The emergence, growth and decline of political priority for newborn survival in Bolivia

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Bolivia is expected to achieve United Nations Millennium Development Goal Four, reducing under-five child mortality by two-thirds between 2021 and 2025. However, progress on child mortality reduction masks a disproportionately slow decline in newborn deaths during the 2000s. Bolivia’s neonatal mortality problem emerged on the policy agenda in the mid-1990s and grew through 2004 in relationship to political commitments to international development goals and the support of a strong policy network. Network status declined later in the decade. This study draws upon a framework for analysing determinants of political priority for global health initiatives to understand the trajectory of newborn survival policy in Bolivia from the early 1990s. A process-tracing case study methodology is used, informed by interviews with 26 individuals with close knowledge of newborn survival policy in the country and extensive document analysis. The case of newborn survival in Bolivia highlights the significance of political commitments to international development goals, health policy network characteristics (cohesion, composition, status and key actor support) and political transitions and instability in shaping agenda status, especially decline—an understudied phenomenon considering the transitory nature of policy priorities. The study suggests that the sustainability of issue attention therefore become a focal point for health policy networks and analyses.

Keywords Health policy, newborn survival, Bolivia, agenda setting, political priority

KEY MESSAGES

- Newborn survival emerged and grew as a political priority in Bolivia during the 1990s and early 2000s in relationship to commitments to international development goals and actions of a strong health policy network.
- Political transitions and instability affected a decline in political priority for newborn survival in Bolivia in the later 2000s. Policy promises were made, but follow-through was weak.
- Health policy networks need to act strategically to ensure health system responsiveness to their issues, thereby sustaining issue attention and increasing the likelihood of policy impact.

Bolivia featured the highest rates of neonatal, post-neonatal/infant and under-five child mortality in Latin America in 2011 (Lozano et al. 2011). Nonetheless, Bolivia has made significant progress in reducing under-five child mortality since 1990; the country is expected to achieve United Nations Millennium Development Goal Four, reducing under-five child mortality by two-thirds between 2021 and 2025 (5–10 years beyond the goals deadline) (Lozano et al. 2011). Overall, child mortality reduction masks a much slower rate of decline in deaths during the neonatal period (age 1–28 days); lagging progress on neonatal mortality reduction poses a barrier to achieving the child health goal nationally and globally.
This study examines the trajectory of newborn survival as a policy issue in Bolivia since the early-1990s, identifying factors affecting its status on the health policy agenda over time. Agenda status is important because it may facilitate policy adoption and intervention scale-up, thus shaping public health outcomes. Bolivia is an interesting case because it was one of the few low-income countries giving policy attention to newborn survival at the turn of the century; priority fell off nationally just when issue attention was increasing globally (Shiffman 2010). In addition, health agenda-setting scholarship tends to be concerned with cases of success (Shiffman 2007; Pelletier et al. 2011; Smith and Neupane 2011) or failure to gain status (Benzian et al. 2011; Maher and Sridhar 2012; Tomlinson and Lund 2012); declining status is rarely studied.

I used a framework for analysing determinants of political priority for global health initiatives (Shiffman and Smith 2007) to understand the trajectory of newborn survival policy in Bolivia. A process-tracing case study methodology guides data collection and analysis. The study draws upon interviews with 26 actors with close knowledge of newborn health policymaking in Bolivia and extensive document analysis.

Policy attention to newborn survival first emerged in Bolivia in relationship to maternal and child survival programmes and commitments in the 1990s, with policy activity concentrated between 2002 and 2004. Neonatal mortality declined between 1998 and 2003 as priority for the issue increased; the mortality rate plateaued between 2004 and 2008 (Table 1, Ministerio de Salud y Deportes 2009) as political priority for the issue fell off. The election of Bolivia’s first indigenous president, Evo Morales, brought new political energy for social welfare policy, encompassing health, mid-decade. But the leadership transition reset the health policy agenda in significant ways, and the newborn survival network was challenged to adapt to the new policy environment. These factors contributed to a relative decline in agenda status for newborns in the later 2000s.

### Setting the health policy agenda

This study draws upon a framework for analysing agenda-setting dynamics in international health (Shiffman and Smith 2007) and refinements suggested by subsequent research and theorizing (Shiffman 2009; Smith and Neupane 2011). The framework is grounded in policy process (encompassing agenda setting, policy adoption and implementation) scholarship writ large and informed by case studies of maternal and newborn health policymaking globally and nationally. The framework, its foundations and proposed refinements are reviewed here as they guide the present analysis.

The framework for analysing determinants of political priority for global health initiatives contains four categories for analysis (actor power, ideas, political environment and issue characteristics). In terms of ‘actor power’, policy entrepreneurs (leaders) and communities (networks of actors linked by shared concern for an issue) draw strength from their beliefs and cohesiveness surrounding policy issues (Kingdon 1994; Sabatier and Jenkins-Smith 1999). Strong guiding institutions lead and co-ordinate initiatives, offering foundations for sustainability (McAdam et al. 1996; Finnemore and Sikkink 1998). Civil society mobilization, engaging grassroots organizations pressing for policy attention to an issue, also increases the likelihood of gaining political support (Harris and Siplon 2007).

In terms of ‘ideas’ and ‘issue characteristics’, Shiffman (2009) and Smith and Neupane (2011) have suggested a merging of analytical categories to enhance explanatory power and theoretical relevance. The framework as originally proposed conceived of ‘ideas’ as the ways in which issues were framed, understood and portrayed internally (within a policy community) and externally (especially with political leaders in control of resources), thereby engendering degrees of commitment to issues (Snow et al. 1986; Stone 1989). ‘Issue characteristics’ encompassed what tend to be perceived as more objective/material features of problems, including existence of indicators (as of severity) and interventions. It is the attachment of meaning to this information that influences policy actor behaviour (Checkel 1998; Berman 2001; Sikkink 2001; Shiffman 2009; Smith and Neupane 2011). Perceived credibility of indicators and effectiveness of interventions motivate action; agreement surrounding these ideas also lends them strength.

In the ‘political context’, policy windows are short periods of time in which political circumstances align in ways that provide enhanced opportunities for concerned actors to influence policy decisions. Windows can open with changes in political leadership, natural disasters, new discoveries, focusing events and other system shocks (Baumgartner and Jones 1993; Kingdon 1994; Reich 1995). Political contexts are also marked by governance structures, institutions (such as rules and norms) that guide behaviour (Ostrom 2007), thus shaping levels of policy attention and resources for health issues. Research on agenda-setting dynamics for newborn survival in Nepal and Bangladesh led Smith and Neupane (2011) and Shiffman and Sultana (2013), respectively, to suggest that relative cohesiveness (vs fragmentation) of governing contexts, degrees of political stability and other characteristics of political systems may also affect agenda status.

The framework identifies a set of factors (organized into analytical categories) shaping political priority for health initiatives, or policy agenda status—terms used interchangeably in this article. Political priority is defined as levels of policy attention and resource allocations to issues, including such indicators as public attention from political leaders; inclusion in national health plans, policies and programmes and allocation of human, financial and technical resources. These are studied over time to assess shifts in agenda status and to identify factors affecting change. The framework has been used to explain the rise and failure of issues to ascend on policy agendas. It is applied here to an understudied phenomenon in which political priority emerges, grows and then declines. Implications for the analytical framework are addressed in the concluding sections of this article.

### Table 1 Neonatal, post-neonatal/infant and child mortality in Bolivia, 1998–2008

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<tr>
<td>Neonatal mortality rate</td>
<td>34</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>67</td>
<td>54</td>
<td>50</td>
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<tr>
<td>Under-five child mortality rate</td>
<td>92</td>
<td>75</td>
<td>63</td>
</tr>
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Source: Ministerio de Salud y Deportes et al. (2009). Mortality rates are deaths per 1000 live births.
Methodology

We used process tracing, a qualitative case study methodology well suited to identifying factors affecting policy processes over time (George and Bennett 2004), to investigate the research questions. The following questions guided data collection and analysis: How have levels of political priority for newborn survival in Bolivia changed over time? What factors have most centrally affected policy agenda status for this issue? Bolivia was selected for study because of its relatively high burden of neonatal mortality compared to other countries in the region (second only to Haiti in Latin America and the Caribbean), its lagging progress on reducing newborn deaths alongside greater declines in child and maternal mortality, and its status as one of the few lower income countries giving significant policy attention to the issue in the early 2000s.

The analysis incorporated multiple sources of data, including interview transcripts, documents and researcher observations to identify patterns of causality and minimize bias (Yin 2003). Informant insights are critical to understanding largely undocumented causes of shifts in levels of attention and resources to health issues. Interviews with 26 individuals with close knowledge of newborn survival initiatives and service delivery in Bolivia, including supporters and critics at senior and technical levels, took place in 2009. Individuals from the following organizations participated: the government sector (Ministry of Health and Sport, hospitals and health clinics), civil society (Bolivian Paediatric Society, Centro de Promoción Agropecuaria Campesina (CEPAC), Centro de Investigacion, Educacion y Servicios (CIES), Programa de Coordinacion en Salud Integral [PROCOSI], the Safe Motherhood and Birth Mesa ['Mesa de Maternidad y Nacimientos Seguros'] and development partners (CORE Group, Family Care International, Pan American Health Organization/World Health Organization [PAHO/WHO], Plan Internacional Bolivia, the Population Council, Project Concern International, Save the Children Bolivia, other donors and international and domestic non-governmental organizations (notably those under the PROCOSI umbrella, a network of health-focused nongovernmental organizations [NGOs]) to scale up the project nationally from 1994 (Gonzales et al. 1998). Bolivia incorporated the ‘Warmi’ methodology into its 1994 National Health Plan (Access Program Community Mobilization Working Group 2007). A national project evaluation meeting in 1996 led to adoption of several key neonatal health indicators by the Bolivian National Information System including perinatal mortality, prenatal visits, tetanus vaccination, deliveries attended by trained community and health personnel (skilled attendants, such as doctors and nurses), contraceptive use and high-risk pregnancy referrals (Gonzales et al. 1998). In 1998, the project had reached more than 200,000 women in 513 communities in eight of Bolivia’s nine departments (Gonzales et al. 1998).

Agenda setting for newborn survival in Bolivia

Findings are presented below in a historical narrative emphasizing causal factors (especially those in the political context, concerning the power of actors and of an ideational nature) and changes in policy agenda status; political priority for newborn survival grew incrementally between 1990 and 2004, and then stagnated.

The emergence and growth of political priority for newborn survival in Bolivia

Policy attention for newborn survival emerged alongside political priority for maternal and child survival in Bolivia. Government participation in scale-up of the ‘Warmi’ Project in the mid-1990s marked emergence of agenda status. Save the Children Bolivia developed the ‘Warmi’ Project with support from the USAID-funded MotherCare programme to demonstrate the effectiveness of community-based interventions for reducing maternal and perinatal mortality (the latter referring to the weeks shortly before and after birth, including the neonatal period). They piloted the project between 1990 and 1993 in 50 communities in Inquisivi Province: the pilot showed 50% or greater reduction in perinatal mortality alongside improved prenatal care, breastfeeding and immunization practices (Gonzales et al. 1998; Howard-Grabman 2002).

The findings led the national and several sub-national governments to partner with Save the Children Bolivia, other donors and international and domestic non-governmental organizations (notably those under the PROCOSI umbrella, a network of health-focused nongovernmental organizations (NGOs)) to scale up the project nationally from 1994 (Gonzales et al. 1998). Bolivia incorporated the ‘Warmi’ methodology into its 1994 National Health Plan (Access Program Community Mobilization Working Group 2007). A national project evaluation meeting in 1996 led to adoption of several key neonatal health indicators by the Bolivian National Information System including perinatal mortality, prenatal visits, tetanus vaccination, deliveries attended by trained community and health personnel (skilled attendants, such as doctors and nurses), contraceptive use and high-risk pregnancy referrals (Gonzales et al. 1998). In 1998, the project had reached more than 200,000 women in 513 communities in eight of Bolivia’s nine departments (Gonzales et al. 1998).

Also in the mid-1990s, WHO/PAHO and UNICEF introduced Integrated Management of Childhood Illness (IMCI) programming aimed at reducing under-five child mortality. Bolivia committed to IMCI strategy implementation alongside 17 other countries in the Latin America and Caribbean region as a signatory of the 1996 ‘Manifesto de Santa Cruz’ (Cordero et al. 2004). The country was an early adopter, one of six countries around the world expanding IMCI programmes by 1998 (Lambrechts 1999). Facilitated by the Santa Cruz declaration and national commitment to the United Nations Millennium
Declaration in 2000, the government made IMCI integral to its national public insurance plans between 1996 and 2003 (Cordero et al. 2004). Initially, IMCI focused on children from the second month through the fourth year, but health experts soon critiqued the programme domestically and internationally for neglect of the neonatal period (Tulloch 1999; i7; i13; Cordero and Mejia 2002).

Just as health experts identified IMCI coverage gaps for neonates, Bolivia’s 1998 demographic and health survey helped to establish the existence of a problem; the neonatal mortality rate was one of the highest in the region and accounted for a large proportion of the country’s under-five child mortality (see Table 1, Ministerio de Salud y Deportes et al. 2009; i4; i7; i9; i10; i14). USAID’s BASICS programme and PAHO/WHO studies identifying causes of neonatal mortality in Bolivia in the late 1990s and early 2000s also confirmed with local data what international research was revealing about the scope and nature of the problem: birth asphyxia, infections and low birth weight were among the primary causes of death (Cordero and Mejia 2002; i3; i4; i7; i12; i13). An informal network of individuals concerned with the problem formed; it included health ministry officials, donors and health professionals associated with such organizations as PAHO/WHO, UNICEF, USAID and the Bolivian Paediatric Society. Network actors drew upon these local studies to adapt international neonatal IMCI guidelines to the Bolivian context (Cordero and Mejia 2002) and the government adopted neonatal IMCI with a clinical focus in 2002.

Two thousand and two was a pivotal year for newborns in Bolivia. The new Saving Newborn Lives programme (housed at Save the Children Bolivia and funded by the Bill and Melinda Gates Foundation) brought additional support in 2002. The programme launched ‘The State of Newborns: Bolivia’ report mid-year with the first lady and health minister in attendance. The programme provided substantial technical and financial support to develop neonatal IMCI programming, training and research focused at the community level (complementing clinically focused neonatal IMCI). Saving Newborn Lives partnered with the health ministry, members of the PROCOSI network and Neonatal Alliance (a group it helped found to focus on advocacy and programme support for newborns apart from the Safe Motherhood Board, formalizing the network of concerned newborn survival policy advocates). The network, drawing strength from its technical expertise and organizational resources, facilitated government adoption of neonatal IMCI with a community focus in 2004 and development of the ‘Motherhood and Safe Birth National Plan, Bolivia 2004-2008’ (Saving Newborn Lives Bolivia 2005; i1; i4; i7; i9; i12; i13).

The government also scaled up support for neonatal interventions in its national health insurance programmes (essentially offering free care for pregnant women and children under-five years) and plans focused on maternal and child health during this period. The 1996 National Insurance for Motherhood, Infancy and Childhood (SNMN) covered four neonatal conditions (including treatment for birth asphyxia, neonatal sepsis, pneumonia and jaundice). The 1998 Basic Health Insurance (SBS) covered seven conditions/interventions (adding routine immunizations, treatment for meningitis and bacterial infections, and regular medical consultations to those covered under SNMN). The 2003 Maternal and Child Universal Health Insurance (SUMI) extended coverage to 67 neonatal conditions (see UDAPE and UNICEF Bolivia 2006, pp. 102–121). Network actors informed the SUMI expansion; Bolivia’s commitments to the maternal and child health Millennium Development Goals were also instrumental (Ministerio de Salud y Deportes 2004; Ramos 2005; Estado Plurinacional de Bolivia 2009a; Tapia 2010).

Policy attention for newborn survival in Bolivia emerged and grew between 1994 and 2004 as a network of concerned actors worked together with the government, primarily health ministry officials, to expanded the ‘Warmi’ Project, collect data concerning the problem, facilitate adoption and implementation of clinical- and community-based neonatal IMCI programming and address newborn survival needs through the comprehensive SUMI insurance plan and in the ‘Motherhood and Safe Birth National Plan, Bolivia 2004–2008’. Newborn survival became a policy priority over the course of the decade.

The decline of political priority for newborn survival in Bolivia

Shifts in the policy environment and network challenges hindered further development of political priority for the issue from 2005. It was a turbulent year for the Bolivian government: widespread protests related to energy resources management hindered government operations. President Carlos Mesa resigned mid-year. Evo Morales was elected president in December, foreshadowing significant changes in governing priorities in the coming months and years.

Morales’s election heralded a new approach to social welfare policy, promoting developmental advances for the country’s large indigenous population as documented in the National Development Plan 2006–10. This had significant implications for health ministry planning and programming (Republica de Bolivia 2006; Estado Plurinacional de Bolivia 2009b). The health ministry introduced SAFCI (‘Modelo de Salud Familiar Comunitario Intercultural’ or Bolivian Family, Community and Intercultural Health Plan) in 2006. SAFCI features live guiding principals for government-supported health policies and programmes including promoting a culturally sensitive and community-based health system; a stronger health ministry; social mobilization in health care; addressing social determinants of health and government leadership of the health system to eliminate such problems as malnutrition, violence and child abuse (Ministerio de Salud y Deportes n.d.). SAFCI guided health policymaking from 2006 (Terán 2008; Estado Plurinacional de Bolivia 2009a,b; Silva et al. 2009), affecting the level of priority given to various health issues.

The health ministry turned its attention towards reducing malnutrition, a goal that cut across population groups to support social development in line with the National Development Plan 2006–10, presidential support for this goal and SAFCI guidance (World Bank 2009; i9; i12; Tapia 2010; Hoey and Pelletier 2011). The new health minister played a lead role in designing the Zero Malnutrition programme, and he continued to champion the issue in this position (Hoey and Pelletier 2011). A bilateral donor representative recounted the health ministry’s focus on alleviating malnutrition as crowding out attention to other significant health problems, including
newborn survival, in the latter part of the decade (i25). For example, health ministry staff assigned to the Zero Malnutrition programme increased from 5 to 15 between 2006 and 2008 (Hoey and Pelletier 2011); neonatal programme staff shrank to two by 2009. A longtime newborn survival advocate suggested that ‘follow-up of neonatal IMCI, it’s very weak’ because of the issue’s position in the ministry (i3). ‘…As a government it was focusing on a different model of attention with more focus going towards families in the rural areas. They have set it [neonatal programming] aside and let it flow merely by inertia…’ a former health minister reflected in 2009 (i26).

SAFCI and the new health ministry priority for alleviating malnutrition had implications for partner organizations. Under SAFCI, health priorities set by the government guide the work of NGOs, international agencies and donors (i7; i9; i12; i25). An NGO representative with more than a decade of experience related to the problem summarized the situation thus:

What I’m seeing right now…is great investments in the Zero Malnutrition programme, which is where children two months and older are…. So, to say right now, ‘let’s work with the neonatal part,’ it’s a little like, where do we get the resources? (i9).

Earlier in the decade, resources had come from the Saving Newborn Lives programme, but it too had changed direction. The first phase of programme support (mainly aimed at putting neonatal issues on the public health agenda) ended in 2005, transitioning from 2006 to a narrower programme primarily of research support that concluded in 2012 (Saving Newborn Lives n.d.). This was not because of any developments within Bolivia but at the direction of its funder (The Bill and Melinda Gates Foundation). Scaled back support from Saving Newborn Lives and the health ministry reverberated throughout the network of actors and organizations that had been most centrally involved in moving the issue on the agenda.

Bolivia’s newborn survival policy network faced several challenges during this period. The Neonatal Alliance—a group of actors centrally concerned with attracting policy attention and resources to newborn survival, led by Save the Children Bolivia/Saving Newborn Lives and including representatives of the health ministry, PAHO/WHO, UNICEF, UNFPA, USAID, the Bolivian Paediatric Society, PROCOSI and others—merged with the Safe Motherhood Board, forming the Safe Motherhood Foundation. Scaled back support from Saving Newborn Lives and the health ministry reverberated throughout the network of actors and organizations that had been most centrally involved in moving the issue on the agenda.

Maternal health advocates outnumbered neonatal health advocates in the forum, and a number of the latter group scaled back participation in meetings because they felt that their issue did not receive enough attention (i4; i10; i12; i13; i14). The decline of the Neonatal Alliance meant fewer conversations and less emphasis on neonates in the Mesa and within the health ministry (i4; i12).

This loss of voice in the primary forum for newborn health policy advocacy was compounded by a decline in official status of the Safe Motherhood and Birth Mesa. The original Safe Motherhood Board was established in 1996 by executive order and led by Bolivia’s first ladies until Carlos Mesa’s presidency. First ladies used their influence to draw attention to maternal and newborn survival issues among policymakers and healthcare professionals between 1996 and 2003. But Mesa’s wife did not assume the role and his successor (Morales) remained unmarried, thus depriving the issues of a traditional ally. The board’s official status declined with its move from executive branch oversight to health ministry authority in 2004. The leader of a technical unit in the health ministry chaired the board in 2009. Maternal and newborn health advocates respected her leadership, but they recognized the limited power of technical officials to attract policy attention and resource allocations for issues (i12; i14).

Network actors commented on their declining status, complaining that they had not been consulted on the only two policies addressing maternal and newborn survival in the latter half of the decade, a 2006 breastfeeding support law (Law No. 3460, ‘Ley de Fomento a la Lactancia Materna y Comercialización de sus Sucedáneos’) and the 2009 ‘Bono Juana Azurduy’, a cash incentive programme to promote access to maternal and child health care among the under-insured (i12; i14). The ‘Bono’ was a product of the political environment, justified on the basis of the new ‘state political constitution’ (passed in early 2009 a right to maternal health care is included in Article 45) and the related National Development Plan 2006–10 (Estado Plurinacional de Bolivia 2009a); it came about with the support of Bolivia’s president and ruling party, ‘Movimiento al Socialismo’ or ‘MAS’ (MAS 2009; Morales 2009).

Maternal and newborn survival advocates were critical of the ‘Bono’ and frustrated that they were not consulted, suggesting that more fully developed and better supported neonatal IMCI programming would better address the needs of newborns (i2; i4; i11; i12; i14; i23; i26). Technical experts questioned the logic, efficacy and financial sustainability of the ‘Bono’. A prominent member of the Safe Motherhood and Birth Mesa said:

We have not been able to get to the [health] minister nor president or a minister’s meeting to show them our concerns [about the Bono]. So this is proof of how the board has lost, completely, the ability to make an impact politically (i14).

Payments on the ‘Bono’ were suspended for several months in 2010 and implementation challenges related to registration, infrastructure, human resources, monitoring and quality assurance, have been reported (Moloney 2010).
Discussion

Newborn survival rose on Bolivia’s health policy agenda from the mid-1990s through the early-2000s, and then experienced a relative decline as changes in the political context shifted attention to other issues and the policy network became less influential. Political priority for newborn survival in Bolivia emerged in relationship to policy windows opened by international commitments to improve maternal and child health in the mid-1990s (‘Warmi’ expansion and IMCI adoption) and early-2000s (United Nations Millennium Declaration). Domestic child health experts came to recognize gaps in IMCI coverage for neonates and evidence concerning the scope, nature and tractability of the problem provided bases for policy advocacy in the later 1990s. An informal but relatively cohesive policy network comprised of important stakeholders (health ministry representatives, donors, NGOs, health experts) formed to advance solutions in this environment, resulting in neonatal IMCI adoption and a significant increase in the scope of neonatal intervention coverage under the SUMI national health insurance plan in the early 2000s.

The framework of analysis used in this study helps to identify key factors in the emergence and growth of political priority for newborn survival in Bolivia over the course of a decade, including factors in the political context and the power of actors and ideas/issue characteristics. The Bolivian case points to some potential framework modifications, however, particularly as differences between periods of emergence and growth are contrasted with a period of declining priority for newborn survival in the later 2000s. Differences between causal factors in these periods are summarized in Table 2 and key insights and implications for the framework are discussed below. Because declining priority is an under-studied phenomenon, further research is needed to investigate the generalizability of conclusions.

To begin, ‘actor power’ declined during the later 2000s, limiting network influence on political priority for newborn survival in Bolivia over the course of a decade, including factors in the political context and the power of actors and ideas/issue characteristics. The Bolivian case points to some potential framework modifications, however, particularly as differences between periods of emergence and growth are contrasted with a period of declining priority for newborn survival in the later 2000s. Differences between causal factors in these periods are summarized in Table 2 and key insights and implications for the framework are discussed below. Because declining priority is an under-studied phenomenon, further research is needed to investigate the generalizability of conclusions.

To begin, ‘actor power’ declined during the later 2000s, limiting network influence on political priority for newborn survival in Bolivia during this period. Several factors played a role: (1) the maternal and newborn survival networks merged; (2) the official forum (the Mesa) moved from executive to technical level health ministry liaison and (3) key network actors, including the health ministry, Saving Newborn Lives and members of the PROCOSI network, scaled back advocacy and programme support (representing declining support from guiding institutions and civil society organizations). The political context affected some of these developments. Nonetheless, changes in policy community cohesion, composition, status and

Table 2 Factors affecting political priority for newborn survival in Bolivia

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<tr>
<td>Poltical context</td>
<td>Strong political commitments to the millennium development priorities</td>
<td>Strong political commitment to IMCI implementation and safe motherhood are made</td>
<td>Leadership transitions and instability redefine development priorities</td>
</tr>
<tr>
<td>Ideas</td>
<td>Research begins to establish neonatal mortality as a problem</td>
<td>Neonatal mortality identified as a significant contributor to under-five child mortality</td>
<td>Neonaatal mortality neglected as a significant contributor to under-five child mortality; IMCI and neonatal mortality are increasingly viewed as distinct issues</td>
</tr>
<tr>
<td>Actor power</td>
<td>A network of concerned actors including researchers, health ministry officials, USAID, Saving Newborn Lives, and PROCOSI representatives begin to emerge</td>
<td>The newborn survival policy network comprised of a broad range of key stakeholders convenes formally, drawing strength from commitment to the issue and organizational support</td>
<td>Newborn and maternal survival networks merge, fewer newborn advocates participate</td>
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investments meant that the issue received relatively less attention and support among the same network actors that were instrumental in advancing the issue in the earlier period; the changes also left the network in a weaker position to cope with transitions in the political context. As such, future research should consider whether adding certain policy community characteristics (composition, status and investments of actor resources alongside cohesion) might enhance insights gained from application of the framework; these factors should be investigated in the context of shifting priority levels so that causality may be assessed.

In the ‘political context’, regime change mid-decade had unanticipated impacts on political priority for newborn survival. Priorities often shift with changes in political leaders and values (Baumgartner and Jones 1993; Kingdon 1994; Reich 1995), but Morales’s presidency came with an agenda promoting the social welfare of the very populations most affected by newborn health problems (poor, rural and indigenous). How could political priority for newborn survival decline in this context?

Bolivia’s new leadership redefined the nation’s approach to addressing health and other social problems, moving from narrowly defined programmes with specific targets (neonatal IMCI) to a more philosophical and less clearly defined approach (SAFCI). A period of instability and adaptation followed with the health ministry ultimately shifting its attention and resources to a new set of priorities, propelling the Zero Malnutrition initiative forward and leaving neonatal programmes to ‘flow by inertia’ (in the words of a former health minister). But neonatal programmes did not have the momentum to propel them forward in this environment. Neonatal IMCI and the SUMI insurance plan were relatively new and the resources needed to promote and sustain effective implementation never materialized. Political transitions, shifting priorities and instability affected weak follow-through on the policy promises; these factors affected priority generation for newborn survival in Bangladesh and Nepal (Smith and Neupane 2011; Shiffman and Sultana 2013) as well, suggesting additional characteristics of political contexts may warrant consideration.

The Bolivia case speaks to a broader point about how we assess the status of issues on policy agendas. If the emergence of policies, programmes, plans and initial resource investments (such as developing protocols and training human resources) are indicators that agenda status has been attained, then newborn survival has been a priority in Bolivia for nearly two decades. However, a lack of follow-through on policy promises suggests that political priority for the issue has waned in recent years. Analysis of the Bolivia case suggests that agenda status is better understood by incorporating indicators of policy attention and its sustainability (see Table 3). In the health policy arena, policy promises need to be backed with provision of skilled human resources, technical and administrative support, sufficient facilities, supplies and budget and robust monitoring and evaluation systems—components of strong health systems. If they are not, then political priority has not been sustained and the likelihood of policy impact is thereby reduced. In the Bolivian case, neonatal IMCI programmes and the SUMI insurance plan lacked sufficient health system support measures; this likely affected the country’s stagnant neonatal mortality rate between 2003 and 2008.

### Conclusion

Newborn survival rose early on the policy agenda in Bolivia—in the 1990s and early 2000s when the problem was just gaining attention internationally. But political priority for the issue also declined early—interrupted by political instability just as the concerned policy community experienced a series of setbacks. Drawing insights from our framework of analysis, the case suggests political priority for health issues may be determined by such factors as: international agreements that commit governments to act; ongoing generation of credible evidence concerning the problem and sustained attention from a relatively cohesive network of key actors with status and resources to support activities over an extended period of time. Newborn survival gained a degree of priority in Bolivia, but remained vulnerable to political transitions and instability. It was vulnerable because policy promises were insufficiently backed. The case of newborn survival in Bolivia suggests that health policy networks need to act strategically to ensure health system responsiveness to their issues, thereby sustaining issue attention and increasing the likelihood of policy impact.

### Table 3 Priority and sustainability indicators for newborn survival in Bolivia

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
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<tr>
<td>1994</td>
<td>Government-sponsored ‘Warmi’ scale-up commences, reaching 200,000 women in eight departments by 1998. The programme continued into the 2000s.</td>
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<tr>
<td>2002 and 2004</td>
<td>Clinically and community-focused IMCI adopted. Protocols developed and training initiated for clinically and community-focused IMCI, but implementation was under-supported in the long-term.</td>
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<tr>
<td>2003</td>
<td>Significantly expanded intervention coverage under SUMI insurance. Evaluations find SUMI expanded coverage, but insufficient investments in health system infrastructure limit impact.</td>
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<tr>
<td>2006</td>
<td>Breastfeeding support law passed.</td>
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<tr>
<td>2009</td>
<td>‘Bono Juana Azurduy’ incentive announced. Reported to increase demand, but funding and implementation challenges limited impact.</td>
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Acknowledgements

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Conflict of interest

None declared.

Endnote

1 In an editorial in Los Tiempos newspaper, the Bolivian vice president was cited denying that the ‘Bono’ was held up by funding problems, pointing to delays in renewing contracts with the doctors responsible for registering women for the ‘Bono’ instead (Los Tiempos, February 26, 2010). A news article in May 2010 documented the government’s request to the Inter-American Development Bank for loans to fund the ‘Bono Juana Azurduy’ (La Razón, May 17, 2010).

References


