

FACTORS OF POWER WITHIN THE AGENDA SETTING STAGE OF
GLOBAL HEALTH POLICYMAKING:

A CASE STUDY ANALYSIS OF MATERNAL HEALTH POLICY
PRIORITIZATION IN RWANDA

By

PRIYANKA KOLAGANI

A Thesis Submitted to the W. A. Franke College

In Partial Fulfillment of the bachelor's degree with Honors in

Public Health

THE UNIVERSITY OF ARIZONA

MAY 2025

Approved by:
Dr. Priscilla Magrath
Department of Health Promotion Sciences

ABSTRACT

In the context of global health, the agenda setting stage of policymaking is pivotal to the effective advancement of global health policy. While global health policy advancement is often portrayed as an objective, altruistic effort seeking to better the health of a population, it is equally necessary to recognize the underlying power dynamics which shape policy outcomes. Researchers in the field of global health policymaking have developed several frameworks to analyze how power dynamics influence health policy advancement on a global scale. Notably, Dr. Jeremy Shiffman proposes a four-factor framework which identifies key actors of power present within the agenda-setting stage of health policy making within a country. This thesis includes a case study of successful Rwandan maternal health policy advancements within the last two decades, and utilizes Shiffman's framework to identify key factors of power which influence health policy prioritization within the country. Key findings from this study have allowed for a deeper understanding of how actors of power interact with one another to shape health policy, and have ultimately highlighted the effectiveness of strong political entrepreneurship, effective decentralization, and a participatory approach to policymaking as central factors in Rwanda's maternal health policy success. These insights contribute to a broader understanding of how power dynamics can be strategically leveraged to advance global health agendas.

METHODS

This research examines how power operates during the agenda setting stage of policymaking through a case study analysis of Rwanda's improvement of maternal health policy in recent years. Shiffman's four-factor agenda-setting framework is used to understand how actors of power operate during agenda setting in policy making. This agenda setting framework alongside findings from Rwanda's case study will be used to identify key power actors and dynamics in policy prioritization.

Detailed research surrounding maternal health policy advancements in the Rwandan case study are used to identify factors of influence during the agenda setting process. Shiffman's framework of agenda setting is then compared against empirical evidence presented in the Rwandan case study to make causal inferences. Using Rwanda's maternal health policy as the case study offers strong empirical grounding to trace how diverse power actors in agenda setting influence policy prioritization and enable successful health interventions in a country.

THEORETICAL FRAMEWORK

Power in Global Health: Shiffman's Social Arena

Global health is often portrayed and viewed as the noble endeavor of advancing health equity and addressing population health concerns around the world. However, this portrayal is limited and does not allow for the recognition of the multi-dimensional web of influence which exists behind a majority of global health decision-making and policy advancement. Recently, there has been a growing awareness among public health experts regarding the influence of power dynamics on global health policy advancement. According to research by Jeremy Shiffman, the current portrait of actors working in global health is incomplete and he argues that global health must be analyzed for what it is - "a field of power relations" (Shiffman,2015). Understanding how power dynamics operate within what Shiffman calls the "social arena" (Shiffman, 2015) of global public health ultimately allows for a more productive and realistic approach toward global health policy improvement. Power must be recognized as a factor which

influences global health and the means by which power operates particularly in the context of global health policy advancement must be clearly defined.

Agenda Setting and Political Will in Policy Prioritization

Health policy prioritization is the first and most critical step in the global health policy making process, as it is the stage of policymaking where key actors on the global health stage come forward to make their voices heard. A thorough study of current literature surrounding this topic has opened the doors to more insight surrounding the question of power dynamics within the process of *agenda setting*, which essentially determines which health issues gain adequate attention to lead to policy change or advancement. Agenda setting is crucial because it is the step of policymaking where power play is often at its greatest, as the successful prioritization of a policy on a health policy agenda is what provides the opportunity to advance the policy to later stages of development and implementation. It is necessary to identify the power wielded by significant actors during this process of health policy prioritization. By recognizing the relationships and power dynamics that exist between these actors, we can identify how these dynamics impact health policy development during the prioritization stage of policymaking.

Actors who are present during the agenda setting stage contribute to generating *political will* for a given global health issue. Political will in the context of policy making refers to the willingness of key decision-makers to support a particular policy advancement. The reason that political will is crucial in the agenda setting stage of policymaking is because without it, there can be no further action surrounding a policy. An article discussing the generation of political will for safe motherhood practices in Indonesia (Shiffman, 2003), makes some key points regarding the agenda setting process in light of global health policy. Firstly, Shiffman identifies that agenda setting in global health involves “an interaction of national and transnational forces” (Shiffman,2003), which convene to “shape the emergence of issues on to policy agendas” (Shiffman, 2003). Emphasizing the importance of “strategic negotiation” (Shiffman, 2003) between national and transnational forces in addition to domestic forces recognizes the existence of a more diverse group of actors involved in the process of policy prioritization.

Shiffman's 4-factor framework for understanding policy prioritization

FACTOR 1: *Clear Indicators*

Shiffman's article highlights 4 key factors that influence policy prioritization during the agenda setting stage of policymaking (Shiffman, 2003) and ultimately act as actors of power. The first factor that is highlighted in the article is the existence of *clear indicators* which Shiffman states have "agenda setting power" and which act as "catalysts for action." Indicators such as maternal or infant mortality rates within a country can sometimes be viewed simply as oversimplified statistics of larger public health issues and may seem trivial in the context of power dynamics during agenda setting. However, Shiffman argues that indicators have a "uniquely power effect of giving visibility to that which has remained hidden" (Shiffman, 2003), and this visibility he argues is crucial to leading policymakers to prioritize certain health policy advancements which they otherwise wouldn't. In this way, reliable indicators which mark the severity of a health concern within a population contribute to the generation of political will among policymakers. When political will is generated due to an indicator during the agenda setting process of policymaking is when action begins to happen.

FACTOR 2: *Political Entrepreneurship*

The second factor which holds power in the agenda setting process of policymaking specified by Shiffman's research is *political entrepreneurship*. According to the article, effective agenda setters are strong political entrepreneurs who do not simply advocate for a particular issue, but rather work toward building strong connections and coalitions which give them the ability to facilitate change over time. A key strength of political entrepreneurs is their focus not only on the intricacies of a particular public health issue in need of advancement, but also on the intricacies of the policymaking environment that they are placed in. As the article states, strong agenda setters "articulate vision amidst complexity" (Shiffman, 2003) and "know the critical challenges in their environments" (Shiffman, 2003). Ultimately, political entrepreneurs leverage their strong rhetorical skills and appeal to social values among their network of colleagues and

subordinates to generate commitment and a “sense of mission” (Shiffman, 2003) regarding specific health policy concerns.

FACTOR 3: *Focusing Events*

Next, Shiffman specifies the occurrence of prominent *focusing events* as a key factor which influences agenda setting. Focusing events are defined as “large-scale happenings such as crises, conferences, accidents, disasters and discoveries that attract notice from wide audiences” (Shiffman, 2003). The article states that such events “function much like indicators, bringing visibility to hidden issues” (Shiffman, 2003). Focusing events are often more apparent and recognizable than indicators, and they promote widespread attention for a public health issue, both amidst the general public as well as amidst policymakers. The larger and more impactful the focusing event, either positive or negative, the more power the event has to lead policymakers to make policy adjustments to address the highlighted issues.

FACTOR 4: *Feasible policy proposals*

Lastly, the fourth factor that Shiffman specifies in his framework for agenda setting is the existence of *feasible policy proposals*. According to agenda setting research, policymakers mainly respond to policy proposals that are “sensible, cost-effective, technically feasible, politically palatable, and relevant to the problem at hand” (Shiffman, 2003). Policymakers also identify policy proposals “that pose minimal threats to their political positions” (Shiffman, 2003) and which give them a chance to increase political capital. In sum, the agenda setting power of a policy proposal increases based on its feasibility, relevance, and overall palatability to political leaders and policymakers.

CASE STUDY

Maternal Health Policy Prioritization in Rwanda

Rwanda: Introduction

Rwanda has seen considerable advancement in maternal health policy in recent years. Major improvements have been made within the country in regards to maternal and child health, and many of these changes have been made possible due to strong government support and increased political will in regards to health policy improvement within the country. A few key maternal health successes in Rwanda have been its prioritization of increasing community health workers, skilled birth attendance, and improved family planning practices. These advancements were significant in allowing for significant improvements in Rwanda maternal health. While Rwanda is now renowned as a global exemplar of health, the journey to its present day success is a story often left untold. Behind its growing reputation as a global health leader in maternal health advancement is a web of power dynamics and policymakers whose opinions and decisions have come together to shape Rwanda's present standing in the global health arena.

Rwanda: Historical & Political Background

The point in time where significant change began to take place in Rwandan maternal health policy and practice is marked by the tragedy of the 1994 Rwandan genocide which left the health system of country in a detrimental state. As one source states, "The genocide was the culmination of decades of division and incitement of hatred towards the Tutsi by extremists in the country's leadership, which was controlled by members of the Hutu majority group. A deliberate process of positioning the Tutsi as a dangerous and inferior minority group, and even as less than human, set the stage for the genocide that was to come" (*What Led to the Genocide against the Tutsi in Rwanda?* | CMHR, 2019). The conflict ended with a change in government to a "coalition of parties dominated by RPF (Rwandan Patriotic Front)." This party is affiliated with the minority group in the country - the Tutsi. Since this event, government officials have made an active effort to broaden the party's base and include Hutu in positions of authority (Kelsall,

2020), and have also made an active effort to improve the position of women in society. It is widely recognised as one of the most “gender-conscious governments in the entire developing world” (Kelsall, 2020). The government is also focused on rebuilding and improving health infrastructure, including establishing health centers in local communities” (Worley, 2015). A decentralized government approach within the country’s health sectors has also played a role enabling the strengthening of community involvement in health policy advancement (Worley, 2015).

Rwanda: Postwar Rebuilding - Maternal Health Policy Prioritization

Following the genocide, Rwanda’s government recognized a severe shortage of health workers within the country, limited health infrastructure, and increased maternal mortality (Worley, 2015). While statistics for population health immediately following the genocide are not very strong due to limited data, sources state the detrimental effects of the catastrophe. Rwanda’s overall health infrastructure was utterly destroyed during this time, with one source mentioning how nearly all facilities had been destroyed, while “three-quarters of all health workers either fled or lost their lives during the conflict” (*Rwanda’s Pay-For-Performance Scheme for Health Services*, 2015). Statistics also reveal that 1 million lives were lost and 2 million individuals were displaced. Prior to this event, maternal mortality was at 1000 deaths per 100,000 live births, and this lack of health infrastructure made maternal health an even greater challenge. With multiple indicators of health in Rwanda signifying its need for maternal health policy advancement, policymakers began to recognize the need for change surrounding these policies. As a result, Rwanda’s prioritization of maternal policy on its national policy agenda has led to maternal health policy advancement and improved outcomes within the country.. Maternal health success in Rwanda is identifiable in a few specific policies, among which are the CHW (community health worker) initiative, increased skilled birth attendance, and investment in family planning practices.

Rwanda: Postwar Rebuilding - Maternal Health Policy Advancements

CHW (Community Health Worker) Initiative

A key policy advancement in Rwandan maternal health is the CHW (community health worker) initiative. Rwanda implemented the Community Health Worker (CHW) program in 1995 in order to address the severe shortage of health workers left by the genocide. The program involved the deployment of CHWs to villages to deliver basic healthcare services, especially to vulnerable populations like pregnant women and children (Worley, 2015). These services include antenatal care, safe support during delivery, as well as postnatal follow-up care (Spratt, 2025). The CHW initiative has successfully overcome multiple barriers to health in Rwandan communities, including barriers of transportation and cost. The program was started in the early 2000s, when the Rwandan government recognized the need for maternal care that would be “closer to home” (Spratt, 2025). The CHW initiative was particularly impactful in improving outcomes regarding maternal deaths due to postpartum loss, which massively decreased once the initiative was put into place (Spratt, 2025). Community health workers are elected by their community and they “connect communities to health services, especially in remote areas, and monitor health at the village level” The current system involves three elected volunteers from each village who are trained by the Ministry of Health: a male and a female, who are in charge of integrated case management of childhood illness and family and a third CHW focused on maternal and infant care.

Increased National Investment in Midwifery training to improve Skilled Birth Attendance

Another significant policy advancement in Rwanda maternal health has been the increase of skilled birth attendance, primarily in the form of trained midwives. The WHO's definition of a “skilled birth attendant is as follows: “a health provider who has at least the minimum knowledge and skills to manage normal childbirth and provide basic (first line) emergency obstetric care” (Carlough & McCall, 2005). “Before 1997, Rwanda had no trained midwives, but by 2015 there were around 1,000” (*Rwanda's Success in Improving Maternal Health*, 2024). The Rwandan government has prioritized and invested in increasing skilled birth attendance within communities by training midwives and deploying them to health facilities and rural

communities. As of 2013, 93% of women gave birth in a health facility, with one of the main contributing factors being educating midwives in the country (*A Collective Effort: Strengthening the Midwifery Profession to Save the Lives of Mothers and Newborns*, 2023)

The Rwandan government also partnered with the UNFPA (United Nations Population Fund) to focus on scaling the number of midwives across the country to support pregnancy and birthing needs. This partnership has “brought in vital equipment such as birthing simulators to some of the country’s universities to support learning conditions” (Spratt, 2025). “The UNFPA works with the Ministry of Health, the Ministry of Education through the University of Rwanda, and other partners to improve the midwifery profession following these four pillars. UNFPA supports (1) midwifery education through scholarships for Master’s and PhD students and providing simulation-based training to enhance midwifery education both pre-and in-service using a mentorship program; (2) strengthening the Rwanda Association of Midwives; (3) Rwanda midwifery’s regulation, for instance, a midwifery task force sub-TWG was introduced; and (4) keeps advocacy for investments in midwifery programming” (*A Collective Effort: Strengthening the Midwifery Profession to Save the Lives of Mothers and Newborns*, 2023). As of 2023, there are 2006 graduated midwives in the country from the University of Rwanda. Statistics from the years 2016-2017 reveal that over 90% of Rwandan women deliver in health facilities with the assistance of a skilled birth attendant (*What Did Rwanda Do?*, 2017), and the presence of trained midwives is a significant contributor to this policy success. By investing in midwifery education as a key form of providing skilled birth attendance, Rwanda has established new standards for quality of maternal care within communities.

Family Planning Resources & Education

A third policy advancement in Rwanda has been its increased efforts to promote family planning within communities. And through the implementation of community health programs and skilled care workers, Rwanda has boosted access to contraceptives and education surrounding them significantly, helping to lower the number of births per child bearer. As a result, the risks associated with frequent pregnancies have been lowered (Spratt, 2025) and maternal mortality has declined” (*What Did Rwanda Do?*, 2017). The government’s prioritization of contraceptive use and family planning have led to a 40% increase in Rwandan women ages 15-19 using modern contraception (*Health in Rwanda*, 2012).

Rwanda Maternal and Child Health Policy Advancement through the lens of Shiffman’s 4 Factor Framework for Agenda Setting

RWANDA: Focusing events

Table 1: Key National & Transnational Events Surrounding Global Maternal Health Policy

Year	Event
1976–1999	Policy attention to maternal mortality emerges and grows on a global scale.
Early 1980s	WHO and UNFPA gather new data on maternal mortality.
1985	WHO’s first interregional meeting on maternal mortality.
1987	An Inter-Agency Group for Safe Motherhood was formed following the International Safe Motherhood Conference in Nairobi, Kenya.
Late 1980s–1990s	Surge in maternal health research; women’s rights norm gains ground.
1990	Baseline year for MDG 5 (maternal mortality).
1994	Rwanda genocide; RPF (Rawandan Patriotic Front) assumes power.
1995	Rwanda launches CHW (Community Health Worker) program.
1996	Rwanda establishes the Women’s Council.
1997	Before this year, no trained midwives in Rwanda.
2000	The UN Millennium Summit creates the MDGs, including MDG 5.
2005	PMNCH (Partnership for Maternal, Newborn & Child Health) is formally established.
2015	MDG 5 target year; new international development agenda replaces MDGs.

Maternal health policy advancement in Rwanda began its steady incline at the turn of the century. However, prior to this incline in maternal health policy prioritization and implementation within Rwanda, came a myriad of focusing events which took place both at a national and transnational level, among which were the global prioritization of maternal health advancement toward the end of the 20th century as well as political tensions within Rwanda following its mass genocide which occurred during the same time. Shiffman's agenda setting framework states that focusing events are key actors of power which affect agenda setting and policy prioritization within a country, and Rwanda's health improvement aligns strongly with the theory presented by this framework

In terms of national focusing events, the single most prominent event which led to Rwanda's prioritization of health policy in general within the country was the detrimental losses it faced to its healthcare infrastructure following what is now known as the Rwandan genocide of 1994. It was during this same time that the global maternal health network was beginning to solidify maternal health as a key global health concern. The parallel rise of maternal health policy on the forefront of global health improvement was a key focusing event as well. Shiffman mentions the impact of both national and transnational forces which hold the power to affect policy prioritization and agenda setting. In Rwanda's case this is true because while the focusing event which affected the country nationally was extremely pivotal, the external influence of MDGs rising as key indicators of global health also allowed for policymakers to view maternal health in Rwanda as an important area of policy improvement.

One article which looks at the power of global health networks and norms in regards to agenda setting for maternal survival states that "Policy attention for global maternal mortality reduction emerged and grew for some two decades before rising to a prominent position on the international development policy agenda in the 2000s" (Smith & Rodriguez, 2015). So while Rwanda's government and Ministry of Health were planning to reverse damages to their health infrastructure and repair their global image, the wider global health stage was in the process of creating specific goals that could be met in order to allow for a global health improvement. The United Nations Millennium Development Goals (MDGs) were created in 2000 following the UN Millennium Summit which took place that year. A total of eight millennium development goals (MDGs) were adopted by member states and were aimed to be achieved by 2015 (World, 2018). One of these goals was MDG 5 which specified two targets: 1) Reduce by three quarters,

between 1990 and 2015, the maternal mortality ratio; 2) Achieve, by 2015, universal access to reproductive health (*United Nations Millennium Development Goals, 2015*). Based on historical responses to the MDG goals it is clear to global health researchers that “The power of the MDG supernorm, its rapid cascade and movement to internalize the framework led to major initiatives that advanced attention and resources to improve maternal health” (Smith & Rodriguez, 2015).

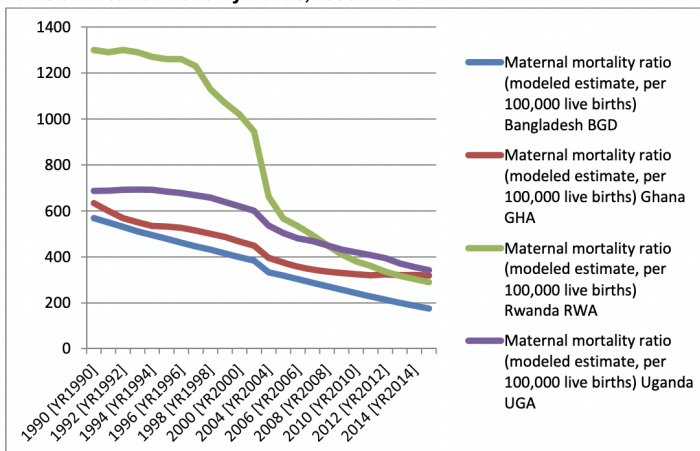
RWANDA: *Key indicators*

When considering maternal health policy advancement, it is important to consider a few key indicators of maternal health status within a population. Most commonly, the MMR (maternal mortality ratio) is viewed as the primary identifying factor of maternal health and even overall health within a country. Whether the MMR increases or decreases during a period of time is taken to be indicative of health deterioration or improvement within a country respectively. Additionally, some other indicators of maternal health in a country would be the percentage of women receiving prenatal care, the percentage of women receiving skilled birth attendance (Kelsall, 2020) or delivering at health facilities (*RWANDA Ministry of Health, Rwanda*), and the percentage of contraceptive prevalence (Kelsall, 2020).

Figure 1: Maternal Mortality Trends (1990-2015)

Political settlements and the implementation of maternal health policy in the developing world:
A comparative case study of Rwanda, Ghana, Uganda and Bangladesh

Table 3: Maternal mortality trends, 1990-2015

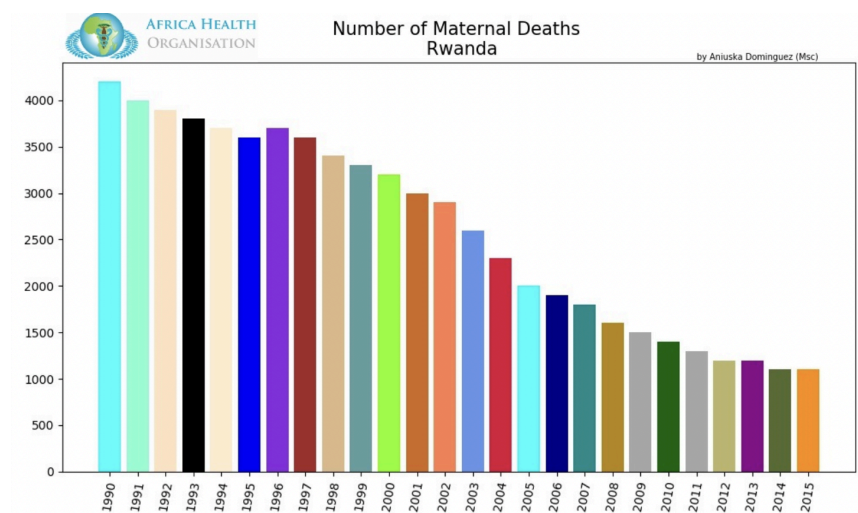


Source: World Data Bank, 17 February 2016.

Source: Political settlements and the implementation of maternal health policy in the developing world: A comparative case study of Rwanda, Ghana, Uganda and Bangladesh. (Kelsall, 2020)

This graphic highlights maternal mortality trends in various countries. “Rwanda shows a very steep decline between the mid-1990s and mid-2000s” (Kelsall, 2020). The maternal mortality trend of Rwanda during this time period reflects the rapid advancement of maternal health policy in the country.

Figure 2: Number of Maternal Deaths (1990-2015)



Source: *Number of Maternal Deaths in Rwanda* | Africa Health Organisation (Dominguez, 2019)

This graphic shows a trend of Rwandan maternal deaths starting pre-genocide and going until 2015, once maternal health policies had been implemented. A gradual and consistent downward trend is seen starting in the year 1996, which is two years after the Rwandan genocide occurred. These statistics reveal the effectiveness of Rwandan maternal health policy advancements which were implemented following the devastating national event.

Table 2: Indicator statistics of maternal health policy advancement in relation Rwandan genocide

	Before Rwandan genocide (~1994)	Immediately following Rwandan genocide	(2012-2015)
MMR per 100k births	1990's: 1000	N/A	2013: 320
% Women receiving prenatal care	1990: 10%	2000: 40%	2012: 64%
% Women delivering at health facilities	N/A	2000: 31%	2012: 69%
% Women using modern contraception age 15-49	N/A	2000: 10%	2015: 48%

Sources: (*Healthy Newborn Network*, 2025), (Dominguez, 2019), (Ford, 2013), (*Rwanda's Success in Improving Maternal Health*, 2024)

Pre-genocide or immediately following, maternal health indicator statistics were at alarming rates. This was due to the fact that Rwanda's health system was already weak prior to the genocide, and the catastrophic event only led to further damage to the country's health system. The implementation of maternal health policy advancements in Rwanda has been incredibly effective in improving the nation's overall maternal health practices and in reversing damage done to the health system by the genocide which took place.

RWANDA: *Political entrepreneurs*

An interesting finding from the research is that the maternal health policy developments made in Rwanda were not necessarily all due to a strong political will solely for increased maternal health in the country specifically. Rather, an overarching political will to increase the country's global health standing became the driving force behind agenda setting in the country's healthcare during the years following the genocide within the country. In the years

post-genocide, a majority of political entrepreneurship surrounding maternal health improvement efforts were led by Agnes Binagwaho, whose influence on maternal health policy prevails as the country continues to improve its maternal health infrastructure. “From 2002-2016, she served the Rwandan Health Sector in high-level government positions, first as the Executive Secretary of Rwanda’s National AIDS Control Commission, then as Permanent Secretary of the Ministry of Health, and then during five years as the Minister of Health” (Agnes Binagwaho, 2024). When asked about rebuilding after genocide, Agnes Binagwaho states that “the government created a health system that reaches out to the poor and vulnerable because ‘when we have them in the loop, we have everybody.’ Health programs are implemented or revised based on evidence of impact on the community” (*Rwandan Minister of Health Dr Agnes Binagwaho Discusses Country’s Health Advances - Fogarty International Center @ NIH, 2015*).

The President and First Lady of Rwanda are both also known to have “championed causes affecting women’s and children’s health” (RWANDA Ministry of Health, Rwanda) and played a large role in authorizing the RapidSMS system used by CHW workers. While Rwanda’s policy implementation process is characterized by a strong top-down approach, where political entrepreneurs typically emerge from individuals already positioned within high levels of power and influence, efforts to decentralize power and adopt a more participatory approach to policy making have increased. These decentralization efforts have led high-level policymakers to actively consult with community-level implementers during the agenda setting stages of policymaking.

Research shows that a “participatory approach to identifying challenges” is extremely effective in the early stages of the policymaking process, and a “diverse network composition [is] crucial to maternal health’s rise on the agenda” (Spratt, 2025). Diverse power actors in agenda setting have been found to influence policy prioritization and enable successful health interventions” (Spratt, 2025). Global health scholars have increasingly turned their attention to how global health problems are both addressed and, at times, even created by global institutions and policies (Rushton & Williams, 2012). They argue that policymaking in global health should be understood as a multi-level process occurring at the local, national, regional, and international levels, rather than simply following a hierarchical model. Evidence from Rwanda, for instance, suggests that when key policymakers and political entrepreneurs engage in meaningful dialogue with actors at lower implementation levels, policies are more effectively prioritized and

contextualized. This reveals the importance of political leaders not only possessing the power to enact change but also the willingness to *listen* to concerns—especially in decentralized systems where local perspectives are vital to successful implementation. The District Council in Rwanda takes this approach and brings together multiple sectors (Social Affairs Cluster of Ministries which includes the Ministries of Education, Health, Gender and Family Promotion, Local Government, Agriculture, and Public Works) and is the decision making and coordinating body at the district level (Kelsall, 2020). Additionally, the monthly Joint Action Development Forum provides a coordinating as well as reporting mechanism bringing all partners, local and international, and sectors together to report on progress against targets as well as to plan. This effort has strengthened partnerships and has allowed for a better use of available funds, which has greatly contributed to Rwanda’s ability to scale up key policy interventions.

Rwanda’s participatory approach to policy making also involves the inclusion of feedback from CHWs as part of their maternal health policy advancement within a community. Because these workers are selected from the community, the individuals in these communities have an increased trust toward these health workers who are able to deliver culturally sensitive care, and CHWs are able to advocate strongly for their community needs. While CHWs do not directly participate in policy-making meetings at the highest levels, their work at the community level provides invaluable insights and data which inform policy decisions. Their involvement in national health programs and the integration of their feedback into policy development ensures that policies are relevant, effective, and tailored to the specific needs of the Rwandan people. CHWs collect health and social-related data to identify factors influencing health outcomes as well as to monitor client’s progress in working with a CHW ((Kowalczyk et al., 2024), and the data collected by CHWs are utilized for evaluation, maintenance, expansion, and dissemination of programs. Data on the outcomes of CHW services can highlight the successes of CHW programs as well as areas for improvement (Kowalczyk et al., 2024). Additionally, The Ministry of Health launched the policy dialogue on Rwanda community health sustainability and resilience to gather different views from key stakeholders to guide the ongoing community health reforms. The Dialogue was held on June 7, 2022, at Serena Hotel in Kigali (*Community Health Workers Policy Undergoes Reform for Better Service Delivery*, 2025). Dr. Ngamiye, the Rwandan minister of health between the years 2020-2022 states that, “Community Health Workers contributed a lot to the reduction of maternal and child mortality in Rwanda, and they helped

improve the health status of the Rwandan population” (*Community Health Workers Policy Undergoes Reform for Better Service Delivery*, 2025).

Using a context-specific approach rather than imposing external models has allowed Rwanda to create local solutions that address the unique challenges faced by women in their respective communities. Rwanda’s approach to maternal health solutions emphasizes the importance of cultural competence and tailoring interventions to the specific needs of each community rather than relying on standardized approaches which often do not “sufficiently consider the nuances of diverse communities” (Spratt, 2025).

Overall, Rwanda has leveraged the diversity of its actors very strongly in order to continue making new improvements within maternal health policy. Not only was maternal health policy prioritized by the government, but there were local partners who worked toward advancing these efforts to lead to a successful implementation of these policy initiatives. In this way, political entrepreneurship in Rwanda is influenced by multiple factors. Additionally, in Rwanda, the need for political entrepreneurship in maternal health is relatively low. This is largely because there is already a pre-existing strong political will within the country to advance health policy to improve Rwanda’s global health reputation following the devastation left behind by the genocide.

RWANDA: *Feasible policy proposals*

MDG 5 is seen by many countries as a feasible policy proposal. Shiffman states in his framework that feasibility is a key factor which influences agenda setting and policy prioritization. Because MDG 5 in particular was extremely specific - “MDG 5 to reduce maternal mortality by three quarters from 1990 levels by 2015” (Smith & Rodriguez, 2015) - policymakers were more likely to view it as a more feasible goal. According to Shiffman’s agenda setting framework, high feasibility and specificity of a policy proposal is a powerful factor which influences policy makers prioritize an intervention as opposed to more complex or ambiguous policy proposals. This has been true for Rwanda. In light of the detrimental effects to the country’s health following the genocide, policymakers needed a feasible and impactful health

policy issue to tackle in order to advance the country's health. MDG 5 was prioritized as this issue. Also in light of the global public health scene, there was a strong agenda to advance global health through the MDGs. "The numerous health sector reforms that have taken place in the last decade confirm the government's prioritization of MDGs 4 and 5. The government's sustained focus on strengthening health systems has been a key factor in providing effective RMNCH services" (*RWANDA Ministry of Health, Rwanda, n.d.*).

Additionally, Rwanda's health sector policy framework, primarily governed by the Ministry of Health (MoH) has prioritized new innovative approaches to health advancement. One example of this is providing community health workers who are traditional birth attendants with mobile [phones and SMS service to alert health workers of cases of emergencies within their communities (Kelsall, 2020). An innovative application developed by UNICEF in 2010 called RapidSMS, "has been scaled up at the national level and is now an integral part of the health system" (*RWANDA Ministry of Health, Rwanda*). "RapidSMS is an information tracking tool that collects data from mobile users through short message service (SMS) text messages" (*RWANDA Ministry of Health, Rwanda*). This program provided 15 000 CHWs responsible for RMNCH promotion with mobile phones linked to a central Ministry of Health server. This initiative was pivotal in allowing community health workers to "stay connected with pregnant women, monitor ANC, [or] identify and refer to women at risk and alert the nearest health facility in case of an emergency. CHWs also use the tool to report births and maternal and child deaths. An initial evaluation of the RapidSMS pilot in Musanze district revealed an increase in ANC visits and facility deliveries" (*RWANDA Ministry of Health, Rwanda*).

DISCUSSION

A somewhat abstract conclusion from this study is the fact that global health policies are rarely as selfless as they are portrayed by media dialogue. Most decisions for policy advancement are driven by selfish motives, even if it is masked extremely well. For example, indicators like maternal mortality rates as well as major focusing events draw attention to the weaknesses of a country, and policymakers have one primary objective: to elevate their country's status on a global scale. In the context of Rwanda, this is the case. Ultimately, the primary drivers of power which influence policymakers is preserving their self image and the method by

which they do that is by preserving their country's global appearance. None of Shiffman's 4 drivers of power within agenda setting include empathy, and it is clear to see that policymaking is not driven by empathy, it is driven by self-interest. While this view of policymaking is somewhat disheartening in the context of how global health is discussed and portrayed by the general public, this research reveals that more often than not, in order to effectively advance policy, the existence of such power dynamics must be accepted as an undeniable part of the policymaking process. Thus, the greatest strength of global health policymaking should come, not merely from the existence of powerful individual actors, but rather from their ability to utilize and work alongside existing power dynamics in the global health arena. As one author puts it, the influence of external actors "is likely to be most beneficial when it 'fits' or 'works with the grain' of the political settlement" (Kelsall, 2020). By doing so, there is a world of difference to be made, as is seen in the case of Rwanda maternal health advancement within the last two decades.

Additionally, Rwanda's advancements in maternal health policy and rise to influence as a global health exemplar of health policy advancement following a catastrophic national event reveal how a participatory approach can prove to be immensely successful in the realm of global health policy advancement. In recent decades, there is a growing awareness in the arena of global health surrounding the idea of redistributing power to "more diverse actors," to ensure that power is exercised constructively to contribute to global health improvement (Shiffman, 2014). Currently, a majority of global health policymaking is dominated by a top-down approach, where decisions are made by actors at the highest levels, with limited input from those at lower levels responsible for implementation. However, as the implications of power dynamics become more widely acknowledged, scholars and practitioners have advocated for more inclusive approaches, such as "bottom-up" or "bottom-top" strategies (Erasmus & Gilson, 2008). Policy implementers - who operate at the lower end of the policy spectrum, - are often excluded from meaningful participation in decision-making. This gap has prompted the implementation of hybrid models such as "top-bottom-bottom-top" approaches, which seek to bridge policy creation and implementation through ongoing dialogue and mutual feedback (Mwisongo et al., 2016). Observing Rwanda's global health success, particularly in regards to maternal health policy advancement serves as a valuable model for how decentralization and participatory policymaking efforts are crucial to effective policy advancement.

CONCLUSION

Power dynamics are constantly at work during the agenda setting stage of policy making, and at first glance, Rwanda's maternal health advancement may seem like the result of an altruistic global health effort striving to advance public health. However, with further study it is clear to see that power dynamics within agenda setting and policy prioritization are what drive decisions to advance any policy. In the case of Rwanda, now renowned as a global health exemplar of maternal health policy advancement, power dynamics, national political climate, as well as global health initiatives all coincided to create the ideal policy making environment for these efforts to be prioritized on the country's policy agenda and later implemented to achieve effective outcomes. Observing Rwanda's maternal health success in recent decades in context of Shiffman's framework for powerful actors behind agenda setting allows for a deeper understanding of how power dynamics shape the prioritization of policy within a country. Ultimately, the environment in which policies are prioritized, created, and advanced is equally, if not more important than the presence of policymakers, as policymaking context is what enables decision makers to choose policies that are effective, feasible, multifaceted, and relevant to the needs of a given population.

References

- A Collective Effort: Strengthening the midwifery profession to save the lives of mothers and newborns.* (2023). UNFPA Rwanda.
<https://rwanda.unfpa.org/en/news/collective-effort-strengthening-midwifery-profession-save-lives-mothers-and-newborns>
- Agnes Binagwaho. (2024). The Rockefeller Foundation.
<https://www.rockefellerfoundation.org/profiles/agnes-binagwaho/#>
- Carlough, M., & McCall, M. (2005). *Skilled birth attendance: What does it mean and how can it be measured? A clinical skills assessment of maternal and child health workers in Nepal.* *International Journal of Gynecology & Obstetrics*, 89(2), 200–208.
<https://doi.org/10.1016/j.ijgo.2004.12.044>
- Community Health workers Policy undergoes reform for better service delivery.* (2025, April 3). Moh.gov.rw.
<https://www.moh.gov.rw/news-detail/community-health-workers-policy-undergoes-reform-for-better-service-delivery#:~:text=The%20Ministry%20of%20Health%20launched%20the%20policy,to%20guide%20the%20ongoing%20community%20health%20reforms.&text=%E2%80%9CCommunity%20Health%20Workers%20contributed%20a%20lot%20to,of%20the%20Rwandan%20population%20%E2%80%9C%20Said%20Dr.>
- Domínguez A. I., *Number of Maternal deaths in Rwanda | Africa Health Organisation.* (2019). Africa Health Organisation.
https://aho.org/data/number-of-maternal-deaths-in-rwanda/?utm_source=chatgpt.com
- Erasmus, E., & Gilson, L. (2008). How to start thinking about investigating power in the organizational settings of policy implementation. *Health Policy and Planning*, 23(5), 361–368. <https://doi.org/10.1093/heapol/czn021>
- Ford, L. (2013, May 29). *Inadequate care during pregnancy and birth exacting deadly toll.* The Guardian; The Guardian.

https://www.theguardian.com/global-development/2013/may/29/inadequate-care-pregnancy-birth-deadly?utm_source=chatgpt.com

Freedman, L. P. (2016). Implementation and aspiration gaps: Whose view counts? *The Lancet*, 388(10056), 2068–2069. [https://doi.org/10.1016/s0140-6736\(16\)31530-6](https://doi.org/10.1016/s0140-6736(16)31530-6)

Global Post: How Rwanda went from genocide to global health model. (2024). *PIH.org*.
<https://www.pih.org/media-coverage/global-post-how-rwanda-went-from-genocide-to-global-health-model>

Grépin, K. A. (2015). Power and priorities: The growing pains of global health Comment on “Knowledge, moral claims and the exercise of power in global health.” *International Journal of Health Policy and Management*, 4(5), 321–322.
<https://doi.org/10.15171/ijhpm.2015.48>

Health in Rwanda. (2012) Wikipedia.org; Wikimedia Foundation, Inc.
https://en.wikipedia.org/wiki/Health_in_Rwanda?utm_source=chatgpt.com

Healthy Newborn Network. (2025, February 27). Healthy Newborn Network.
https://healthynewbornnetwork.org/country/rwanda/?utm_source=chatgpt.com

Kelsall, T. (2020). Political settlements and the implementation of maternal health policy in the developing world: A comparative case study of Rwanda, Ghana, Uganda and Bangladesh. *SSRN Electronic Journal*. <https://doi.org/10.2139/ssrn.3651095>

Kowalczyk, M., Yao, N., Gregory, L., Cheatham, J., DeClemente, T., Fox, K., Ignoffo, S., & Volerman, A. (2024). Community health worker perspectives: examining current responsibilities and strategies for success. *Archives of Public Health*, 82(1).
<https://doi.org/10.1186/s13690-024-01313-5>

Mwisongo, A., Nabyonga-Orem, J., Yao, T., & Dovlo, D. (2016). The role of power in health policy dialogues: Lessons from African countries. *BMC Health Services Research*, 16(S4). <https://doi.org/10.1186/s12913-016-1456-9>

Raimondo, E. (2021). *Process tracing*. Pressbooks.pub; Quebec City: Éditions science et bien commun.

<https://scienceetbiencommun.pressbooks.pub/pubpolevaluation/chapter/process-tracing/#:~:text=Process%20tracking%20 seeks%20to%20 test,a%20 contribution%20was%20 actually%20 produced>

RWANDA Ministry of Health, Rwanda. (n.d.).

https://iris.who.int/bitstream/handle/10665/178638/9789241509084_eng.pdf

Rwandan Minister of Health Dr Agnes Binagwaho discusses the country's health advances - Fogarty International Center @ NIH. (2015). Fogarty International Center.

<https://www.fic.nih.gov/News/GlobalHealthMatters/september-october-2015/Pages/barnes-lecture-2015-agnes-binagwaho-health-minister-rwanda.aspx>

Shiffman, J. (2003). Generating political will for safe motherhood in Indonesia. *Social Science & Medicine*, 56(6), 1197–1207. [https://doi.org/10.1016/s0277-9536\(02\)00119-3](https://doi.org/10.1016/s0277-9536(02)00119-3)

Shiffman, J. (2007). Generating political priority for maternal mortality reduction in 5 developing countries. *American Journal of Public Health*, 97(5), 796–803. <https://doi.org/10.2105/ajph.2006.095455>

Shiffman, J. (2014). Knowledge, moral claims and the exercise of power in global health. *International Journal of Health Policy and Management*, 3(6), 297–299. <https://doi.org/10.15171/ijhpm.2014.120>

Shiffman, J. (2015). Global health as a field of power relations: A response to recent commentaries. *International Journal of Health Policy and Management*, 4(7), 497–499. <https://doi.org/10.15171/ijhpm.2015.104>

Shiffman, J., Quissell, K., Schmitz, H. P., Pelletier, D. L., Smith, S. L., Berlan, D., Gneiting, U., Van Slyke, D., Mergel, I., Rodriguez, M., & Walt, G. (2015). A framework on the emergence and effectiveness of global health networks. *Health Policy and Planning*, 31(suppl 1), i3–i16. <https://doi.org/10.1093/heapol/czu046>

Smith, S. L., & Rodriguez, M. A. (2015). Agenda setting for maternal survival: The power of global health networks and norms. *Health Policy and Planning*, 31(suppl 1), i48–i59. <https://doi.org/10.1093/heapol/czu114>

Spratt, A. (2025). What's behind Rwanda's decreased maternal mortality rates? *Global Citizen*. <https://www.globalcitizen.org/en/content/behind-rwandas-decreased-maternal-mortality/#:~:text=Rwanda%20recognized%20the%20importance%20of%20community%2Dbased%20care,care%2C%20safe%20delivery%20support%2C%20and%20postnatal%20follow%2Dup.>

TEAM RWANDA Agencies Represented: The Ministry of Health and The Rwanda Biomedical Center. (n.d.). *Results for America*.

<https://results4america.org/wp-content/uploads/2018/07/Rwanda-Team-Policy-Brief.pdf>

United Nations Millennium Development Goals. (2015). Un.org.

<https://www.un.org/millenniumgoals/maternal.shtml>

What did Rwanda do? (2017). *Exemplars in Global Health*.

<https://www.exemplars.health/topics/under-five-mortality/rwanda/what-did-rwanda-do#:~:text=This%20practice%20%2D%20accompanied%20by%20the%20fact,in%202010%20and%2081%20percent%20in%202015>

What led to the genocide against the Tutsi in Rwanda? | CMHR. (2019). CMHR.

<https://humanrights.ca/story/what-led-genocide-against-tutsi-rwanda#:~:text=Retired%20Lieutenant%E2%80%90General%20Dallaire%20recalls,Associated%20Press%2C%20Jean%2DMarc%20Bouju>

World. (2018). Millennium Development Goals (MDGs). *World Health Organization*.

https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-%28mdgs%29?utm_source=chatgpt.com

Worley, H. (2015). Rwanda's success in improving maternal health. *Population Reference*

Bureau. <https://www.prb.org/resources/rwandas-success-in-improving-maternal-health/>

Yarlagadda, S. (2022, March 7). Growth from Genocide: The Story of Rwanda's Healthcare System. Harvard International Review.

<https://hir.harvard.edu/growth-from-genocide-the-story-of-rwandas-healthcare-system/>