance of health workers (e.g., "*I was surprised to see the level of corruption in the doctor brought before me*"), as well an official obligation.

This case found that White Ribbon played multiple roles: It was a channel through which social dialogue and communication took place; it was also an agent for change and active facilitator of that process. It was enabled to play these roles because of the trust and social capital it had accumulated through its work with network members as well as government leaders (e.g., "*I look to you to provide a blueprint for action*").

White Ribbon was enabled to play a trusted role with the *Deliver Now India* campaign because of its previous experience in coordinating the safe motherhood *adalats*, as well as its long-term investment in state relations. Interviewees (i15, i2) suggested that the accumulation of history and social capital with network actors through these previous activities enabled White Ribbon to acquire rapid community buy-in for the *Deliver Now* campaign plans.

In attempting to “make societies legible” and ultimately easier to comprehend and control, the state promotes social norms that prioritise “scientific” understanding of natural laws and simple quantitative measures, rather than “messier” social processes informed by experience, habits and histories (Scott 1998). As women in Orissa made “legible” their realities to a blinkered and/or arrogant bureaucracy through public hearing testimonies, they exposed the realities and consequences of one-size-fits-all government schemes designed in far-away New Delhi. The emotional burden of maternal and child deaths, the costs of corruption, and the loss of dignity were laid bare in these public venues, transmitted to further audiences by media coverage of the public hearings.

Thus, interpersonal communications processes, produced and expressed through public hearings, can be used by networks to structure social relations in both positive and negative ways. In a positive sense, public hearings organised by White Ribbon and supported by government offer the possibility of mitigating risks of one-size-fits all “high modernist” policies. They can strengthen civic self-expression as part of implementation, planning and monitoring processes. Interpersonal communication processes produced by advocacy networks such as White Ribbon may also act as a collective shield against the personal risks of protest, protecting individuals against reprisals by the state and other powerful interests.

On the other hand, civic advocacy networks, dependent on the ebb and flow of external financing, may trade independence and member trust (social capital) for capital infusion (economic, as well as cultural/reputational) from governments and other donors, including global networks (e.g., “*There’s too much kow-towing to governments*”).

Declining impartiality and social trust can undermine network expansion and influence. It can also enlarge space for greater state indifference and legibility. This may be so if public hearings themselves are perceived as a venue for hollow promises by officials, or a “kangaroo court” in which unproven claims trigger formal or informal reprisals (e.g., “*The fellow was positively trembling!*”).

Networks may indeed be “effective” by facilitating interpersonal communications between citizens and the state, but not always to the wider good.

While collective participation and social dialogue are necessary to social change, sharing personal stories and grievances in high-profile forums such as this may invite reprisals, whether at the hands of the health system or through the disapproval of family and neighbours. Those reprisals and punishments may not be meted out evenly – poorer, less advantaged women may feel their only option to be heard is to participate in a public forum, while higher-educated, better-connected women may not need to resort to public forums to be heard, even if they too suffer from poor health services and government corruption.

Further, findings from literature suggest that the health-focused format of the *Deliver Now India* public hearings themselves may have been insufficient to address the non-health related determinants of maternal inequities (Hamal et al. 2018). Cultural barriers to care-seeking, not addressed by state-sponsored health schemes like JSY in Orissa (Mahapatra 2015), may also be difficult to address in such venues, given the focus on accountability for state-sponsored programmes and policies.

Yet without official monitoring mechanisms for social accountability (e.g., public ombudsman offices, parliamentary monitoring and reporting, public rapporteurs, etc.), the simple dissemination of information or expression of “voice”, however important as a human right, remains inadequate to resolve policy bottlenecks and spur state accountability (Mansuri and Rao 2013; Banerjee et al. 2010). Similarly, social trust – essential to collective action – may be undermined if public hearings are perceived to be captured by elites or if citizen testimonials given at public hearings invites social embarrassment, sanction or public reprisals.

Conclusion

This study found that interpersonal communication campaigns can be an effective strategy for global health networks to improve civil society mobilisation and network coherence. Public hearing campaigns, activated through an extensive network of district-based civil society partners, may contribute to the development of reciprocal ties among community level network members in acting together to pursue shared interests.

This, as well as other forms of capital, enabled the Orissa-based White Ribbon network to use global campaign resources to seek issue attention for women's and children's health issues at district and state level, but also at global level in association with PMNCH and the global White Ribbon Alliance, including in powerful agenda-setting venues like the World Health Assembly.

Generation and exercise of power occurred at multiple levels, including through resource exchange processes among global and sub-national levels of the network. The role of White Ribbon at global level, in galvanising other NGO partners of PMNCH to disseminate messages based on Orissa public hearing evidence, suggest that interpersonal communication campaigns may also contribute to global network coherence and reach.

The global PMNCH network provided economic and cultural capital to the White Ribbon network in exchange for access to White Ribbon's extensive network of partners at state and district level, enhancing its own knowledge and credibility in "speaking for" the disadvantaged at the global level. White Ribbon in Orissa used its social capital with district-based network members to solidify its relationship with the global partnership through the *Deliver Now* public hearing campaign, raising economic capital for the social accountability programme it had long championed through the forerunning safe motherhood *adalats*, and thus sustaining district-level cooperation from its members and improving its public profile.

In this way, the global women's and children's health network benefitted in scale and influence from association with the local level network. Far from power being exercised by the global over the local, or by the state over non-state actors, this study found that power is multi-sited and that interpersonal communication campaigns offer an important lens for exposing the competitive tactics of actor-networks in seeking issue attention from an indifferent state (*"Every day, I have a new priority. Today, it's safe motherhood, tomorrow I'm going to a meeting of HIV/AIDs people and I might say something different"*).

Shiffman and Smith's framework on global health prioritisation is enriched by understanding how history, habit and capitals structure the ways in which actors are enabled to generate power. Network power depends not only on how skilfully actors deploy their capitals, but how they are habituated to act in relation to wider circumstances surrounding them.

This study is limited by lack of follow-up data about whether the women who participated in the *Deliver Now* public hearings felt gratified or punished for their risk in participating, and whether they saw the role of White Ribbon as positive or negative in this process. This data would be valuable in understanding the severity of risks to network cohesion and reputation over the medium or longer term in association with interpersonal communication campaigns. This study also lacks data on the ways in which the global-level effects of community-based interpersonal campaign experiences may have reverberated back to local level communities through civil society groups, and whether power had been generated among community members and local representative structures.

Yet findings from this study suggest limitations to civil society mobilisation as an element of network actor power, especially when risks occur to social trust, cohesion, and reputation if networks fail to secure capital and to use it effectively. These risks represent potential limits to network growth and influence. This may occur, for instance, when networks become habituated to certain ways of thinking and acting that enable some interests, but jeopardise others. This includes circumstances when civil society networks struggle to

address tensions inherent to balancing multiple roles as “outside” critic of government, as well as “inside” collaborator on state policy reform.

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Chapter 8: Discussion and conclusions

8.1 Introduction

Public-private advocacy networks, uniting policy actors through common causes and norms, have been an important feature of the global health landscape since the late 1990s. As discussed in this thesis, these networks, operating across geographic and disciplinary boundaries, have generated funds, solidarity, new technologies, and health system innovations. They have provided platforms for non-state actors to participate in global health decision-making, allowing space for multiple ideas, opinions and voices. This has enlarged democratic space, while also raising questions about legitimacy and accountability for influence.

The presence and use of power in global health is important to examine because cross-border networks are not subject to the rule of law, nor other features of democratic practice. Yet their practices contribute to how health is produced and experienced, and by whom. These practices help shape how certain issues rise to political attention, attracting budget and policy commitments, or are prevented from doing so. This agenda-setting influence is manifested in multiple forms, including which types of research are funded, which interventions are prioritised, and how accountability is practiced.

This thesis investigated the nature, characteristics and pathways through which global health networks have pursued attention for specific health issues. Study was focused on the UN Millennium Development Goal period (2000-2015) because of the rapid expansion of advocacy networks during this time, and on the global women's and children's health network, which gained in size and resources during this period, offering rich scope for study. Maternal and child health represented two of eight MDG goals, encouraging advocacy networks to use the global goals to focus their efforts.

This thesis does not investigate whether, and the degree to which, such networks directed overall political attention in the MDG era; multiple factors were likely at play, beyond networks themselves. Rather, what was of interest is how this network sought to sustain and enrich this attention through its strategic choices and behaviours, including the powerful ways in which it developed and used communication campaigns for this purpose.

In reviewing literature for this thesis, it became apparent that many approaches to agenda-setting mention power, but do not develop this concept. This was true of the guiding framework for this thesis too. Shiffman and Smith's framework on the political determinants of global health (2007) offered an important starting point to thesis research because of its well-tested approach to analysing the agenda-setting influence of global health networks; yet an absence of attention within the framework to power and contention among network actors offered opportunity for conceptual development of how and why power is developed and exercised.

For this reason, political and social theory from Sabatier (1988) and Bourdieu (1986, 1977) was used in this thesis to enrich and complement the Shiffman and Smith approach by understanding how power is produced for issue attention. The spatial and scaled ways in which this occurs was investigated through "social ecology" concepts of the dynamic between social behaviours, communication campaigns, and wider policy environments (Maibach, Abrams and Marosits 2007). In bringing health communication literature together with health governance literature, this thesis aimed to bring attention to the contribution of communication campaigns to the production and exercise of global health network power.

The study of communication and power is valuable to global health because such dynamics often remain unseen or unaccounted for; powerful frames and campaigns are not subject to tests of legitimacy or credibility, and network decision-making processes are not always open to scrutiny. Close analysis of how

power is created and used through these processes can enable transparency and accountability.

Literature review also guided the development of specific research questions (below). That review included the examination of historical contexts and processes that led to the development of prominent networks, champions and campaigns in the MDG era. On a practical level, the author's professional involvement in the global women's and children's health network, as a secretariat member of the Partnership for Maternal, Newborn & Child Health, facilitated the collection of case evidence through participant-observation methods, in addition to other, mostly qualitative, methods such as document review, semi-structured interviews, and analysis of survey data. While this experience may have had limitations of bias, it was felt that insights gained were instructive to overall research purposes.

Literature review also assisted in identifying communication campaigns as a window into the development and exercise of influence by global health networks. This is because campaigns act as arenas of both normative and interest-based struggles among competing global health actors and networks, enabling influence and power to be seen. The author's experience in designing and producing communication campaigns, including in Orissa and together with the Government of India and non-state partners, also contributed to the development of guiding questions about the role of network-based campaigns as an instrument through which power is exercised, as well as an arena in which power relations shape how campaigns are developed among network members.

This thesis was constructed as a set of four linked research chapters (chapters 4-7), each responding primarily to one of four main study questions relating to the overall research question of the thesis on how global health advocacy networks seek issue attention:

- *What was the role of the global women's and children's health network in influencing attention to these issues during the MDG era?*

- *How does conflict and negotiation between network members influence actor-power?*
- *How do networks use media campaigns for issue visibility and for augmenting network power at different scales?*
- *How do networks use interpersonal campaigns to increase network growth and power to gain issue attention at local and national levels?*

Data organisation, analysis and case discussion in this thesis were guided by the Shiffman and Smith framework, which highlights the interplay of actor-power, ideas, political contexts, and issue characteristics in explaining how global health priorities are established. Also, Shiffman’s later work directed attention to the concept of “productive power” produced by actor-networks through the knowledge forms, discourses and frames they negotiate and champion (see chapter 2.4). Such forms of power, often difficult to interrogate, are deeply embedded in the daily practices of networks. This, too, became a guiding concept in this research, since communication campaigns can be understood as important mechanisms for conveying productive power.

The remainder of this chapter will summarise and discuss the findings of the four research papers (chapter 8.2); reflect on the overall contributions of this thesis, particularly in terms of the conceptual approach and the theoretical framework (chapter 8.3); point to future challenges and research directions in the era of the SDGs (chapter 8.4), and to policy implications (chapter 8.5).

8.2 Summary and discussion of findings

This study found that communication campaigns are both a driver and product of global health advocacy network actor-power. Campaigns unite heterogeneous actors through the production of shared messages and normative claims; they promote visibility for network messages and goals; and they contribute to network growth and replication by linking actors across different scales, from local to global, and vice versa.

In producing these campaigns, this thesis found that the women's and children's health network in the MDG era behaved in highly competitive ways, populated by members vying for dominance based on their ideas, beliefs, histories and resources. The complex interactions of policy network members, across multiple spaces and scales of activity, were shaped by the political and social environments in which they were located, as well as by their disparate histories, ideas, beliefs, resources and constraints.

This thesis found that communication campaigns catalysed ideational debate, and produced shared resources that were instrumental to the pursuit of issue attention, including campaign frames, messages, and strategies. This enabled the global women's and children's health network in the MDG era to strengthen bonds among members across different sites of campaign activity, from sub-national to global.

Examples of such processes are discussed below, with reference to findings drawn from chapters 4-7. The first of this sub-chapter synthesises results from chapters 4 and 5 at the global level; the second part summarises those from chapters 6 and 7 on the interactions of global networks at (sub-) and national levels; and the third part sums up overall finding of the thesis.

Global-level networks, coalitions and campaigns

Chapters 4 and 5 traced the evolution of advocacy networks related to women's and children's health with reference to the policy context of the MDG era and the construction of ideas and frames at the global level.

Chapter 4 found that the global women's and children's health network deployed techno-managerial concepts, frames, and evidence forms to strengthen network claims for attention during the MDG era. Such frames drew upon positivist forms of knowledge found in disciplines such as the natural sciences, common in the study of medicine and public health, and were disseminated through the framing of scientific articles and authoritative commentaries published by network leaders in highly cited medical journals as the *Lancet*, as well as global reports,

strategy documents, conference presentations and other forms of policy communication produced by network members. Knowledge products related to quantitative estimates of health status, financing, and intervention coverage – for instance, as produced by the highly respected Countdown to 2015 research group – were more frequently discussed in the network than research based on qualitative concerns, such as quality and experience of care, barriers to equity, and related policy/legislative bottlenecks. This may have reflected, in turn, the funding priorities of research donors, but also the neoliberal orientation of the MDG framework itself, which was often used by the network to justify action.

In general, this paper found that moral and human rights frames were not prioritised in messages produced by the women’s and children’s health network during the MDG period. Discussion of the social determinants of health, including dimensions of power, was also scant. One possible explanation is that rights-based frames and explicitly political discourse courted the risk of dispute and disagreement among heterogeneous actors seeking to advance quickly to achieve progress together against the 2015 MDGs. Also, a field with a long history of dispute over technical strategies and priorities, as seen in the safe motherhood movement in the 1990s, avoidance of conflict in the women’s and children’s health network may have been both cultural and tactical.

In contrast, scientific and technical frames were promoted by network leaders as robust, evidence-based, and therefore reliably “free” of politics. Yet such frames can be understood as a hidden form of productive power (Shiffman 2014), and a deliberate effort of network leaders to depoliticise dialogue and reduce the “messiness” of debate. For instance, network leaders, many from medical and public administration backgrounds and fewer from disciplines like law or sociology, often framed progress in terms of supply rather than demand: population coverage of biomedical interventions, evidence on effective delivery strategies, and costing of health packages were frequently discussed in the pages of the *Lancet* and at global conferences.

Less commonly discussed in such venues during the MDG era were the rights and entitlements of those most at risk: for instance, adolescents at risk of early marriage and early pregnancy; women with unmet need for contraception and abortion; women and children in conflict and humanitarian settings; and all others whose health in general depended on the fulfilment of rights and entitlements outside of the health sector, including access to education, water and sanitation, public infrastructure, political representation, and protection from violence.

Yet suppression of debate, and a reliance on neutral, “evidence-based advocacy” within the network, may have introduced opportunity costs by limiting progress on structural issues that depend upon debate and consensus for action, including issues such as entitlement to abortion and sex education; inequities in health status based on gender, race, and culture; and the need for good governance and practices of state accountability that induce remedies to problems, and not merely review.

During the MDG period, the network produced a new coordinating platform, the Partnership for Maternal, Newborn & Child Health, founded on the principle of a “continuum of care” conceptual framework uniting the differing stages and conditions of reproductive, maternal, newborn and child health (RMNCH). While this framework focused on the role of the health system in providing care, and not on the underlying social and economic determinants of health, evidence from this thesis found the RMNCH continuum of care framework to have been a unifying device for disparate professional constituencies within the health sector, contributing to network coherence.

Chapter 4 concluded that while the global women’s and children’s health community had succeeded in expanding attention during the MDG era, the arrival of the 2016-2030 SDGs presented both opportunities and risks for future network cohesion. The type of evidence, frames, messaging, and leaders that attracted attention during the MDG period may not be effective in a different political era, with new norms and priorities. How maternal and child health

advocacy network actors realign, readjust, and renegotiate their frames and strategies in response to the SDG targets would determine how effectively the network will proceed. This supported Shiffman and Smith's finding that global health issue attention does not rise and fall of its own accord, but is produced with respect to how networks choose to communicate, cohere, and strategise within certain contexts and in relation to certain issue characteristics.

Chapter 4 demonstrated the importance of political context to communications produced by the women's and children's health network in the MDG era. Yet, these findings alone do not reveal *how* network choices are negotiated: What are the hidden, unacknowledged struggles within networks that shape network behaviours and choices? This thesis drew upon Sabatier's Advocacy Coalition Framework to guide analysis in chapter 5, highlighting the role of network contention through competing beliefs and ideas in the development of the 2010 *Global Strategy for Women's and Children's Health* and the related *Every Woman Every Child* campaign.

This case found that the *Global Strategy* was produced through constructive competition between two coalitions of actors within the global women's and children's network – one concerned primarily with maternal, newborn and child health (MNCH), and one concerned primarily with sexual and reproductive health and rights (SRHR). The two coalitions shared a common view that women and children deserved greater attention, but differed in their histories, resources, and core policy beliefs.

For example, the MNCH coalition believed the lives of mothers and children could be saved through greater, and more efficient, applications of technical expertise, money and data, drawing upon the MDG framework as a guiding resource. The SRHR coalition, initially less influential in the MDG era, focused on recognising and realising human rights for women and adolescents more generally, not only in women's capacity for childbearing, and through the development of protective legal measures and legislation, drawing upon rights-based treaties and frameworks.

Case findings revealed considerable debate and contention between two competing coalitions. Despite their differences, MNCH and SRHR network members agreed in 2010 to collaborate in producing the *Global Strategy/Every Woman Every Child* campaign to capitalise on the opportunity of the MDG momentum and championship of the campaign by the UN Secretary-General. Collaboration was encouraged in part by the emergence of PMNCH as a brokering platform.

This paper found that campaign collaboration was beneficial to both coalitions, attracting written commitments for financing, policy and service delivery to implement the Global Strategy that benefited both SRHR causes and MNCH causes. Over time, the SRHR rights-based coalition also found tactical benefit in adopting positivist forms of economic and biomedical-based messaging that had proved powerful for the MNCH coalition, drawing on MDG framing.

Yet process of contention and debate within the network during the MDG period challenged the dominant MDG discourse on health, as SRHR advocates questioned whether health is a product of technical and managerial inputs, or rather of social relations, including gender bias. This also encouraged the global women's and children's health network, long dominated by MNCH leaders, to think more critically about its advocacy "asks".

The updated *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* reflected this shift, and positioned health as a universal human right, contingent on attention to all stages of the reproductive life cycle. Unlike the 2010 *Global Strategy* in the MDG era, health was not defined as the absence of mortality and the product of efficient supply-side inputs directed at southern populations. Rather, health was seen through an SDG lens of universal well-being, rights and accountability for everyone everywhere, whether in Chicago or Kinshasa, contingent on effective partnerships between health and non-health actors.

Such shifts in network frames may be understood to reflect the incipient pressure of the rights-oriented SDGs, and/or contestation of the SRHR coalition to accept the normative conflation of “women” with “mothers”, putting pressure on MNCH members of the global network to broaden their appreciation of rights-based approaches to health, as well as of the social and economic determinants of health.

In conclusion, this paper found that communication campaigns act as venues for productive competition among network members, forcing member realignment and reframing that can be helpful to networks in responding to shifting political contexts. Network contention and debate served a productive purpose in the case of the *Every Woman Every Child* campaign. The redevelopment of the *Global Strategy* points to the adaptive capacity of the global women’s and children’s health network. In this chapter, campaigns can be understood as bounded arenas in which contention and normative debate take place, as well expressions of network power.

Global-local health advocacy network interaction

In chapters 4 and 5, power was examined through a global lens, looking at global-level coalitions of actors cohering across heterogeneous disciplinary, epistemic, and thematic interests. In chapters 6 and 7, the multi-level, multi-sited nature of network actor-power was a guiding theme for exploration, i.e., among and between global and local sites of health policymaking. Together, these chapters found that power relationships between global network actors and policy structures are formed not only within the global space, but also through linkages at national and sub-national level. Such linkages influenced issue visibility and promoted network replication at sub-national and local levels.

India was selected as the case site for these chapters because of the weight it brings to the global burden of maternal and child mortality, as well as its active policy interests in these issues during the MDG era. Because health planning and financing is decentralised in India, policy influence and power relations have broad scope, occurring within and among different levels of the health system

(national, state, district, block, village), as well as in relation to external actors, including those at global level. This offers rich scope for study.

Applying communication campaigns as a lens for study, the two chapters looked at differing forms of campaigns, and how power was represented in them, in Orissa, where high levels of maternal and child mortality prevailed during the MDG era. Chapter 6 analysed a mass media-based campaign organised by the global network to improve maternal and child health behaviours at household level; chapter 7 looked at a parallel campaign in Orissa, organised by the White Ribbon civil society alliance in Orissa, to encourage women to demand their rights and entitlements to quality maternity care. The global network instigated and financed both campaigns in 2007-09 as part the global *Deliver Now for Women + Children* advocacy campaign, working in partnership with India-based media, government institutions and civil society organisations.

The investigation of the mass media campaign in chapter 6 is undertaken through a social ecology framework from the field of health behavioural communications, Maibach, Abrams and Marosits's "People and Places Framework for Public Health Influence" (2007). This approach complemented the Shiffman and Smith framework by guiding analysis of how global networks develop and exercise influence at multiple scales, including in relation to wider policy environments. Thereby, mass media campaigns were conceptualised as a strategic approach used by global health networks for issue visibility, membership development, and developing and exercising actor-power at scale.

The paper found that the *Deliver Now India* mass-media campaign (2008-2009) enabled the global network to disseminate messages successfully to media audiences in India, with potential evidence of public demand for policy action, contributing to global network goals of community-level network replication and policy influence. At the same time, negotiations between the global network, national media organisations, and state-level health policy actors in Orissa changed global network strategies in important ways, including those related to campaign financing and message control. Global campaign resources

represented a strategic opportunity for local policy actors to capture and repurpose such resources for their own needs.

This study also found that local media had the capacity to lend or deny resources to global networks underlining the duality of media as a passive channel for message dissemination, as well as an active agent that influences how power is constructed and used by networks. In this way, mass media may be a force for network accountability, as well as a catalyst of social processes that put pressure on policy environments for reform and accountability. Yet as an actor with its own power, incentives and agendas, media can also hinder such processes, disrupting network strategies and plans.

This case in Orissa reflected the influence of national health policy and media environments on global health networks. Power was seen to operate at multiple scales and in multiple directions, not only from global to local, but from local to global. This case found that this multi-sited, multi-directional development and transmission of network power was based on public-private resource exchange, growth, and accountability, including through the potential instigation of social dialogue and “collective efficacy” attitudes through mass media campaign exposure. This finding suggests that collective efficacy, generated through behavioural change campaigns directed at individuals, may also be a precursor and a determinant of network strength. This finding assists in bridging a conceptual gap between behavioural change communication campaigns, usually considered at the level of individual impact, and media advocacy campaigns, usually considered at the level of social/environmental impact.

Chapter 7 builds on the concept of person-to-person communications, introduced in chapter 6. This paper examines how an interpersonal communication campaign can also be an instrument for civic mobilisation, producing powerful effects on network cohesion and influence at differing scales, global and local. The *Deliver Now India* social accountability campaign in 2008-2009 was based largely on a set of “public hearings” in district capitals of Orissa involving some 15,000 women. The interpersonal communication campaign was

designed to improve health system accountability and generate heightened awareness among women of their rights and entitlements to quality maternal and child health care.

This chapter used Bourdieu's social relations theory to analyse case data, based on his concept of differing and unequal forms of "capital" (economic, cultural and social) generated and exchanged across different scales, i.e., between the civil society partners of the Orissa-based White Ribbon Alliance for Safe Motherhood and the global Partnership for Maternal, Newborn & Child Health (PMNCH), which had instigated and funded the *Deliver Now India* campaign.

This case found that the Orissa network relied upon global network capital to finance interpersonal communication campaign activities, provide technical expertise through links with the WHO, and enhance its reputation, locally and globally. Collaboration with the civil society network in Orissa also contributed to the goals of the global network: It introduced community-level evidence and messages about the importance of quality of care to important global policy audiences, and contributed to network practices in social accountability. This also strengthened PMNCH's claim to legitimacy in facilitating the views of disadvantaged women and children. This demonstration could be used as evidence to donors and other influential global partners about the "value" of PMNCH, still new and struggling for credibility at the time of the *Deliver Now* campaign in 2008-2009.

Thus, network "capital" stocks, deployed through campaigns, act as competitive resources to enable networks to improve their position. This paints a picture of advocacy networks as not only normative and value-driven, but rational actors with material interests in resource mobilisation and reputational power.

In conclusion, the accumulation of network power depends on how skilfully actors deploy and exchange their capital, as well as on how they are habituated to behave in relation to their environment and circumstances. Resources exchanged between global and local actors assisted in the transmission of

district-level evidence and messages to the global level, and in the provision of campaign financing from the global to the local level, sustaining social trust and capital among members of the state-level alliance. But risks may occur to the sustainability of network power in respect to such relationships.

Findings from interviews suggested that network economic capital stocks may be threatened by dwindling amounts of campaign financing; or network social capital may be threatened by perceptions among network members of too much “kow-towing” to government, occurring in the struggle to balance tensions among network members who seek greater “inside” collaboration with policymakers to influence policy priorities and those who believe “outside” campaigning is essential for driving state accountability and transparency.

In this sense, too much collaboration with the state can weaken civic capacity to demand redress unless there are clear checks and balances within civic networks, including a history and culture of internal debate and self-reflection. This case, therefore, raises questions about risks to network coherence if internal accountability and governance structures are found wanting.

This study lacked follow-up data to understand repercussions of the *Deliver Now India* public hearing process. For instance, community members participating in the public hearings also risked loss of time, income, social status, and potential reprisals if their experiences and stories were not valued or denied. Policymakers may participate in public hearings only to demonstrate “responsiveness”, which may not affect actual policy or behaviour. This can perpetuate inequalities in power, and risk network coherence and motivation when success is not evident. Future study of community-level mobilisation processes will benefit from attention to these factors in studying the contribution to network actor-power.

Overall findings

In responding to the main question of this thesis: *How do global health advocacy networks seek issue attention?*, this study identified the important role of social relations and communication in the production and exercise of actor-power at multiple levels. It also found value in combining existing theories and frameworks to organise multiplicity of data. If power can be seen, it can be scrutinised for effect. Thus, in concluding that global health networks seek issue attention through complex, iterative social communication processes, power in global health is made more visible and offered to account.

By using communication campaigns as the primary lens for the study of the global women's and children's health network, this thesis undertook close examination of ideas, discourses, strategies, and tools used by global networks, including at differing scales. Mass media campaigns enabled state-level saturation and reach of network messages, with potential to contribute to community mobilisation processes. Interpersonal campaigns contributed to social trust and mobilisation in Orissa, as well as to the expanded reach of local level evidence and messages to the global level. In both cases, the global network, interacting with national and state-level policy actors, facilitated increased policy dialogue and exchange, contributing to public debate and improved accountability.

More specifically, this study found that communication campaigns have two main functions in relation to network power: one, as a participatory venue for network idea production and framing (chapter 4), including through contention and debate of contrasting policy ideas among network members (chapter 5); and two, as a tool for influencing the dissemination of policy ideas at scale, including through citizen knowledge and social mobilisation catalysed by the mass media and interpersonal communications processes (chapters 6 and 7, respectively).

Such processes may contribute to reducing inequities in global health by raising attention to neglected issues. However, they may also detract from greater

accountability and improved global health governance when network power remains invisible and unexamined.

Network communication campaigns contribute to the production of network power, as well as result from network power. Inequalities in power among different network members are rarely acknowledged in public discourse. This is partly because norms within this network strongly encourage consensus and discourage public dissent, even though policy beliefs and priorities among network members may differ substantially, as discussed in chapter 5.

Campaigns assist networks in producing this power, influenced by wider political contexts and issue characteristics. Chapter 4 demonstrates that the global maternal and child health advocacy network increased its power by producing campaigns that echoed the neo-liberal norms of the MDGs, disseminating technical evidence that prioritised supply-side interventions and suppressing debate on human rights-led approaches, which could stir network conflict and disturb network coherence.

In that chapter, the *Global Strategy for Women's and Children's Health* campaign was found to have contributed to the visibility of inequities facing women and children, but may also have perpetuated and disseminated normative network beliefs about health policies and systems as technical inputs to mortality reduction that resulted in reinforcing traditional ideas and hierarchies. This may have suppressed discussion of health as a social process through which human rights and wellbeing are produced and sustained, reducing opportunities for innovation and change, and for new partnerships outside the health sector and new policy approaches that could challenge health inequities.

Network accountability efforts in the MDG period, such as evidence reports produced by the Countdown to 2015 group, were influenced by MDG and network norms in tracking data and measuring trends on intervention coverage. While highly respected and widely cited, Countdown's data and measurement work on a narrow band of technical indicators neglected the development and

use of qualitative measures that may have contributed to shifting norms on accountability during the MDG era, recognising the wider social and political determinants of health. At the same time, the multiplicity of data and measurement reports in the MDG era, supported by donor interests, contributed to overlap and duplication in the global health architecture, placing burden on country health systems.

In this respect, campaigns hold potential to be participatory venues for debate of norms, as discussed in chapter 5 in relation to the development of the *Global Strategy* and in chapter 7 in relation to community-level public hearings on maternal and child health. Civil society members within multi-constituency networks can play an important role in this process, especially in challenging donors, governments, multilateral agencies and others to consider how alternative approaches (e.g., rights-based) to health can protect and promote human development. Yet disparities in power among constituency groups within global health networks can suppress such conflicting perspectives. As noted in chapter 4, it was not until eight years after its launch, in 2013, that a civil society chair was appointed by PMNCH, even though such groups constituted two-thirds of its membership by number.

Lack of transparency can also apply to financial resources raised by communication campaigns. By 2015, the *Global Strategy for Women's and Children's Health* attracted USD 60 billion in financial commitments and more than 425 individual written pledges from more than 300 different organisations, including nearly 80 national governments⁴⁵. Yet analysis showed a total of nearly 50 pledges were made to India and South Africa, neither of which appeared on the list of 49 low-income countries prioritised by the *Global Strategy*. Less than

⁴⁵ *Partnership for Maternal, Newborn & Child Health (2015)*. Partnership for Maternal, Newborn & Child Health 2015 accountability report: strengthening accountability: achievements and perspectives for women's, children's and adolescents' health. Available at: https://www.who.int/pmnch/knowledge/publications/pmnch_report15.pdf. [Accessed 15 January 2019].

15 commitments in total were made to Somalia and Chad, both among the 49 “high priority” countries⁴⁶.

In this sense, the *Global Strategy/Every Woman Every Child* campaign reflected prevailing donor preferences, and perpetuated lack of attention to countries most in need of improvements to women’s and children’s health. Such campaigns are forged through highly political negotiations and trade-offs rarely discussed in the public domain, making it difficult to assess how decisions are made, led by which network members, and through which types of capital – economic, cultural or social.

This dissertation also identified the need for effective policy dialogue venues to advance accountability of the women’s and children’s health network. Global health networks may intervene decisively in global health, but it is often unclear on whose behalf they do so, with what legitimacy, and on what principles. The launch of the Commission on Information and Accountability for Women’s and Children’s Health at head of state level in 2011 marked the advent of greater attention and investment in the development of shared accountability principles, priorities and indicators. Yet in practice, there is scant evidence of how such mechanisms have influenced network norms and practices in the MDG era. Under-investment in national health information systems and social accountability processes continued apace in the MDG era, as chapter 4 found.

An under-recognised venue for improvements in independent accountability is mass media, including social media. As discussed in chapter 6, the independent decision of media actors and organisations to lend or deny support to network claims can curb or redirect network behaviours, affecting agenda-setting efforts. Networks that do not prioritise media engagement may be unable to transmit their messages at scale and attract new members, including those who participate through social media.

⁴⁶ *Partnership for Maternal, Newborn & Child Health (2012)*. PMNCH 2012 report: analyzing progress on commitments to the *Global Strategy for Women’s and Children’s Health*. Available at: https://www.who.int/pmnch/topics/part_publications/2012_pmnch_report_full_publicaton.pdf. [Accessed 15 January 2019].

Lack of media engagement also reduces opportunities for debate, self-reflection, and innovation, since media-based campaigns may promote participatory learning. While Keck and Sikkink (1998) describe transnational advocacy networks as sites for collective ideation, strategy and action among *organisations* collaborating across borders, this case suggests that *individuals*, not only organizations, can be facilitated by media campaigns to contribute to this struggle, even if they may not consciously identify themselves as “activists” or become formal members of advocacy organisations.

The young mother in Orissa who speaks to her friends and family about the role models seen in the *Deliver Now* TV spots, or the women in the gold/red sari who protested her mistreatment by public health system during the public hearing in Bolangir, can contribute to shaping positive community norms about community health leadership, bringing greater pressure on local policymakers for health system reform. Bringing their social networks to the service of campaign goals, Orissa’s young mothers can be active grassroots members of the global women’s and children’s health network, localising its effects in their day-to-day actions.

More people in more places access media than ever before. Yet despite the potential influence of media on network accountability and effectiveness, the subject receives scant attention in health policy literature. Evidence presented in this dissertation suggests that media-based communication processes do indeed contribute to, and reflect, network power. How such effects occur differ by medium (e.g., print, TV, social media, etc.). How media may be incentivised to recognise and interrogate network power in global health, and how networks may partner effectively with media, are important questions for future agenda-setting research in global health.

This dissertation also indicated risks and threats to network stability in relation to internal, or mutual, accountability norms within advocacy networks. The case of the interpersonal communications campaign on social accountability led by the White Ribbon Alliance in Orissa, India, suggests that networks use communication processes to inculcate mutual trust and social capital, although

such capital may be dependent on other type of capital flows for sustainability, such as economic capital in the form of sustained campaign financing.

Mutual trust can promote mutual accountability, but disagreements on network strategy and positioning can also threaten such trust. In chapter 5, contention and debate can be productive sources of network power because competition between network members can generate timely and innovative responses to shifting political conditions. Dissension can disrupt network power when conflict causes members lose trust and confidence in network goals, strategies and/or leadership. The tensions within the White Ribbon Alliance in Orissa in balancing competing roles as government watchdog and government collaborator suggest that network power is affected by ebbs and flows in social capital.

The imperative of maintaining member coherence and collaboration for network effectiveness can therefore act as a form of internal accountability pressure, with members subjecting network leadership and strategies to scrutiny. Effective governance mechanisms within networks can provide a venue for members to express concerns, agree intentions, and propose remedies and redress.

8.3 Conceptual and theoretical contributions

This thesis generally affirms Shiffman and Smith's framework as a valuable conceptual tool for analysing how and why the global networks seek issue attention. The framework facilitated the collection and categorisation of evidence about network agency (e.g., network actor-power and ideas), as well as network structure (e.g., political context and issue characteristics).

In 2016 – after some conceptual retooling – Shiffman called for an integration of social and political theory in the framework to better understand how actor-power, ideas, and policy environments interact. This thesis took up this call by bringing together theoretical and conceptual literature across different disciplines, including international relations perspectives in global health governance, social-behavioural perspectives in health communications, and

general social and political theory. This included sociologist Pierre Bourdieu's theory of social relations (1986, 1977) and political scientist Paul Sabatier's advocacy coalition framework (1988). In doing so, the thesis has built upon and enriched the original 2007 framework through the analysis of how processes of conflict and negotiation influence network power and issue attention.

This effort has added to the framework in three main ways:

One, it draws necessary attention to the competitive, highly political ways in which "actor-power" arises within networks. Key theoretical concepts from political and social theory (e.g., norms and beliefs as competitive assets deployed by networks; economic, cultural and social capital as structuring forces for actor behaviour) assisted in explaining how framework variables interact and together promote issue priority. Internal politics influence the external behaviours of global health networks. Success in balancing and reconciling internal tensions determines how effectively networks can address external challenges.

As demonstrated in this thesis, conflict within networks influences network effectiveness. Shiffman and Smith identify civil society mobilisation as a key factor in producing actor power, yet this dissertation highlighted how tensions within civil society-based advocacy networks can also undermine network power, including when members disagree on the importance of collaborating with government versus opposing government, or when networks are forced to behave in ways that attract one type of capital (e.g., campaign financing), but may undermine other types of capital in the process (e.g., social cohesion or reputational image). Civil society-based networks and campaigns that are dependent on the patronage of donors or governments may be particularly vulnerable to disruptions in member coherence and effectiveness for this reason.

Two, this thesis adds spatial and scalar dimensions to the Shiffman and Smith framework by demonstrating that global network power is multi-level and multi-sited, cohering not only in Geneva or New York, but among coalitions and members located at varying levels of the health system, from sub-national to

global, shaped by wider environmental conditions. Social ecology behavioural concepts enabled network choices and actions to be understood as products of multiple interactions at multiple levels, dispersing power throughout health systems, from village to global, and back again. This dissertation found that agenda-setting processes occurred at national and sub-national level as a result of global investment of campaign funds, technical inputs, and reputational assets in national and sub-national domains.

However, this is not a one-way street: global network ideas and structures are also shaped by local social relationships, evidence, and accountability approaches emerging from sub-national networks and their interpersonal communications campaigns. This underlines the growing inseparability of health actors across borders and geographies, as well as the need for global governance structures to acknowledge that global health is co-produced through interaction of actors at multiple, simultaneous levels, and not only in New York or Geneva.

Third, and finally, this thesis focused on an under-addressed topic – the contribution of communication campaigns to global health networks – and introduced campaigns as a lens for the study of power relations within and among such networks. This research affirms the study of health communication campaigns as an important arena in which power relations take place through the production of campaign frames, messages, champions, discourses, and knowledge products. Although campaigns are technical tools for health promotion and behavioural influence at individual and community levels, they are also powerful venues for political change with global system-wide impact. Communication campaigns can promote issue visibility, strengthen network alignment and increase the speed and scale at which networks can expand. Media is an important facilitator of linkages between global networks, national and sub-national networks, and individuals.

As found in this thesis, communication campaigns can catalyse the productive interaction of disparate actors, including through processes of normative competition and frame negotiation, which is integral to innovation and network

repositioning during periods of instability and transitions in external political environments. This can be a positive force to improve network coherence when actors are incentivised to cooperate. However, such incentives are not permanent in nature and may be negatively affected by lack of network financing or other forms of capital, encouraging member tensions and conflicts to surface. Such findings highlight the importance of communications and capitals to the Shiffman and Smith understanding of actor power.

Media influences the health behaviour of individual actors, but also that of social networks, communities and policy environments, making it a powerful resource for both network advocacy and accountability. Behavioural change health media campaigns are not only controlled instruments that instruct individuals what to think and how to behave in standardised ways. As catalysts for social dialogue and engagement, they may also produce social and political behaviours that strengthen demand for issue prioritisation, health policy implementation and accountability.

These three insights -- on the productive force of network contention; on multi-sited locations of power; and on the value of communication campaigns to the study of power in public health -- enable speculation on the future of the global women's and children's health network and its capacity for issue influence.

8.4 Reflections on network challenges in the SDG era

While the global women's and children's health network grew in scale and resources during the MDG era, this thesis suggests it may be hampered in adapting to the SDGs because of engrained resistance to open policy conflict, lack of collaboration with non-health actors, and a history of dominance of technical leadership and framing strategies. Despite recognition of need, efforts to broaden links with other sectors and networks are yet to succeed. Also, recent efforts to prioritise human rights frames, internal and external accountability mechanisms, and civil society leadership are still largely untested in the post-2015 SDG era.

In recent years, the proliferation of national authoritarian populist governments, aided by like-minded civic and media organisations, have challenged attempts by more liberal civil society networks to establish and protect rights-based norms. This occurred in the MDG era, when reproductive health was kept off the agenda for several years by a combination of determined states and conservative allies. This suggests that, while UN accords may be an important structural determinant of policy attention, actor behaviour and *habitus* is at least as important, if not more so.

In October 2018, the principles of the 1978 Alma-Ata declaration were renewed in Astana, Kazakhstan on their 40th anniversary, and framed in relation to universal health coverage (UHC), recognising how politics shape individual, community, national and global health. In accepting a human rights approach to health accountability, echoing the more political narrative of UHC and the SDGs⁴⁷, members of issue-specific health partnerships such as PMNCH may find themselves grappling with debates about where women and children “fit” within the holistic agendas of primary health care (PHC), UHC and the SDGs.

Similarly, PMNCH’s conceptual allegiance to an RMNCAH continuum of care approach is now confronted with rising popularity of a “life course approach” to health, embedded in the UHC framework, and predicated on the importance of good health at every stage of life, both as a human right and as a contribution to wider social and economic development. Defending a prioritised focus on RMNCH may be difficult in an era of increased attention to the settings in which suffering takes place. For instance, in conflict and humanitarian settings, it is difficult to argue that the health of adolescent boys and older women are not also of consequence.

Global health advocacy networks that experienced considerable success in the MDG era also confront the challenge of sustaining priority for their cause, while

⁴⁷ *SDG 3.8 calls on all UN member-states to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*

also responding to the dominant SDG and UHC narrative of health system integration and cross-sectoral solidarity. Change may be difficult in the face of “path dependence”, as the habit of certain ideas and policy preferences influence future replication of network structures and discourses. For instance, influential members of the global women’s and children’s health networks who have invested in vertical or technical approaches in the MDG era, may rally others to complete an “unfinished agenda” in the SDG era, even at the expense of network coherence⁴⁸.

Continued debates in the women’s and children’s health network suggest that sustaining ideational and structural coherence among members may be a challenge in the SDG era, especially combined with other challenges to global health network strength, such as stagnating development assistance for health, shrinking civil society space, and rising attention to other health claims, such as non-communicable diseases – the subject of a 2017 special UN assembly.

Several years on from 2015, the narrow view of progress promoted by the MDGs, translated into successful evidence-based advocacy by the women’s and children’s health network, now appears a relic of a distant time. It is perhaps not surprising that the theme of the 2019 Women Deliver conference is “power” – a considerable distance from the instrumentalism of Women Deliver’s first conference slogan in 2007, “Invest in women: it pays”.

⁴⁸ This can be seen, for instance, in continued debate on the role of the Global Financing Facility in support of Every Woman Every Child (GFF), convened in 2015 by the World Bank and supported by the Governments of Norway, Canada, UK, and the Bill & Melinda Gates Foundation, who were important donors to RMNCH issues in the MDG era. As an instrument for mobilising international and domestic resources for RMNCH and nutrition issues, the GFF has been the subject of intensive discussion by network members on its structure and practices, including weak CSO engagement at country level. GFF funding has expanded at a cautious pace since 2015, and debates continue to spill into public view. The online media platform Devex framed its news headline about a 2018 GFF replenishment meeting as follows: “Donors put up \$1 billion for Global Financing Facility, with notable absences”. The report cited critical comments by Anders Nordstrom, the influential global health ambassador of the Government of Sweden, about the risk of health system fragmentation and potential country debt distress through further investments in GFF.

Such shifts in network discourse, coinciding with the transition from the MDG to SDG era, marks a return to the structural questions on health and power raised by four decades ago in the Alma-Ata people-centred approach to development. This underlines the relevance of political context, as well as issue characteristics and ideas, to the development of global health network actor power.

Yet recognising different aspects of power in global health, and understanding how actor-power operates in relation to global health networks, can improve current debate on how to achieve the SDGs, through universal health coverage and improving health equity; improving quality of care and the experience of care; and improving health systems through community-based monitoring and accountability.

The new 2030 SDG framework promotes important connections across issues and sectors, reframing health as a product of wider social, economic, and environmental conditions. Now in the SDG and UHC era, the capacity of networks and guiding institutions to successfully renegotiate power arrangements and discourses in relation to the newly dominant SDG frames is unknown. If unsuccessful in transitioning to the new SDG norms, MDG-focused networks and institutions like PMNCH may fray, and women's and children's health may lose ground to other worthy claims if other, more coherent networks take their place.

In the coming years, how much networks manage to transition their frames and membership under pressure of shifting contexts and norms, will be of interest to global health governance practices, which have been shaped so profoundly in the past 15 years by the proliferation of powerful public-private networks.

8.5 Policy implications

This thesis, based on close study of the global women's and children's health network over the MDG era, produced several findings about the relationship of

communications to actor-power in the day-to-day practices of the network and its guiding institutions, such as PMNCH.

Social communication processes are important in global health because they produce power at multiple levels, and in multiple sites. This thesis concludes with three policy proposals to assist in channelling this power to accelerate greater equity and progress, and to promote greater transparency in the exercise of power. In this way, the global women's and children's health network can use communications to play a stronger and more accountable role on behalf of those whom they claim to represent.⁴⁹

First, public and private health actors in the SDG era who wish to support stronger inter-sectoral collaboration should recognise and support the power of communications platforms, processes and tools to promote closer relations between health network-actors and those from other sectors – social, economic, political and environmental. Flexible, multi-donor funding for cross-sectoral campaigning can scale up impact through the production and dissemination of joint ideas, frames and resources. A successful example of this was collaboration by the World Bank, UNICEF, the WHO, SUN and others on a cross-sectoral campaign to the G20 in 2018 to adopt early childhood development issues, requiring inputs from the education, health, anti-violence, and nutrition sectors.

The SDGs offer common ground to networks with disparate interests, proposing new partnerships to advance global health and rights. Participatory and accountable communications among a plurality of actors with differing ideas, power and histories is central to that process. In an increasingly interconnected world, the communication behaviours of global networks have material and ideational effects on health policy actors in national and sub-national domains, and vice versa. Communication is not a technical input to a technical process. It is a powerful social process in which political structures are shaped, challenged and reproduced, including those that govern global health.

⁴⁹ *Policy recommendations influenced by McDougall et al. (2015), reproduced in Annex D.*

Secondly, and in support of the above proposal, greater policy development, financial investment and multi-stakeholder partner engagement are required to generate more venues for dialogue and accountability among national and sub-national partners and stakeholders. Linked to global health governance platforms, such national platforms will contribute to more effective and accountable advocacy for women's and children's health issues in the SDG era.

Communication campaigns and venues that amplify, support, and reflect dialogue conducted through such national platforms will widen opportunities for participation in this discourse, including by ordinary citizens. As the Orissa case study indicated, global networks can provide resources and support to enable horizontal learning among citizens, who may also benefit from ideas, resources and experiences generated by national and sub-national networks. This can contribute to overall global network effectiveness and accountability.

Third and finally, partnerships with professional media organisations can facilitate this process. Global health networks that improve their understanding, attention, and investment in both online and traditional media partnerships and structures can facilitate stronger sub-national-national-global network relations, including through digital and interactive communication platforms and media partnerships that promote real-time dialogue and generate debate about network performance and behaviour. This can benefit the impact and accountability of national multi-stakeholder platforms, as discussed above.

Through such partnerships, global health actors can better observe and learn about how to design and operationalise media-based strategies for agenda-setting influence, as well as contribute to improved participation, legitimacy and accountability.

Annex

A *Deliver Now India* endline household survey

The endline evaluation survey for the *Deliver Now India* media campaign was conducted in November-December 2009 in six districts of Orissa, including 1,100 married women (aged 20+) with either no children (if married for less than five years) or 1-2 children (with most recent birth in the past five years). Questions produced by the author of this thesis for the *Deliver Now* survey are R239-244, R601-605; copied below. More information about this survey is contained in Chapter 6.

WOMAN'S QUESTIONNAIRE

0 CHILDREN (PLEASE SELECT ONLY THOSE THAT HAVE BEEN MARRIED FOR LESS THAN 5 YEARS AND ARE AT LEAST 20 YEARS OF AGE) AND WOMEN WITH 1 OR 2 CHILDREN WHO HAVE HAD AT LEAST LAST BIRTH IN THE LAST 5 YEARS.

Woman IDENTIFICATION

Name of village: _____

Household identification code: _____

Date of interview: _____

SECTION 1. RESPONDENT'S BACKGROUND

INTRODUCTION AND INFORMED CONSENT

Namaste. My name is _____ and I am working with Health and Development Initiatives (HDI). We are conducting a survey in Orissa about the health of women and children. We would very much appreciate your participation in this survey. Several different health-related topics will be discussed including where you get information about health, the use of health services and the quality of health care. This information will help the government to assess health and information needs and to better plan health services. The survey usually takes about xx minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and if you choose to participate, you may stop answering questions at any time. However, we hope that you will take part in this survey since your participation is important. At this time, do you want to ask me anything about the survey? In case you need more information about the survey, you may contact the person listed on our card. May I begin the interview now?

I WILL NOW ASK SOME MORE DETAILS ON YOUR <u>LAST PREGNANCY THAT RESULTED IN A LIVE BIRTH</u>			
INTERVIEWER: CHECK NAME IN FIRST ROW OF TABLE R202-R208 (if no children go to R243)			
	Q232 Where did you give birth to (NAME)?	YOUR HOME 1 PARENT'S HOME 2 SUB-CENTRE/ANM 3 UPGRADED PHC 4 CHC/PHC/ RUR. HOSP/ 5 DISTRICT/SUBDIVISIONAL 6 OTHER PUB. SECT FACILITY 7 PRIVATE HOSP/ MATERNITY HOME 8 OTHER PVT.SECT FACILITY 9 NGO/TRUST HOSP/CLINIC 10	IF 1 or 2, GO TO R243
R239	Q___ On the whole, do you feel the quality of health care offered during your delivery was good, medium, or poor?	GOOD 1 MEDIUM 2 POOR 3	
R240	Q___ Did you complain about any bad experiences you had with the services you received for this pregnancy or birth?	YES 1 NO 2 NO BAD EXPERIENCES 3	IF 2, GO TO R242 IF 3, GO TO R243
R241	Q___ To whom did you complain? (MULTIPLE RESPONSES POSSIBLE)	HEALTH WORKER (ANM/ASHA) 1 HEALTH MANAGER (HOSPITAL DIRECTOR/FACILITY MANAGER) 2	GO TO R243

		<p>SELF-HELP GROUP 3</p> <p>PANCHAYAT REPRESENTATIVE/VILLAGE GOVERNMENT COMMITTEE 4</p> <p>NGO 5</p> <p>OTHER (Specify) _____ 8</p>	
R242	Q___ Why did you not complain to anyone? (MULTIPLE RESPONSES POSSIBLE)	<p>PROBLEMS CANNOT BE CHANGED; IT IS MY FATE 1</p> <p>THEY WOULDN'T LISTEN TO ME 2</p> <p>EVEN IF THEY LISTENED, NO ONE WOULD ACT 3</p> <p>I AM TOO BUSY 4</p> <p>MY FAMILY/NEIGHBOURS WOULD NOT LIKE IT 5</p> <p>I WAS AFRAID OF BAD TREATMENT 6</p> <p>I WAS AFRAID MY INCENTIVE WOULD BE WITHHELD 7</p> <p>OTHER (Specify) _____ 8</p>	
<p>NOW I WOULD LIKE TO TALK TO YOU ABOUT YOUR VIEWS ON PUBLIC HEARINGS. PUBLIC HEARINGS ARE MEETINGS THAT ARE OPEN TO THE PUBLIC WHERE PEOPLE ARE ABLE TO VOICE THEIR COMMENTS AND OPINIONS REGARDING THE SERVICES THEY RECEIVE FROM THE GVT.</p>			
R243	Q___ Have you ever heard of public hearings?	<p>YES 1</p> <p>NO 2</p>	

PEOPLE WHO PARTICIPATE IN PUBLIC HEARING CAN PUT THEIR VIEWS IN FRONT OF GOVERNMENT REPRESENTATIVES REGARDING THE SERVICES THEY RECEIVE FROM THE GVT.																			
R244	Q___ If a public hearing was organised near your village, would you attend such a meeting if it concerned:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>EDUCATION</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>HEALTH SERVICES FOR CHILDREN</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>HEALTH SERVICES FOR PREGNANT WOMEN OR DELIVERY CARE</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	EDUCATION	1	2	8	HEALTH SERVICES FOR CHILDREN	1	2	8	HEALTH SERVICES FOR PREGNANT WOMEN OR DELIVERY CARE	1	2	8	
	YES	NO	DK																
EDUCATION	1	2	8																
HEALTH SERVICES FOR CHILDREN	1	2	8																
HEALTH SERVICES FOR PREGNANT WOMEN OR DELIVERY CARE	1	2	8																

CHECK TO SEE THAT RESPONDENT HAS BEEN EXPOSED TO CAMPAIGNS IF 'YES' IS NOT SELECTED FOR ANY QUESTIONS Q512a-e AND Q518a-e → END INTERVIEW																	
R601	Q___ Have you talked to anyone about <u>ANY</u> of the TV/radio spots you saw/heard?	<table border="1"> <tbody> <tr> <td>YES</td> <td>1</td> </tr> <tr> <td>NO</td> <td>2</td> </tr> </tbody> </table>	YES	1	NO	2	If 2, GO TO R604										
YES	1																
NO	2																
R602	Q___ Who have you talked to about these spots? (MULTIPLE RESPONSE POSSIBLE)	<table border="1"> <tbody> <tr> <td>HUSBAND</td> <td>1</td> </tr> <tr> <td>MOTHER-IN-LAW/MOTHER</td> <td>2</td> </tr> <tr> <td>SISTER-IN-LAW/SISTER</td> <td>3</td> </tr> <tr> <td>NEIGHBOUR</td> <td>4</td> </tr> <tr> <td>FRIEND</td> <td>6</td> </tr> <tr> <td>HEALTH WORKER (ASHA, ANM,etc)</td> <td>7</td> </tr> <tr> <td>OTHER (specify) _____</td> <td>8</td> </tr> </tbody> </table>	HUSBAND	1	MOTHER-IN-LAW/MOTHER	2	SISTER-IN-LAW/SISTER	3	NEIGHBOUR	4	FRIEND	6	HEALTH WORKER (ASHA, ANM,etc)	7	OTHER (specify) _____	8	
HUSBAND	1																
MOTHER-IN-LAW/MOTHER	2																
SISTER-IN-LAW/SISTER	3																
NEIGHBOUR	4																
FRIEND	6																
HEALTH WORKER (ASHA, ANM,etc)	7																
OTHER (specify) _____	8																

R603	Q___ Why did you discuss them? (MULTIPLE RESPONSE POSSIBLE)	I WANTED MORE UNDERSTANDING ABOUT THE INFORMATION GIVEN 1 I WANTED TO KNOW WHAT OTHER THOUGHT ABOUT THEM 2 I WANTED TO SHARE THIS INFORMATION WITH OTHERS WHO WOULD BE INTERESTED 3 OTHER (specify) _____ 8 DON'T KNOW 99	GO TO R605
R604	Q___ Why did you not discuss them? (MULTIPLE RESPONSE POSSIBLE)	THE INFORMATION WAS COMPLETE AND DID NOT NEED FURTHER DISCUSSION 1 THE TV/RADIO SPOTS WERE NOT INTERESTING ENOUGH TO DISCUSS 2 I DIDN'T THINK ANYONE ELSE WOULD BE INTERESTED IN DISCUSSING THEM 3 OTHER (specify) _____ 8 DON'T KNOW 99	
R605	Q___ In the past 3 months, have you visited a government health facility because of what you heard in the TV/radio spots?	YES 1 NO 2	

B Sample transcript: *Deliver Now India* public hearing

The following transcript was produced by the White Ribbon Alliance Orissa from a public hearing on maternity care in Bolangir district, Orissa, on 25 June 2008 during the *Deliver Now India* campaign. This was one of 12 such hearings to take place during 2008-2009 supported by the Partnership for Maternal, Newborn & Child Health.

The hearing took place during a session of two hours in the district capital, and was attended by approximately 1,300 women from the area. This included self-help group leaders, local governance council representatives, the district Collector and other administrators, health providers, media representatives, local NGO representatives, development partners working on maternal health issues, and members of the White Ribbon Alliance. All hearings were documented and made publicly available, including through media reporting.

Reference

<http://www.who.int/pmnch/activities/delivernowindia/en/index2.html>; accessed 5 January 2019.

Edited for length

Woman in green sari

“In my village there are no health facilities. We are not getting any medicines or health services. Our pregnant women are getting only iron tablets and tetanus injections. Apart from that they are getting nothing. We have to spend money going to the district hospital in Bolangir to get health services there”.

Dr Nabin Pati (Assistant Coordinator, White Ribbon Alliance Orissa; Co-Chair, White Ribbon Alliance India):

“What is the name of the health centre in your village?”

Woman in green sari:

“There is a health centre near my village but not in my village”.

Woman in green sari:

“In the health centre near my village there are no proper facilities. After delivering a baby, one woman was bleeding so profusely that she had to spend money to come to the District HQ hospital for treatment. Poor people don’t have the money to do that”.

Woman in dark red, green and white sari:

“Doctors are asking for money. It happened to my sister-in-law. They told her that if she didn’t give them money, they wouldn’t handle her case”.

Woman in blue sari:

“In my area there’s one hospital that’s 50 km away from my village and there’s only one doctor there. If a woman goes to the hospital at midnight for treatment, he might not even be there. While she’s searching for the doctor, the patient could die. What should we do?”

Chief District Medical Officer, Bolangir (Dr. Ananta Charan Nayak):

Says that two doctors have already been posted to that area so the problem will be sorted out soon and that the cost of transport will be covered if a doctor refers a case to the district hospital.

District Programme Manager, Bolangir (Mr. Himansu Ranjan Kar):

Says the new doctors are will be trained as Skilled Birth Attendants so there will be no problems handling deliveries. It will take two or three months to sort out the problems in the area.

Woman in gold/red sari with dark red blouse:

“When a maternal death occurs, our family is ruined. You, the Collector and the CDMO, never feel the sorrow and the panic that our families feel. You are meant to provide us with a quality service but we are not getting it. So, whom do we hold accountable for maternal deaths?”

Woman in gold/red sari with dark red blouse:

“My child died in the district hospital and no one could explain why. That’s why everyone is questioning the doctors. The doctors are not taking timely action and are unable to identify the risks. That’s why maternal deaths are occurring”.

Project Director, District Rural Development Agency (Mr. Sanjay Kumar Howarda), talks about the need to create awareness, to empower women to demand their entitlements, to take care of their nutritional needs of pregnant women and advise them to seek institutional care.

Woman in gold/red sari with dark red blouse:

“Answer us before you give any speeches. Can you identify one woman in this huge gathering who has given birth safely in a hospital without bribing a doctor?”

Dr Nabin Pati:

“This is a problem we’ve found in all the districts. Women put the same question. You should demand your rights without giving bribes. If women are deprived, they should meet the Chief Medical Officer and submit a grievance in writing and, if possible, send a copy to the White Ribbon Alliance so that we can follow up the case”. (He also gives examples of the various entitlements women should demand).

Woman in yellow sari:

“In every delivery, we only get the JSY (*Janani Suraksha Yojana*) incentive money after we have paid a bribe of Rs 200. If we do not give them any money, they make things difficult for us”.

Dr Nabin Pati:

“Do not give money. Demand your rights without paying a bribe”.

Woman in yellow sari:

“The Health Department puts pressure on us to pay bribes”.

Woman in yellow sari:

“We are illiterate. We give thumb impressions (instead of signing our names). They demand bribes and put pressure on us. Even though you say there is provision for free medicine in the hospital, we are not getting free medicine. We have to buy it from an outside store”.

Exchange between participants about paying Rs 200 bribe to get incentive money. The District Programme Manager (Mr. Himansu Ranjan Kar) asks for details and writes them down.

Woman in yellow sari:

“The AWW (Angan Wadi Worker) is not providing the nutritional support that pregnant women need”.

DPM (District Programme Manager):

“Since the DSWO (District Social Welfare Officer) is not present, the question cannot be answered”.

Woman in cream striped salwar kameez:

“The headmaster of the school in our village is drinking habitually with his friends, abusing woman and misbehaving with girls. The women in the village are up in arms. They want action taken immediately to get him removed”.

Unspecified representative

“This isn’t the right forum to raise this issue but we will inform the block authority of the issue immediately”.

Mr. Satya Ranjan Mishra

“It’s now time for the Collector to say a few words...”

Woman in yellow salwar kameez:

“No, first answer my question! I am an AWW (Angan Wadi Worker) working closely with women’s groups and providing services to pregnant women. But

there are other AWWs who are not doing their job properly. Even ANMs (Auxiliary Nurse Midwives) are not doing their job properly. You should punish those who are guilty of neglect rather than blaming all of us”.

The Collector (In Charge) (Mr. Bijay Chandra Mohapatra)

He refers back to earlier question and says he will instruct his block level officer to take care of the issue. He says this kind of question and answer session is very helpful in enabling women to demand their rights.

Dr Nabin Pati:

He thanks the Collector, repeats the objectives of the programme and asks if there are any more questions.

Woman in green sari:

“The ASHA (Accredited Social Health Activist) in my village is not well educated. That’s why, when women ask for medicines, she is unable to give the right ones. Well educated ASHA should be appointed so we get good service”.

Woman in green sari:

Repeats same question

District Programme Manager (Mr. Himansu Ranjan Kar):

“Usually ASHAs are selected according to government guidelines. But I have noted down the name of your ASHA and your village and will look into the matter. We are giving training to ASHAs to improve their skills but still we will look into the matter”.

Woman in pink sari:

“When we go for medical examinations, the doctors demand money. Rs 500, 1,000 and sometimes 5,000 is taken from us by the doctors, health workers and nursing staff in a normal delivery and more money is taken in Caesarean cases. If a delivery is normal, why are doctors encouraging us to have Caesareans?”

Dr Nabin Pati:

Says WRA is doing its best to solve these kinds of problems. Women can write to the CDMO (Chief District Medical Officer) or inform the WRA, district or state office, so they can take action.

Woman in pink sari:

“In my opinion, the doctors and the medical officers don’t want safe motherhood – they want money”.

Dr Nabin Pati:

“If it is not solved by the CDMO, inform us so we can go with you to deal with the issue”.

Woman in mauve sari:

“If I am a patient and suffering, how can I write to you?”

Dr Nabin Pati:

“Don’t write yourself, ask the person accompanying you to write”.

Woman in mauve sari:

“If you write and complain the doctor might deliberately give you the wrong medicine”.

“It’s not just my problem I’m talking about – it’s everyone’s problem”.

Chief District Medical Officer (Dr. Ananta Charan Nayak):

“If you don’t want to write, come and tell me”.

Woman in mauve sari:

“But an illiterate woman coming from a rural area doesn’t know who you are or where you are. How is she going to find you?”

Even if our pregnancies are normal, the doctors are telling us to have Caesareans and that we have to pay them money. I was in your District HQ Hospital and I was told that I needed a Caesarean and that I had to pay money. So, I left the

government hospital and went to a private one. But at the private hospital, I delivered my baby normally”.

Chief District Medical Officer (Dr. Ananta Charan Nayak):

Says doctors know which pregnancies are normal and which have complications.

Woman in mauve sari:

“No, when I went to the private hospital, I delivered my baby normally”.

Chief District Medical Officer:

Says doctors advise women to have Caesareans in pregnancies with complications and if they think there is a danger to the mother or child – not to make money

Woman in mauve sari:

“In normal cases too, doctors are encouraging women to have Caesareans in order to get more money”.

Woman in mauve sari:

“No, in my case, I went to a private hospital and delivered my baby normally”.
(Repeats it over and over again)

Chief District Medical Officer:

“No one can predict what will happen: sometimes a pregnancy appears to be normal but there are complications, sometimes it appears to have complications but turns out to be normal.”

Woman in mauve sari:

“It’s fine if it’s the decision of the doctors but the doctors are not behaving properly”.
(Repeats it twice)

District Programme Manager:

“On behalf of the NRHM (National Rural Health Mission), a grievance cell is going to be opened. So, every three months, grievances will be heard. There will be a complaint box and complains will be opened in front of the CDMO (Chief District Medical Officer) and other medical officers and the matter will be considered”.

Woman in mauve sari:

“Because of the doctors’ bad behaviour, illiterate rural women do not want to come to the hospital. When a woman is pregnant and delivering in pain and fear, the doctor should behave properly. It’s not just myself I’m talking about, I’m speaking on behalf of all women”.

District Programme Manger asks if the grievance initiative he has outlined is good.

Woman in mauve sari:

“Yes, it is good”.

C *Deliver Now India* interview guide

Chapters 6 and 7 report findings from 18 semi-structured, face-to-face interviews conducted by the author with key informants in Bhubaneswar, Orissa, in June-July 2009. Informants were identified mainly by snowball sampling technique, resulting in representatives of different stakeholder groups with knowledge of the *Deliver Now India* campaign (state government, UN and technical cooperation agencies, media, state and district NGOs, researchers on women’s and children’s health, and national representatives of foreign donor agencies. Each interview was conducted in English and lasted up to 90 minutes in length (see chapters 2.1, 5.2 and 6.2). Notes were taken by hand and then typed up into transcripts. General research categories and questions are below, tailored to each stakeholder group.

Category questions

Women's and children's health policy context

- How important do you think women's and children's health is to the government in Orissa and at the federal level?
- Has this changed over time? What indicators do you see?
- If so, why do you do believe this has changed?

Media environment in Orissa and India

- Does the media in Orissa report regularly on women's and children's issues?
- Has this changed over time? If so, why do you think it has?
- Do you trust the media to report accurately on these issues?

Civil society structures and government relations

- What is the nature of your relationship with the White Ribbon Alliance?
- What are key milestones in the history of the White Ribbon Alliance in Orissa?
- How do you view the work of the White Ribbon Alliance – strengths, weaknesses, opportunities, risks?
- What other networks work on women's and children's health in Orissa, and how do you perceive their work vis-à-vis that of White Ribbon?

Barriers and facilitators of civil society mobilisation and accountability in Orissa

- What are the public accountability structures for women's/children's health?
- What are effective mechanisms for mobilisation and accountability and why?
- What are ineffective mechanisms for mobilisation and accountability and why?
- What do you think about public hearings as a way to improve accountability?

Relationship between local, national and global campaigns

- Are you aware of any national or global network activities and communication campaigns on women's and children's health?
- Do you perceive a relationship between the Deliver Now work in Orissa and at the national or global level?
- Do such campaigns influence political attention to women's and children's health? Why or why not?

D Recent peer-reviewed publications by author

2018

- Adeniran A, Likaka A, Knutsson A, Costello A, Daelmans B, Maliqi B, Burssa D, Freer J, Askew A, Bowen L, Kak L, **McDougall L**, Zaka N, Tuncalp O, ten Hoop Bender P, Syed SB, Peterson SS, Luchesi T, Zeck W, Were W, Barker P, Naimy Z. Leadership, action, learning and accountability to deliver quality care for women, newborns and children. *Bull World Health Organ*. 5 Feb 2018. doi: 10.2471/BLT.17.197939

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- **McDougall L**. Discourse, ideas and power in global health policy networks: political attention for maternal and child health in the Millennium Development Goal era. *Globalization and Health*. 2016. 12:21. doi: 10.1186/s12992-016-0157-9
- **McDougall L**. Power and politics in the global health landscape: Beliefs, competition and negotiation among global health coalitions in the policy-making process. *International Journal of Health Policy and Management*. 2016. 5(5):309-320. doi: 10.15171/ijhpm.2016.03
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2015

Full text follows

- **McDougall L**, Sharma A, Franz-Vasdeki J, Beattie AE, Touré K, Afsana K, Boldosser-Boesch A, Dare L, Draganus F, Eardley K, Garcia Ruiz C, Gronseth L, Iversen K, Kuruvilla S, Marshall A, McCallon B, Papp S. Prioritising women's, children's and adolescents' health in the post-2015 world. *BMJ*. 2016. 351: suppl1. doi: 10.1136/bmj.h4327.

2014

- Mason E, **McDougall L**, Lawn JE, Gupta A, Claeson M, Pillay Y, Presern C, Lukong MB, Mann G, Wijnroks M, Azad K, Taylor K, Beattie E, Bhutta ZA, Chopra M. Every Newborn: from evidence to action to deliver a healthy start for the next generation. *Lancet*. 2014. 384 (9941):455-467. doi: 10.1016/S0140-6736(14)60750-9.

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Prioritising women's, children's, and adolescents' health in the post-2015 world

Lor Jougall and colleagues set out a three point agenda for strengthening advocacy: invest in multipartner national platforms for action; innovative communication circuits to unite advocacy; and multidonor funding mechanisms to scale up advocacy efforts

Since their adoption, the millennium development goals (MDGs) have played a crucial role in improving global health. The MDGs raised awareness of key priorities for health and development, stimulated policy and budget attention, and created a common agenda for action. Child health was prioritised by MDG 4 calling for a two thirds reduction of deaths in children under 5 years old, maternal health was promoted by MDG 5a calling for a three quarters reduction in maternal deaths by 2015, and the MDG 5b ambition was to ensure universal access to reproductive health. Despite significant progress, MDGs 4 and 5 will not be met. Other health goals, including MDG 6 (on HIV/AIDS, malaria, and tuberculosis) and MDG 1c (hunger), are marked by major gaps in progress for women and children.

Launched in 2010, the Global Strategy for Women's and Children's Health ("Global Strategy") has fuelled efforts to deliver the MDGs. The Global Strategy and the Every Woman Every Child advocacy movement have promoted collective action, joint messaging, and effective partnerships. These efforts have led to more money, improved policies and service delivery, and a new focus on accountability and multi-stakeholder partnerships (box 1).¹

To sustain progress beyond 2015, the Global Strategy is being updated to build on

KEY MESSAGES

Strengthening citizen led local action is core to the mission of advocacy and communication for the Global Strategy

Effective action requires investment in strong coordinating platforms among diverse stakeholders, led by respected champions

Building a robust investment case for advocacy requires greater attention to developing clear performance monitoring and evaluation indicators

Creating stronger advocacy partnerships within the health domain, and between health and other related sectors, is required to deliver the vision of the sustainable development goals

Advocacy is the process of bringing evidence and information to bear on the decision and ability to act in response to people's needs. Advocacy and communication shape opinion, crystallise common or shared thinking, mobilise action, and drive decision making. The result of advocacy and communication can be political will, the decision to mobilise resources, policy and planning, reprioritisation, and stronger accountability.

lessons learnt during the MDG era and to reflect the priorities of the new sustainable development goals to be adopted by governments in September 2015.

How did women's and children's health rise on the global agenda, and what can be learnt about how to sustain attention beyond 2015? What was the role of advocacy and communications in framing and communicating evidence, highlighting solutions and results, promoting joint action, and enabling voice and action among women, youth, families, and communities?

Applying Shiffman's health policy analysis framework of stakeholder power, ideas, context, and issue characteristics (table),²⁻⁹ we look at the experience of Every Woman Every Child during the past five years as a key factor in explaining the rise in prominence of these issues. Going forward, we consider how the updated Global Strategy can improve its performance as an advocacy

instrument for women's, children's, and adolescents' health, and then set these findings against an analysis of gaps and challenges, which inform the main section of this paper. We conclude with a three point agenda for action for advocacy and communications in the updated Global Strategy.

Methods

In the following sections, we summarise the findings of three qualitative approaches used to better understand the role and impact of the updated Global Strategy for Women's, Children's and Adolescents' Health, as well as lessons learnt from the initial years of the Global Strategy (2010-15). The first approach was a global stakeholder consultation process in late 2014 and early 2015 that captured the views of 4550 respondents.¹⁰ The second was to synthesise the views and conclusions from three teleconferences held during February

BOX 1: EVERYWOMAN EVERY CHILD: A JOINT PLATFORM FOR ACTION

In 2010, there was a high degree of consensus and commitment among stakeholders in reaching the 2015 millennium development goals (MDGs). There was a concentration on a "continuum of care" approach—in which reproductive, maternal, newborn, child, and adolescent health are understood to be inextricably linked—enhanced by integrated care across the life cycle and from home to hospital. A positive message of, "Progress is possible, it pays to invest" was adopted by partners based on best available evidence of epidemiological and economic progress. In an increasingly global public health environment of private-public alliances, the Every Woman Every Child movement was launched by UN secretary general Ban Ki-moon as a common advocacy platform for diverse stakeholders to work together to implement the Global Strategy for Women's and Children's Health and the MDGs.

The pay-off has been substantial: by 2014, there were more than 300 commitments from a diverse range of stakeholders (figure) through the Every Woman Every Child platform—a three fold increase from the launch in 2010.^{3,5} Financial pledges have risen to nearly \$60bn, with many additional, uncosted commitments aimed at strengthening policy, service delivery, and advocacy.² The Global Strategy has drawn attention not only to more resources, but to better use of those resources, brokering agreement on cost effective interventions, integrated efforts for scaling up, innovation, and joint funding channels.⁵

Such global campaigns can be a timely "hook" for stimulating national dialogue and brokering consensus about priorities and resources. They can also be a promise of greater external coordination and resource exchange, as well as an aid to mobilising new commitments among global stakeholders. For example, the G8 Muskoka Declaration in June 2010 of an additional \$5bn for maternal and child health⁶ paved the way to a successful launch of the Global Strategy for Women's and Children's Health in September 2010, which itself built on years of active health advocacy and increased visibility for maternal health issues.

Framework of determinants for political priority for the Global Strategy for Women's and Children's Health (2010-2015)	
Description	Factors shaping political priority
Stakeholder power—The strength of the individuals and organisations concerned with the issue	Policy cohesion, leadership, guiding institutions, mobilisation of civil society—The EWEC movement, championed by UN secretary general Ban Ki-moon, brings together reproductive, maternal, newborn, child, and adolescent health stakeholders working through coordinating platforms such as the H4+ multilateral agencies, PMNCH (including more than 400 NGO members), Women Deliver, the Network of Global Leaders, and the Global Campaign for the Health MDGs.
Ideas—The ways in which those involved with the issue understand and portray it	Positioning within the health sector and among health and related sectors—The adoption of a RMNCAH "continuum of care" conceptual model has facilitated consensus across diverse policy constituencies, including governments, NGOs, health professionals, donors, private business, the UN, and academia. Positioning is important to ensure women's and children's health is seen as a human right as well as a determinant, outcome, and indicator of economic, social, and political development.
Political contexts—The environments in which stakeholders operate	Policy windows, global governance structure, convening and driving the process—The 2015 MDG framework, with twin goals on maternal and child health, opens policy window for urgent action. The Global Strategy legitimised as an agenda for national and regional action through inter-governmental resolutions and communiqués (UN 2010, World Health Assembly 2011, UN Human Rights Council on maternal mortality 2011, Inter-Parliamentary Union 2012) and frameworks (African Union integrates Global Strategy into policy frameworks, building on Maputo Plan of Action for SRHR, CARMMA, and Abuja Declaration).
Issue characteristics—Features of the problem	Credible data, evidence of gaps (severity of the problem), effective interventions available—Robust evidence on causes, solutions, trends, and gaps increasingly available through a wide range of sources, including Countdown to 2015, UN reports, <i>Lancet</i> special series, and others. Multi-stakeholder consensus on effective interventions brokered at global level, offering clear policy directions.

EWEC=Every Woman Every Child. PMNCH=Partnership for Maternal, Newborn & Child Health. NGO=non-governmental organisation. MDG=millennium development goal. RMNCAH=reproductive, maternal, newborn, child and adolescent health. SRHR=sexual and reproductive health and rights. CARMMA=Campaign for Accelerated Reduction of Maternal Mortality in Africa.

and March 2015 with advocacy leaders of the women's and children's health community and those who contributed to the Global Strategy consultation process. Thirdly, we conducted a literature search on definitions, theories, and examples of successful advocacy and communications practice as well as relevant conceptual frameworks for agenda-setting and issue-framing. The literature search enabled us to expand on the findings of the expert consultations and triangulate our own observations.

Problems

The implementation of the Global Strategy has been marked by challenges that have inhibited civic leadership and national ownership, and implementation of the top priorities identified within the strategy itself. Three of these challenges are discussed.

Lack of awareness and ownership of national commitments

While engagement with the Global Strategy has been consistently strong among global level stakeholders, at the country level it has been more variable. For example, in the first consultation report on the 2010-15 Global Strategy published in January 2015, respondents at country level commented that lack of country engagement with the Global Strategy was an important limitation (see www.womenchildrenpost2015.org). Important national stakeholders, including parliamentarians, have been unaware of pledges made by their country. This has inhibited their ability to engage with relevant policy and budget planning.

Many national stakeholders lack access to relevant platforms for policy dialogue and information sharing. Sub-national and national accountability systems, if rigorously monitored and connected to global

processes, are critical for ensuring monitoring, review, and remedial action. Civil society coalitions at sub-national, national, regional, and global levels can gather evidence for multi-stakeholder review processes and recommend remedies (see box 2). A large scale stakeholder survey on the Global Strategy (April 2015) found that more than 80% of respondents thought that global accountability did not affect country level processes. This indicates a clear role for local, citizen led processes.¹⁰

Stronger monitoring and evaluation for advocacy impact

Effective advocacy is the product of a complex mix of actors, context, and opportunity, making the impact of individual contributions difficult to measure.¹¹ Even so, advocates benefit from robust monitoring and evaluation approaches to assess progress and improve practices.⁴ Two specific prob-

BOX 2: STAKEHOLDER POWER DRIVES ISSUE ATTENTION: CITIZEN LED COALITIONS

Tanzania

The White Ribbon Alliance for Safe Motherhood Tanzania united civil society members, health professionals, academics, donors, and UN partners in a three year (2013-15) campaign to improve access to comprehensive emergency obstetric and newborn care (CEmONC) at health centres and with the help of qualified health workers. The campaign calls for a specific budget line item with funds for CEmONC in Tanzania's council health plans. As a result of tactical outreach aimed at communicating the gaps in access to CEmONC and its major causes (poor financing for CEmONC), media campaigning, and one-on-one meetings with key champions, the prime minister of Tanzania on the White Ribbon Day (15 March 2014) gave a directive that all councils establish a budget line for CEmONC with funds to ensure that these lifesaving services are available at health centres. The campaign has also yielded a petition on CEmONC signed by 16428 citizens and 96 members of parliament.

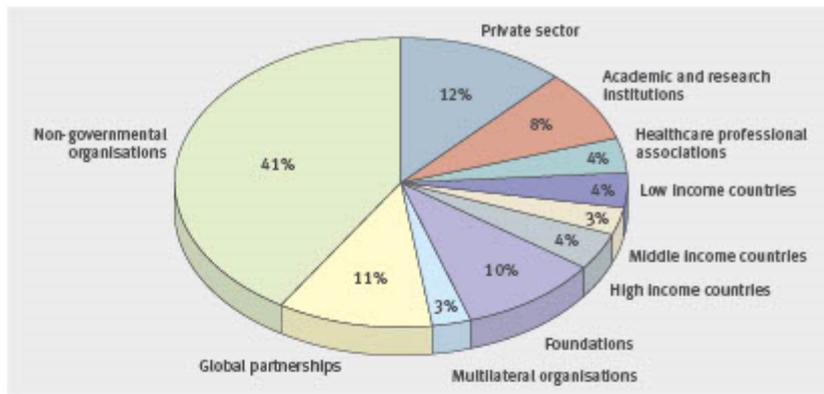
Nigeria

In support of improving accountability and aid alignment, including in relation to maternal and child health, CHESTRAD International and the IHP+ Results Consortium worked with Nigeria's Senate Committee on Appropriations and the National Planning Commission to document the flow of official development assistance (ODA) into health and education and recommend improvements in managing aid flow. This report led to a parliamentary multi-stakeholder dialogue hosted by the Senate and Nigeria's Federal Ministry of Finance and the National Planning Commission, with participation from development partners and civil society. The dialogue resolved to better align ODA flows with appropriation processes, expand efforts at inclusive national budgeting and transparency, and establish a civil society aid effectiveness and accountability fund. This process also catalysed the creation of a new parliamentary committee on coordination and engagement with development partners in Nigeria.

Data sources:

Partnership for Maternal, Newborn & Child Health. *Progress report. Budget advocacy for improved women's and children's health: experiences from national civil society coalitions*. 2013. www.who.int/pmnch/media/events/2013/progress_report.pdf?us=1

Statement: parliamentary stakeholder dialogue on aid effectiveness and results. National Assembly Complex, Abuja, Nigeria 16-17 May 2011. www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Nigeria/StatementParliamentaryDialogue-25.05.2011.pdf



Advocacy commitments for the Global Strategy for Women's and Children's Health by constituency (data from the PMNCH 2013 report²)

lems (both vital ingredients for success) are, firstly, the availability of adequate data and evidence with which advocates can take action and, secondly, robust methods for tracking advocacy impact.

Data and evidence—While the MDGs and the Global Strategy have been useful tools for advocacy, the lack of costed implementation plans and consolidated mechanisms for tracking resources and results have hampered its effectiveness. Greater transparency of government data and information, supported by stronger national data collection systems, will benefit advocacy efforts, as would greater emphasis on community based efforts to improve accountability. Examples of this policy effort are the national and sub-national “citizen hearings” bringing stakeholders and policymakers together in policy dialogue (see also: <http://whiteribbonalliance.org/campaigns/citizens-hearings-2015/>).¹²

Tracking impact—In regard to evaluating the effect of advocacy, the lack of standard indicators, processes, and structures for monitoring and reviewing the Global Strategy and Every Woman Every Child has hindered efforts to improve quality and impact. It has also made it more challenging to build an investment case for advocacy. For example, while it is relatively simple to measure “interim” or “process” indicators, such as the number of commitments made or media hits (box 3), it is often difficult to determine the extent to which a particular activity by a particular stakeholder or coalition contributes to broader national impact on policies or budgets.

Scaling financing for advocacy Underfunding remains a barrier to successful advocacy. A recent survey of civil society organisations in Africa indicated that lack of financing was the most commonly cited bar-

rier to participating in multi-stakeholder platforms for reproductive, maternal, newborn, child, and adolescent health (see, for example, <http://chestrad-ngo.org/communications/publications-reports/>). Yet relatively few donors fund such advocacy, especially at national level. Governments often prefer not to make investments that could put them in the “line of fire.”

A review of progress of Global Strategy commitments made between 2010 and 2013 found that reproductive, maternal, newborn, and child health organisations were often understaffed. This resulted in a limited capacity for advocacy because of poor staff training and reluctance by donors to fund advocacy and related staff positions. The financial crisis of 2008 and the subsequent poor economic climate further destabilised funding for advocacy and thus the ability of partners to conduct advocacy.²

Priority actions

Successful advocacy in the post-2015 era will depend on the ability to identify how investments can deliver multiple goals across sectors, including in complex settings such as during a humanitarian emergency or conflict, where ill health is disproportionately clustered. This section sets out a three point agenda for effective advocacy and communications around the Global Strategy beyond 2015.

Invest in national multi-stakeholder platforms for advocacy and accountability Uniting partners with disparate skills, disciplines, epistemic traditions, and networks for joint advocacy and providing these advocacy networks with timely information about commitments is critical to ensuring the implementation of the Global Strategy. This requires investment in leadership, coordination, and communication skills at all levels.

In 2012-13, for example, the Partnership for Maternal, Newborn & Child Health provided a small level of support for national coalitions of civil society organisations in 10 countries. This enabled joint advocacy and improved accountability, including for national commitments to the Global Strategy. In most of the participating countries, these are the first coalitions of civil society organisations to cover the entire continuum of care from preconception to child and adolescent health. The partnerships have resulted in a number of innovative approaches, such as a joint advocacy toolkit in Tanzania to increase the enrolment of youth in midwifery training; in Ghana, Indonesia, and Uganda, voluntary contribution schemes have been created to cover the cost of alliance activities.¹³

The most successful of these coalitions have established relationships with parlia-

BOX 3: MEASURING MEDIA IMPACT: BORN TOO SOON

Media advocacy can promote consensus on framing and solutions, generate attention on policy, and prompt united action among different stakeholders. An example is the 2012 launch of Born Too Soon: The Global Action Report on Preterm Birth, which highlighted preterm birth as the leading cause of newborn mortality. A communications campaign coordinated by the Partnership for Maternal, Newborn & Child Health brought together more than 50 partner organisations to advocate for attention to preterm birth. This included civil society groups such as the March of Dimes, corporations such as Johnson & Johnson, and health professional groups such as the International Paediatric Association, the International Confederation of Midwives, and the International Federation of Gynecology and Obstetrics.

The campaign reached an estimated media audience of 1.1 billion through the *Hindu*, the Xinhua news agency, the front page of the *New York Times*, and others. This was complemented by a television advert on CNN International with celebrity singer and parent Celine Dion, as well as a global Twitter “relay” and an interactive map on which Facebook members could “pin” their own stories of preterm birth. In total, Born Too Soon resulted in more than 30 new Every Woman Every Child commitments to preterm birth and newborn health. It catalysed the expansion of World Prematurity Day, with events in 70 countries in 2014. It also set the foundation for a broader policy effort, the Every Newborn Action Plan, supported by a resolution by 194 member states of the World Health Assembly in 2014.

Data sources:

March of Dimes, Partnership for Maternal Newborn & Child Health, Save the Children, World Health Organization. *Born Too Soon: the global action report on preterm birth*. WHO, 2012.

Howson CP, Kinney MV, McDougall L, Lawn JE. Born Too Soon: preterm birth matters. *Reprod Health* 2013;10:S1.

BOX 4: IDEAS DRIVE ATTENTION TO ISSUES: LONDON SUMMIT AND FP2020

Family planning was framed in the Global Strategy as an important issue for investment and policy, creating a new hook for advocates to align and take action. A good example of this is the Family Planning 2020 (FP2020) Initiative, which has emerged from the London Summit on Family Planning in 2012. The summit gained commitments from more than 20 governments and donor funding of \$2.6bn, elevating political commitment to modern contraceptives and reproductive health in support of the wider remit of the Global Strategy. Since 2013, more than \$1.3bn has been disbursed for family planning programmes. This has resulted in more than 8.4 million extra girls having access to modern contraception and at least 77 million unintended pregnancies avoided. The FP2020 example illustrates how global and national health advocacy fosters and builds on widespread agreement on the urgency of an issue.

Data source: Family Planning 2020 (FP2020). www.familyplanning2020.org.

ments and the media. In many countries in Asia and Africa, private media are a major growth industry. The media can be a powerful platform for voice and accountability, capturing public energy and anger, and shifting cultural norms. Yet, too often, the media are seen as a target for pre-packaged public relations campaigns and not as viable partners with essential networks and skills. Investment in partnerships with leading national and regional media networks, especially those focused on young media consumers, is an essential area for development. Social and behavioural change campaigns that stimulate positive individual behaviours, as well as positive changes within policy environments, are important ways of promoting community health and improving policy impact.¹⁴

Beyond 2015, these advocacy networks will need to integrate partners from health enhancing sectors, including those engaged in education, women's political and economic participation, access to clean water and sanitation, poverty reduction, and economic growth in line with the evidence of the importance of these sectors on health.¹⁵

Build digital platforms for knowledge and action

Advocacy operates in real time. National, regional, and global advocacy coalitions require timely, cost effective information "circuits" to source new evidence for action and to identify new opportunities for advocacy.

Improving the circulation of information increases the effectiveness of transnational advocacy. This is likely to be especially true beyond 2015, as the number and distribution of partners seeking to collaborate across sectors increases. Regional platforms can provide relevant support in this process. For instance, the African Union/CARMMA (Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa) has developed scorecards of indicators and a user friendly online database of indicators, helping member states track progress towards regional commitments such as the Maputo

Plan of Action on Sexual and Reproductive Health and Rights and the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (see africanhealthstats.org and <http://carmma.org/scorecards> for more information). When geared to local needs and priorities, and properly promoted for use, innovative web and mobile phone based approaches hold much promise, including in relation to advocacy, communication, and coalition development.¹⁰

Build flexible, multidonor funding mechanisms for advocacy

Effective advocacy requires reliable yet flexible financing to capture sudden and unexpected opportunities as well as to address longer term strategic goals. In the past, donor funding for advocacy has too often prioritised individual strategic plans, missing an opportunity to invest in broad based coalitions supporting collective goals. Recent promising efforts include the multidonor "Amplify Change" fund for sexual and reproductive health and rights, as well as support to the Every Woman Every Child movement from such donors as the Bill & Melinda Gates Foundation, Canada, Norway, and the Rockefeller Foundation.

Experience from the global nutrition community also bears out the benefits of pooled financing mechanisms. For example, pooled donor funding for civil society partners as part of the multipartner trust fund for the SUN (Scaling Up Nutrition) movement has enabled greater coordinated action. Of the 33 established and active SUN civil society alliances in countries, 27 are funded through this trust fund or by bilateral donors (see <http://scalingupnutrition.org/the-sun-network/civil-society-network>).

In line with the goals of Every Woman Every Child, the new Global Financing Facility (GFF)¹⁶ is designed to encourage increased commitments of domestic resources for health.¹⁷ This is a promising development, requiring multipartner domestic budget advocacy, including with media and parliamentarians, to mobilise and sustain domestic allocations for

health. Without such national and sub-national advocacy, the GFF ambitions are unlikely to be fully realised. It is important, therefore, for the GFF facility to support national advocacy, both in principle and in fact.

Conclusion

Advocacy and communication matter not for their own sake but because they are essential in facilitating the social and political pact that drives forward the Every Woman Every Child movement.

There are important lessons from the recent Global Strategy experience, especially in promoting country ownership and engaging with national and regional policy processes. Stronger evidence is needed about what works in advocacy, why it works, and how to measure and improve advocacy in the future. The updated Global Strategy provides an opportunity to further that learning and apply new techniques.

Going forward, advocacy success must be measured not by the quantity of global commitments taken in the name of citizens and countries, but the extent to which people themselves demand to be at the centre of the dialogue, insisting on their right to monitor, review, and act upon that to which they are entitled.

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