

Lessons from the Effective Promotion of Safe Motherhood in Zambia

Alice Evans

Paper provisionally accepted for publication in *Women Studies International Forum*, special issue, 'Rethinking Gender and Social Policy: In the Changing Contexts of Development across the World'.

This paper explores how safe motherhood is effectively promoted in Zambia. Top-down pressure to improve maternal health indicators appears to motivate the prioritised allocation of available resources. Otherwise, when supportive supervision and workers' intrinsic commitment waivers, capacity-building is seldom sufficient to ensure the implementation of skills learnt. Likewise, at national level, safe motherhood champions are rarely created through sensitisation. Empathy is more commonly due to personal experience in this sector. With a critical mass of such individuals now in the executive and strong macroeconomic performance, sector budget allocation has increased. Additionally, maternal health indicators are strongly emphasised, from national to district level, in light of looming failure to achieve Millennium Development Goal 5 and thereby successfully partake in the global development project. These narratives share a common thread, indicating the effectiveness of rewarding, or otherwise celebrating, the achievement of those results that are already prioritised by government institutions and personnel.

Introduction

A growing number of studies have explored how safe motherhood comes to be prioritised at country level (Chrichton, 2008; Shiffman, 2007; Shiffman and Smith, 2007; Okonofua et al, 2011). These questions are pressing, for '[d]espite political will being cited as critical in getting decision-makers to display serious interest in major health problems, such as... maternal mortality, we know very little about how it emerges and how it is sustained' (Buse et al, 2007). Such studies then prompt questions about how high-level attention impacts service-delivery on the ground. Even if maternal health is championed by national leaders, 'there is no guarantee that the government will implement programmes effectively' (Shiffman and Ved, 2007:785). Accordingly, it seems crucial to explore how such commitments percolate down to health care facilities.

Meanwhile, a wealth of research has examined wide-ranging innovations to improve service delivery. Yet these are somewhat disconnected from the politics of policy-making, rarely explaining why successful initiatives emerged. For example, qualitative and quantitative research in Rwanda points to the importance of performance-based management, but not how this culture developed (Basinga et al, 2011; Chambers and Booth, 2012). In order to understand how safe motherhood is effectively promoted it appears critical to explore the entire chain, from policy-making to implementation.

This paper is organised into two sections, outlining the drivers of improved service-delivery for safe motherhood. Starting at the level of health facilities and District Health Management Teams (DHMTs), the first section compares the impact of community-based pressure, capacity-building workshops, supportive supervision and performance-based management. The second section then considers the national and international level factors underlying the recent push for attention to maternal health indicators, as well as increased budget allocation for health.

Methodology

These findings are based on a study conducted in Zambia, in partnership with the Ministry of Health (MoH) and the Ministry of Community Development and Mother and Child Health (MCDMCH), with ethics approval from the University of Zambia. Research methodologies included interviews with mothers, health care workers, health managers (at district, provincial and national level), as well as co-operating partners. In addition, I observed a number of

workshops (on clinical care, planning and policy formulation) as well as the routine activities of District Health Management Teams (DHMTs): outreach, planning and technical support. For over a month I also lived at the National Assembly Motel, to discuss these issues with Members of Parliament (MPs). Names of people and places have been changed to preserve the anonymity of participants.

LOCAL VARIATION IN MATERNAL HEALTH INDICATORS

Widespread resource shortages - vehicles, equipment and staff - constitute a major impediment to the promotion of safe motherhood (Gabrysch et al, 2011; Herbst et al, 2011; McPake, 2011; MoH, 2011; Picazo and Zhao, 2009; Stekelenburg et al, 2004). However, notwithstanding these general obstacles, some clinics and districts have achieved relatively high maternal health indicators by maximising the efficiency of available resources. Committed to the promotion of maternal health, they have prioritised effective interventions: quality care, outreach activities, incentives for clients (such as soap and cloth, as well as shorter queues for fathers), and maternal waiting shelters. So the question is, why do these activities come to be stepped-up in some contexts but not others?

Another type of variation concerns planning. One DHMT, when strategising about how to spend a grant for maternal health, suggested the same strategies that they were already implementing. As the District Medical Officer (DMO) later lamented, 'it was just business as usual, the colleagues below they are not analytical. They come, they do the routine work, they still get paid'. This begs an additional question, what motivates careful reflection about the best means to promote maternal health?

Bottom-up accountability

Improvements to the service-delivery of maternal health-care do not seem to stem from grassroot demand. Neighbourhood Health Committees in rural areas have largely been trained to disseminate health education on a voluntary basis; their participation in planning and accountability appears limited. As one District Maternal and Child Health [MCH] Coordinator explained, 'in some [rural] areas, even if outreach is not done for a year they will just keep quiet until the health worker decides to resume'. Similarly in urban areas, educated and otherwise confident interviewed mothers explained that they did not complain about poor treatment because they were anxious to secure treatment from nurses. Occasionally dissent has been voiced through private media, as several journalists have triggered high-level political attention through exposing instances of inadequate maternal health care.

Yet even if civil society organisations have been relatively quiet and peripheral, dissatisfaction with the state of socio-economic development, including health services, was clearly expressed in the 2011 national elections. The new administration has increased health expenditure, as promised in their manifesto.

The remainder of this paper explores top-down efforts to enhance access to and quality of maternal health care provision, commencing with a discussion of information dissemination and training.

Capacity-building and information dissemination

'Many of the Medical Doctors assigned with managerial and administrative responsibilities have limited or no training in management' (MoH, 2011:22). Accordingly, MoH proposes that 'strengthening the management and leadership skills of managers to ensure adequate supervision of HCWs [Health Care Workers] will facilitate efficient and effective utilisation of resources (ibid:22,26,34). Although higher education (such as diplomas in 'Management for Health Professionals' - a programme that ran for one year) was widely lauded, financial considerations have meant that co-operating partners rather fund short-term workshops, to enhance knowledge and capabilities.

Trainings vary in style; some are more valued than others. Horizontal learning (from peers in similar situations), as well as practicals and participatory discussions are often appreciated by those eager to improve their indicators. However, it seems difficult to foster self-critique amongst managers. Even if encouraged to consider 'management weaknesses', participants tend to attribute poor performance to factors 'beyond our control, like cultural beliefs and erratic supply of commodities', to quote one District Health Planner. Similarly, when urged to improve the quality of service-delivery (at a week-long workshop on this topic), one DMO privately reflected, 'for us to address these things you need to bring us resources'. It is likewise rare for health facility staff to recognise, much less address, negative attitudes and behaviour towards clients. The tendency is to blame the community for low demand, rather than recognising one's own role in this regard. This overlooks dissatisfaction with health care services and treatment - widely voiced by mothers, from across the socio-economic spectrum.

Ways of overcoming limited reflection include careful facilitation, such as by asking 'what could convince mothers to come early [to antenatal]?' This question led DHMT staff at one workshop to think about the quality of service provision, including long waiting times and the attitudes of nurses. Bottleneck analysis is also promoted through routine bi-annual Performance Assessments and Technical Support at all levels in MoH.

Knowledge gained may not be implemented in practice

Selected individuals are invited to trainings on the assumption that they will share information with colleagues and then implement best practices collectively. However, this technocratic conception of knowledge dissemination overlooks group dynamics. Managers and health workers alike envisaged difficulties persuading their colleagues about lessons learnt at the aforementioned workshop on quality assurance:

It will be difficult to implement. There will be resistance. They will resent the money I got.

Nurse at rural hospital.

They will say he's gone on an 'IGA' trip, Income Generating Activity! Whatever you say they won't listen. [They will think] 'We didn't get that money, so why should we listen?'. Those who have attended must have very good persuasive powers. At my office we spread it out [workshop attendance], so the frictions are reducing.

DMO. (see also Leenstra, 2012:116-117 on frictions and resentment relating to selection for workshops).

Furthermore, even amongst those who had personally attended workshops, examples of non-implementation abounded. While capacity-building may enhance knowledge (of how to do what is supposed to be done), service delivery also depends on motivation, as well as available resources (see also Rowe et al, 2006; UNFPA, 2005:21). The question then is, how to enhance concern for safe motherhood? Performance-related pay might be one solution, potentially galvanising staff to explore and address all obstacles, rather than excusing poor outcomes. Before considering monetary incentives, I will first discuss alternative ways in which managers have inspired careful attention to maternal health.

Supportive supervision

Some managers inspire and motivate staff through their own prioritisation of safe motherhood. One DMO is passionate about safe motherhood; he is readily available to provide medical advice to nurses and ensures vehicles are used for their outreach activities, rather than administrative programmes. 'He fights for us', explained the District MCH co-ordinator. Additionally, given his 'seniority and status as a doctor', he has been more able to persuade nurses to improve their interactions with clients, one senior midwife noted. Besides these concrete instances of practical support, he has also fostered the perception that maternal health matters.

Many health workers and managers also stressed the importance of supportive supervision - to resolve problems and communicate appreciation - though this was often said to be inadequate. As noted in the National Reproductive Health Policy, '[t]he majority of health providers do not receive routine supportive supervision from the centre' (MoH, 2008:21; see also UNFPA, 2005:9-10). Extended periods of absence from line-managers, who do not check on whether agreed strategies have been implemented, often leads nurses to feel that their efforts are not valued, that no one cares about what they are doing. As one in-charge explained of their previous supervisor,

Kunda: He used to come more often to give us support, quarterly and more. We felt they were really concerned about what we were doing and it made us work extra hard, but now [given the paucity of such visits] it's made us more relaxed. We'll just say, 'Oh, we didn't have this, we didn't have that'. Dr Mwila, he just used to come... and be sure the district was shaken a bit and do some supervision and support. Personally, I was motivated. He had that heart and concern for us in the rural area, so we felt a sense of belonging. But now we feel we're just working on our own...

Alice: What is the best kind of supervision?

Kunda: The random one [visit] means I'm always on my feet. It's always up there in your mind, someone there is to check on you, if that one is not there then you become relaxed a bit. But when they come for Technical Support they've got no time to see all our records. They just depend on what we tell them, so you can lie. But those days they would just pick on one of your files and ask what went wrong. There have been no random visits in the past two years.

The more thorough the monitoring and unannounced visits, the more health workers and managers feel pressured to improve performance and take pride in their recognised accomplishments. Participants also highlighted the importance of friendly, participatory interactions, where they felt free to raise concerns and 'come up with solutions as a team', rather than being told what to do. Both kinds of supportive supervision seem to enhance motivation, fostering the perception that work on maternal health is not only valued but also scrutinised. However, as noted, such supervision is not always provided. This leads to the question of how can effective managerial practices, with particular attention to and support for safe motherhood, be fostered more widely?

Performance-based management

Increasing attention to maternal health indicators

Participants universally maintained that there has been increasing pressure from central government to improve maternal health indicators: antenatal coverage, average antenatal visits, institutional deliveries and post-natal coverage. The National Health Strategic Plan for 2012-2015 identifies maternal health as a 'national health priority' (MoH, 2012:47). To varying degrees, provincial health teams pay attention to these results and provide more supportive supervision to under-performing districts, as one District MCH Co-ordinator explained:

We were relaxed because our performance was good. Then, all of a sudden, we dropped to among the last districts in terms of MCH performance, so a number of follow-ups have been made both by the national office and the provincial office. That's what made people sit up... If the indicators are going down, he [the DMO] will make an appointment with me. He will try to find out, he requests that I be honest, so we come up with realistic solutions... He will ask questions like, 'Is it me that makes you not perform well? If there's anything I'm doing let me know'. Because he knows that at the end of the day his name is tarnished. He will be said to be a non-performer, so he gets concerned, he tries to dig deeper to find out why the district does not perform to expectation.

Many DMOs have become focused on maternal health in order to satisfy managers at provincial level. Being held accountable for their district's performance, desiring career progression and believing in the meritocracy of that system, seems to galvanise efforts. DMOs who feel pressured to improve their indicators seem more open to criticisms about their own behaviour. Top-down targets can thus foster the kind of supportive supervision and passion for which more intrinsically-motivated managers are praised.

However, notwithstanding the apparent importance of performance-based management, many health care workers and managers feel that there is little pressure to improve. The MoH (2011:26) characterises itself as having 'a lax attitude to poor performers'. Additionally, high performing individuals and institutions also complained that the current system provides insufficient recognition of their efforts:

The last time I was in Luo it was the best performing health centre, now I moved here, it is the best performing health centre. But I've never been given anything to show appreciation, nothing. Nothing! Even if people are singing about me [she is widely praised by DHMT staff], nothing ever has been done to motivate me.
In-charge, rural clinic.

Results-based financing pilot programme

In April 2012, the Ministry of Health commenced a two year Results-based Financing (RBF) programme, funded by DfID and NORAD, through the World Bank. The programme was originally designed in 2006, responding to a global call for proposals. This performance-related pay initiative is being piloted in eleven districts in Zambia, following a pre-pilot in Eastern Province. Health facility staff are financially rewarded according to their institution's quantity and quality scores, as well as their own individual assessments, adjusted for their cadre level. The quantity score incorporates a number of MCH indicators, each of which has a unit fee, multiplied by coverage.

External parties undertake quarterly evaluations of the quality of selected health services. These results are multiplied by the health facility's quantity score to generate a financial bonus, which is distributed according to workers' individual performance assessments. Also, at district level, managers are rewarded according to their institutional and individual scores. Interviews with participating staff suggest that this combination of incentives has amplified behaviour elsewhere associated with high maternal health indicators: more motivation and supportive supervision.

Rebecca (midwife): It has changed our attitude, we are working hard because of the money. Way back we were so relaxed... Our attitude has really changed, people used to come late for work, now everyone is on time. We were doing shortcuts, but now we are doing full procedures. When a patient comes to the labour ward, you do the partograph [a tool to monitor the progress of labour], but before it was an 'I don't care attitude': you forget, you just want to finish so you can sit and relax... People have changed now. If the results are poor you're not going to get anything. [Previously] the Performance Assessment was done after six months, maybe they don't even come, they just get the registers [i.e. it was not always a thorough investigation]. Now, RBF, it's daily, there's quantity and quality [monitoring]. The more deliveries you have, the more money in your pocket!
Alice: Which is better, increasing the salary or RBF?
Rebecca: They can increase the salary but RBF is the only way of motivating us because we're paid according to the number of deliveries...

RBF, it encourages people to work hard and to do things correctly, not shortcuts like it used to be... If it was not RBF we were not going to pressure them [pregnant women] to come here. Can you pressure yourself when the government

is not doing anything? I would like to do only a few things then I go home and rest. The money we are given by the government is very little, the time we spend here is much, so are you going to be doing a lot of things? They'd rather be sitting. But now they've started encouraging people to come here.
Sarah (nurse at rural health facility).

Another reason nurses expressed a preference for RBF is that 'it is inclusive. It doesn't leave out anyone at the facility (in terms of financial rewards), but a workshop like this only targets a few'. In this way, RBF may promote more cohesion within health teams. This said, there is still the potential for resentment and division about the distribution of RBF monies. Health facility staff also stressed an appreciation of the increased regularity of monitoring visits, for which DHMTs are financially rewarded (see also Furth, 2006:8):

Controversies and concerns relating to results-based financing

The RBF pilot is similar to an earlier Central Board of Health policy, 'performance-based contracting'. However, the latter was not implemented, due to political concerns about an entire district potentially being penalised for having an incompetent DMO or other constraints beyond their control. Hence health financing remained input, rather than results, based. More recently though, a number of districts had piloted performance-based funding and showed improvements. Support also grew as several MoH policy-makers undertook learning visits to Burundi and Rwanda, subsequent to winning the RBF contract.

Notwithstanding this institutional history and authorship, a number of MoH senior management still express concerns about this intervention, particularly regarding cost (which is currently borne by the donor). Several senior managers were unpersuaded by the necessity of performance-related pay, yet still supported the programme in order to procure additional resources for safe motherhood. While many point to evident human resource-based constraints, these impediments may be lessened by making existing workers more efficient. Early reports indicate that RBF is motivating increased productivity and reducing the amount of underperforming staff. This may prove significant. As MoH et al (2006) note, eliminating health workers' self-reported absenteeism and tardiness would be equivalent to gaining 187 full time staff. Furthermore, though financial concerns are raised [about monitoring and incentives], existing expenditure could be rerouted. As one former MoH staffer commented, 'the Government is already sending allowances, why can't they PBF it?'

It will be interesting to explore how Government concerns are shaped by ongoing comparative evidence of performance and cost-effectiveness. A control district in each province receives exactly what some maintain is missing, namely additional equipment (which costs the same as the RBF intervention). Government reactions to this information may also help us understand the nature of their qualms.

Perceptions of limited government ownership may underly such qualms. As one senior manager explained, 'It was an initiative in the World Bank, they wanted to push it to show evidence... There was resistance to World Bank handling of the programme [in terms of choosing locations and recruitment of programme managers]'. Although donors privately protested, maintaining that 'there is alignment and coordination with the use of government systems', such as in terms of procurement and auditing, it seems that this kind of technical ownership has not been perceived as sufficient.

Another worry is that performance-related pay may lead workers to focus exclusively on financial benefits (see Ireland et al, 2011:695-696). However, it seems unrealistic to think that all workers might be intrinsically motivated to improve service-delivery. While a number of passionate health care workers and managers endeavour to improve their maternal health indicators, others are less dedicated to this project. Performance-based management seems to persuade the latter group. Furthermore, said pecuniary concerns are not particular to RBF alone. Staff already undertake a range of activities in order to augment their incomes. Recall,

workshops have been coined as 'IGAs, Income Generating Activities'. Second, many health workers already undertake additional work to supplement their salaries (Global HIV/AIDS Initiatives Network, 2008). This said, it is questionable whether nurses' enthusiasm for RBF reflects mercenary motivations, rather than the symbolic value of the reward - widely perceived as representing recognition of good performance. Recall, health workers often feel that their efforts are not appreciated.

NATIONAL PRIORITIES AND GLOBAL DEVELOPMENT AGENDAS

Notwithstanding the importance of attitudinal change, there is equally a clear need for more resources, such as trained health workers and equipment (Stekelenburg et al, 2004; McPake et al, 2011). Amplified attention to and spending on maternal health care are largely the outcomes of the ways in which changes in the international development community (in terms of shifting agendas) have interacted with local priorities. Mirroring the structure of the previous discussion, this section then compares the impacts of two processes, information-dissemination in the form of safe motherhood advocacy, as contrast with the emergence of increasing attention to maternal health indicators at national level.

Global development agendas

Safe motherhood may have been historically overshadowed by divergent global health agendas. A preponderance of clinical trainings previously focused on HIV, rather than maternal health. Not matched by increased recruitment, this compounded staff workload (Brugha et al, 2010; Chansa, 2008; Global HIV/AIDS Initiatives Network, 2008). This donor emphasis on HIV/AIDS meant that even if the Zambian government sought to promote maternal health (as indicated by successive Poverty Reduction Strategy Papers, National Development Strategies and National Health Strategic Plans), external support has been limited. As summarised by a former Minister of Health:

Donors would lobby through technical planning meetings, to indicate one health issue to be prioritised... The donors were not so much focused on safe motherhood. Now there has been a change.

Three senior managers at the Ministry of Health similarly reflected, in two separate interviews:

In SAG [Health Sector Advisory Group] meetings [prior to 2006], we would discuss it [maternal health] very superficially, not being focused and giving attention to it. It would be a routine part of what is presented... It was a quick run through. It was like any other programme, what was drawing the attention was the programmes with a lot of money: HIV, TB and malaria.

Dr Mwale: The ministers can have the passion, but the donors set the agenda. All the funding was Global Fund, this time Global Fund is interested in maternal health. That time they were not.

Lombe: With health systems strengthening to cut across all sectors you can then get a lot of resources to strengthen maternal health... [Previously] donors wanted to focus on HIV, so the Government couldn't obtain funding for safe motherhood. For example, my former director had to fight to oppose the building of a new theatre for male circumcision, which would mean that a mother would give birth on the floor and the baby would be transferred to a new building!

Although the extremes described above may not be entirely literal, such sentiments represent widespread resentment of some co-operating partners' previous priorities. Lately however, there has been an international redirection of attention towards safe motherhood and health systems strengthening more generally (see also Crichton, 2008:343). In Zambia, aggregate official development assistance to maternal, newborn, and child health per live birth increased

from US\$24.7 in 2003 to US\$46.1 in 2008 (Pitt et al, 2010:1491). DfID recently announced ZMK105 billion (£14.8 million) in funding for family planning over four years in Zambia.

Increasing attention to and support for maternal health, on the part of the international development community, seems due to growing interest in obtaining Millennium Development Goal (MDG) 5. A number of co-operating partners (such as DfID, EU and SIDA) are focusing on reproductive and maternal health in the run up to 2015. UN agencies have long been particularly supportive of MDG 5. The latter was referenced more broadly, by all donors, parliamentarians and senior civil servants when explaining their attention to maternal health. Additionally, the vast majority of district and national action plans commence with a commitment to attaining the MDGs.

However, the amplification of efforts to reduce maternal mortality in Zambia did not actually commence with these global commitments. Focus only sharpened more recently, with the realisation that the country was lagging behind, unlikely to meet agreed international targets. Many senior managers in the Ministry of Health expressed their keenness to avoid the embarrassment of trailing behind other countries making rapid progress:

In last year's budget, there was a big increase. We looked at the MDGs and felt it necessary to support MCH. We recognised we may not achieve the MDGs.

We are getting towards the MDGs deadline and our graphs have not been very good. We haven't done much in mother and child health [hence recent increase in funding for reproductive health].

MDGs - we have to be part of the world... We found that we are not on track. The commitment has been there but it was enhanced by the MDGs.

We are a stable country; to be put in that place [sharing rankings with conflict-afflicted states] is a shame.

If you look at our performance towards the MDGs, the only indicators that are quite a challenge are MDGs 4&5, so it prompted us to say, 'What can we do?'. To meet the targets we need to do some extraordinary things [i.e. RBF].

International benchmarking and consequent awareness of comparatively poor national performance appears to have increased attention to maternal health indicators within MoH (see also Freedman, 2003:99). While studies of Nigeria and India have likewise emphasised the role of the MDGs in galvanising attention to safe motherhood (Shiffman and Okonofua, 2007; Shiffman and Ved, 2007), Zambian narratives reveal the importance of domestic perceptions of those commitments. Of particular significance is the desire to be 'developing' (i.e. achieving shared socio-economic targets) at par with other countries, not lagging behind. The dawning prospect of failing to successfully partake in a global development agenda seems to have fostered greater support for maternal health, within MoH in particular - an institution already working towards this objective. However, as will be elaborated upon in the next section, it is important not to overstate the influence of external development agendas. While safe motherhood advocates within government may have historically been financially constrained due to global neglect of this issue, it is not evident that a shift in international priorities can create such concern amongst otherwise disinterested parties.

Advocacy

To amplify support for maternal health care, there have been a number of sensitisation workshops and conferences, on the presumption that some people are unaware of the numerical occurrence of maternal deaths. This section will explore the extent to which this kind of information dissemination can create safe motherhood champions.

The effectiveness of awareness-raising interventions varies. Most participants stressed the importance of comparative evidence. For instance, glaring regional differences in maternal mortality rates were identified as revealing the avoidability of such deaths. This realisation gave some confidence in their ongoing efforts to promote safe motherhood. Exposure to neighbouring country data often invokes a sense of competition: 'No, Zimbabwe can't do better than us!'. Parliamentarians, once shown regional statistics, promptly introduced a separate budget line for reproductive health. This said, the actual funding allocated suggests limited political support for this sector.

Those with limited intrinsic commitment to reproductive health may also be persuaded to support this sector by appeals to 'smart economics', as one senior civil servant explained:

What works to get more funding is to have a good bankable document, that maternal health is a development agenda: when you invest the nation benefits. You need to quantify in economic terms. If you can package it as a development agenda then the money will follow. Family planning saves money: women spend more of their time in productive activities. Essentially what works is to have a business case.

Meanwhile, for interested stakeholders, horizontal learning and international conferences can provide valuable lessons (as in Nigeria, Shiffman and Okonofua, 2007:131). Besides sharing information, interviewed participants (parliamentarians and technocrats alike) also extolled the benefits of collectively deliberating and developing an 'African' agenda, on how to tackle shared constraints and concerns relating to safe motherhood. Regional level discussions include those facilitated by the African Union, WHO Africa Region and the Southern African Development Community. With explicit reference to the continent's likely failure to achieve MDG 5, maternal health was made the thematic focus of the 2010 African Union Summit. One former minister insisted that safe motherhood was not a donor-driven, but an African, agenda developed through continental meetings. While there is some plausibility to this account, given long-standing donor attention to HIV/AIDS, what is perhaps more important is his perception of regional ownership,

In my recollection, the agenda for safe motherhood came from Africa, not from outside. We discussed at AU, 'What could we do to prevent needless deaths of mothers?'... We proposed a 'Maputo Declaration of Action'... [then], driving out of that, 'Plan Africa'... and CARMMA [the Campaign for the Accelerated Reduction of Maternal Mortality]... We wanted this message of safe motherhood to be acted upon.

The Zambian launches of 'Countdown to 2015' and CARRMA were similarly identified as influential, though this was primarily by those closely involved in their organisation, such as one former director at the Ministry of Health,

Before, people didn't see the seriousness of the problem. Now [after the Countdown to 2015], people become clear about what should be done and appreciated the challenges we were having, in terms of scaling up interventions, there are so many competing issues [attracting their attention]. When issues came in, everyone in management was very supportive and wanted to be involved. When doing budgeting they agreed to include reproductive health commodities, e.g. contraceptives. Before, we were depending on donors, UNFPA. We bought nine ambulances, one for each general hospital. The Countdown just made things happen the way we wanted, there was a lot of frank talk... [Then, with the CARMMA launch], the moment they saw the President is involved they realised if we don't do our part we risk being exposed and being kicked out.

It is worth noting however that this speaker may have a heightened sense of the event's involvement, given that it consumed so much of their time in planning and preparation. Outsiders, like a former Minister of Finance, colleagues in the Ministry of Health, and other

targets of such lobbying, had little or no recollection of these events, when asked. Indeed, the vast majority of policy-makers downplayed the significance of such advocacy. As one senior manager explained, 'we have so many awareness campaigns', single issues are rarely the subject of sustained attention, which is instead forever shifting to the next matter of expressed concern in need of prioritisation.

Political space and critical mass of health champions

Even for those who do feel empowered by networking at a regional level, like the former minister of health as quoted, their domestic influence may be limited without a critical mass of support for health in the executive. Resistant former elites were described by colleagues as regarding education as an 'investment' and health spending as 'wasteful'. Accordingly, although the Zambian government pledged to increase public health spending to 15% of total government expenditure, in accordance with the Abuja Declaration, this target has not been met. From 2006 to 2009, the allocation was only 9%, on average (Cuesta et al, 2012:12).

It seems ambitious to assume that persuaded parliamentarians might effectively advocate for increased allocation from the national budget, prioritise health when spending CDF [Community Development Funding] and also sensitise constituents about the importance of coming for institutional deliveries. Interviewed MPs insisted they were significantly constrained in each of these respects

Everyone wants more expenditure on health and more clinics, so they will be happy if the executive proposes [increased spending]. But we [as backbench MPs] are powerless. This is why we want a Budget Act, we are still using the same system they had in the one party state.

Backbench MP, with a background in reproductive health.

If the focus is on parliamentarians, they're wasting their money. Parliamentarians have very little power with CDF. My own role is to ensure I know how the money is allocated. As regards the budget, the MP has almost zero role. The executive might bend slightly, the MP can maybe talk during the year, the executive might listen, maybe. I don't think the donors understand. I was Minister of Health, I travelled the whole country I never saw the importance of the MP in the health sector.

Former Minister of Health.

Parliamentarians not inclined to undertake community sensitisation identified obstacles like cultural boundaries that made such discussions with women inappropriate, as well as the financial cost involved in meeting constituents, with inevitable financial demands.

Safe motherhood advocacy more generally seems to stem from long-term involvement in this sector, which often fosters particular empathy and concern. Without this background, 'if something is complex, if you don't understand, you may see it as just a talkshop', as one senior staffer at a multilateral co-operating partner. As a number of individuals with experience in the health sector have gained power (with the 2011 national election), there now seems to be high-level political support for health. The President is a former Minister of Health, the First Lady is a practising Obstetrics and Gynaecology doctor, and a number of ministers are health professionals, with expertise in maternal and child health. As one senior manager at MoH commented,

[The former Minister] was good but he was constrained by the general political environment. Now they're all sold out already, they don't need further talking. They know where they want to be, they know the system, they can only push it forward.

With health having been identified as a priority by the new administration, Government budget

allocation for MoH grew by 45%. This intervention came from the top. One senior party leader explained of the President, 'he was previously Minister of Health, so he understands the problems and is easily convinced they need more money'. A multilateral co-operating partner staff commented, 'it was all done by the Government. It caught us by surprise. We hadn't imagined they would increase it by that much'. This episode is revealing. Notwithstanding multiple historic attempts to lobby previous administrations for increased expenditure on health, through information-dissemination and sensitisation workshops, political will actually emerged through a critical mass of those with personal experience in health in the executive. However, note that even though absolute health expenditure has increased, it still remains a small proportion of the total budget (rising 8.6% to 9.3%). This said, Government has committed to double its allocation for family planning, as announced at, and also perhaps galvanised by, the 2012 London Family Planning Summit.

The motivational force of personal exposure to the difficulties pregnant women face in rural areas was also stressed by concerned back-bench parliamentarians, who have pushed for Community Development Funding (CDF) to be spent on building health clinics, and spoken out about reproductive health policy and budget allocation. Commitment may be further galvanised by guided tours of health clinics, which provide first-hand evidence of the need for action. Leaders' receptivity to these issues also seems to depend on their ideology. For example, one relatively feminist MP attributed his outlook to the exposure he gained from living overseas, in a more egalitarian environment. Of the workshops he commented,

This is just to give me the statistics to use... Once in a while we must converge, but workshops will not make us champions of these issues.

This explanation was echoed universally, including by a former Minister of Finance, when explaining why he increasingly allocate resources to health,

For me it's personal conviction, rather than international conferences. I bought into that [the policy about health posts because I had personal experience, I was brought up in rural areas... I know access to health is severely limited by distance. We are aware of the problems. These are the things we see ourselves. Workshops were started by donors then public service got hooked. It's massive wastage. They need to be reduced.

Thus while collective discussions on reproductive health were sometimes cited as inspirational and informative by those already interested in this topic, disinterested others largely remain so, even when a range of innovative discursive frames are used. Awareness-raising activities were rarely said to have mobilised people to prioritise safe motherhood. As one senior personnel at a bilateral co-operating partner commented: 'I think it's about if they perceive the information as relevant to them'. Advocates often attribute their commitment to safe motherhood to long-term, first-hand experience, which enabled them to see the need for more resources but moreover be personally affected by trauma of maternal deaths. People also interpret their experiences according to their background ideologies. Neither empathy nor outlook seem to be easily shifted by sensitisation alone.

National level attention to indicators

However, even if related awareness campaigns have been of limited significance, MDG 5 has still proved influential, because it has become institutionalised as a Performance Assessment Indicator (PAI) of the Ministry of Health. As a result of discussions with government and partners (in the Monitoring and Evaluation Technical Working Group and also the Sector Advisory Group), Traditional Birth Attendants were excluded from the indicator on institutional deliveries, on in line with international consensus about their ineffectiveness, as reflected in MDG 5. This revision mobilised a shift in attention to human resource constraints amongst donors and MoH senior management alike. As two senior managers at MoH explained, in separate interviews,

These were the indicators looked at in the Joint Annual Review [where senior management and country representatives of co-operating partners evaluate progress]. There would be threats of delayed release of money [by donors providing Sector Budget Support, such as the European Union], if there were poor indicators.¹ It helped us mobilise more resources, they said, 'Why is it not improving?'. It allowed us to raise issues. Unless you address Human Resources, there'll be no impact. Then the donor community contributed. By putting in that indicator on skilled attendance that was a trigger to recruitment, to have more nurses and midwives, so that brought in the Human Resource Strategic Plan, scaling up the Retention Scheme and increased funding for medical training institutions. That indicator triggered a lot of things. After two years we had doubled the production for nurses. We chose that [MDG5] as an indicator to address the underlying problem of human resources.

You see this indicator was really low. That's how we began to really address issues of HR [human resources]. The indicator reinforced the policy direction.

This indicator became important, in galvanising greater attention to and funding for human resources, not because it was merely included on paper but because strategic actors collectively developed a shared commitment to this global goal. This much enhanced through regular interactions, in the quarterly Interagency Committee Meetings on maternal, newborn and child health. This partnership, guided by a roadmap that provided a clear strategic direction, was further strengthened through organising key events (such as the launch of the 'Countdown to 2015' and 'CARMMA'). According to one former director at the Ministry of Health, a sense of 'mutual accountability' emerged, with 'pressure on everyone to ensure their part has been done'. Those who let the side down 'would be exposed and everyone would know the cause of the delay'. Notwithstanding increased concern to prevent maternal mortality, some relevant programmes (like abortion access) remain unsupported, even on the part of those knowledgeable about the role of unsafe abortion, with most policy-makers emphasizing preventative family planning instead.

These perspectives on the international development community (the historic overshadowing of safe motherhood due to earlier emphasis on HIV/AIDS; MoH's expressed concerns about failing to achieve MDG5; the role of a critical mass of champions, owing to personal experience; as well as the value of Pan-Africanism) all reiterate the importance of country (and regional) ownership. Priorities, policies and programmes relating to safe motherhood seem to have been made more operational when they are demanded and valued by government agencies. Meanwhile, perceptions of World Bank ownership and control may have endangered the sustainability of the RBF programme. The apparent necessity of country-level support for global goals may hold also lessons for efforts towards 2015: rather than ensuring that more radical reproductive health goals are enshrined on paper, it may be more crucial to ensure they reflect shared priorities of member states. For it is only on account of local concerns that maternal health indicators have become the subject of increasing attention, scrutiny and resource allocation at national and in turn district level.

Conclusion

This research suggests that service-delivery in the health sector improves with performance-based management, that is top-down pressure to improve indicators, or financial incentives. Commitment also seems to be enhanced when workers feel valued and appreciated, such as through supportive-supervision. Though some staff are already intrinsically committed to their work, this ethic is not universal. Awareness-raising and disseminating information via trainings

¹ Disbursement of EU funding for health depends on two types of conditions. Fixed funding depends on process indicators of public financial management; variable funding depends on the achievement of the Government's own Performance Assessment Indicators. For example, in 2010 and 2011, the latter share was reduced because targets for institutional deliveries were not met.

do not appear sufficient to motivate the latter to promote safe motherhood.²

At national level, it seems incredibly difficult to persuade (otherwise disinterested) policy-makers to prioritise maternal health. What matters is personal commitment, which generally stems from personal experience in the health sector and is rarely recreated through sensitisation workshops or awareness-raising campaigns. On the other hand, some people may come to promote maternal health due to broader concerns. For example, potential funders want to see the cost-effectiveness of investment. While events may stimulate attention for a short period, impact largely depends on the extent to which they are used to create a partnership with a shared vision, performance targets and accountability processes. Increased attention to maternal health indicators at all levels of the Ministry of Health seems partly driven by evidence pointing to Zambia's (and Africa's) likely failure to participate in the global development agenda (as partly defined by the MDGs) at par with other countries. Since maternal mortality reduction is lagging globally, such concerns are widely shared. This has created a conducive international environment, with increased funding for reproductive health in the run up to 2015. Furthermore, with a critical mass of vocal health professionals now in political power, presiding over a growing economy, sector budget allocation has been increased.

References

African Union (2010) 'Africa Cares: No Woman Should Die While Giving Life', AU Message.

<http://www.africa-union.org/root/UA/Newsletter/SA/2010/African%20Union-1.pdf>

Basinga, Paulin; Gertler, Paul J.; Binagwaho, Agnes; Soucat, Agnes L. B.; Sturdy, Jennifer; and Vermeersch, Christel M. J. (2011) 'Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation', *Lancet* 366:1421-28.

Brugha, Ruairi; Kadzandira, John; Simbaya, Joseph; Dicker, Patrick; Mwapasa, Victor and Walsh, Aisling (2010) 'Health Workforce Responses to Global Health Initiatives Funding: A Comparison of Malawi and Zambia', *Human Resources for Health* 8,1:19.

Bucagu, Maurice; Kagubare, Jean M.; Basinga, Paulin; Ngabo, Fidele; Timmons, Barbara K. and Lee, Angela C. (2012) 'Impact of Health Systems Strengthening on Coverage of Maternal Health Services in Rwanda, 2000-2010: A Systematic Review', 20(39):50-61.

Campbell, J. And Caffrey, M. (2009) 'Zambia: Taking Forward Action on Human Resources for Health with DfID/OFAC and Other Partners'.

Chambers, Vikki and Booth, David (2012) '*Delivering Maternal Health: Why is Rwanda doing better than Malawi, Niger and Uganda?*', Briefing Paper 74 (London: Overseas Development Institute).

Crichton, Joanna (2008) 'Changing Fortunes: Analysis of Fluctuating Policy Space for Family Planning in Kenya', *Health Policy and Planning* 23:339-350.

Cuesta, Jose; Kabaso, Pamela and Suarez-Becerra, Pablo (2012) 'How Pro-poor and Progressive is Social Spending in Zambia?', Working Paper 6052 (Washington, D.C.: World Bank).

² Prior to departure, this paper was discussed with a number of actors: civil servants at district and national level, as well as bilateral and multilateral co-operating partners. This process revealed something of a paradox. No one at MoH seemed surprised by, nor even questioned, my substantive findings. Recognition of the limitations of workshops and prevalent managerial practices seemed widespread. However, even if commonly felt by individual readers, these sentiments were less commonly articulated in meetings or written public outputs. This may indicate the value of the research, in so far as it is perceived as accurate though largely unsaid. As one deputy director commented,

This is not news, but it's not something we highlight when we bring out issues. It's just self-denial, if you're the one in management you don't want to put the blame on you, [claiming] 'I haven't done anything wrong'.

Fraser, A. (2008) 'Zambia: Back to the Future?', in Lindsay Whitfield (ed.) *The Politics of Aid. African Strategies for Dealing with Donors* (Oxford: Oxford University Press).

Freedman, L. P. (2005) 'Achieving the MDGs: Health Systems as Core Social Institutions', *Development* 48:1, 19-24.

Furth, R. (2006) 'Zambia pilot study of performance-based incentives, operations research results', Quality Assurance Project (Bethesda, MD: USAID).

Fukuda-Parr, Sakiko (2012) 'Should Global Goal Setting Continue, and How, in the Post-2015 Era?', DESA Working Paper No. 117 (New York, NY: United Nations Department of Economic and Social Affairs).

Ministry of Health (MoH) (2011) *National Human Resources for Health Strategic Plan 2011-2015* (Lusaka: Ministry of Health).

Global HIV/AIDS Initiatives Network (2008) 'Global HIV/AIDS initiatives in Zambia: Issues of scale up and health systems capacity', (London: Frontiers Development and Research Group, Royal College of Surgeons in Ireland and London School of Hygiene and Tropical Medicine).

Greco, Giulia; Powell-Jackson, Timothy; Borghi, Josephine; and Mills, Anne (2008) 'Countdown to 2015: Assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006', *Lancet* 371: 1268-75.

Hafner, Tamara and Shiffman, Jeremy (forthcoming) 'The Emergence of Global Attention to Health Systems Strengthening', *Health Policy and Planning*.

Herbst, Christopher H.; Vledder, Monique; Campbell, Karen; Sjoblom, Mirja; and Soucat, Agnes (2011) *The Human Resources for Health Crisis in Zambia : An Outcome of Health Worker Entry, Exit, and Performance within the National Health Labor Market*, Working Paper No. 214 (Washington, D.C.: World Bank).

Herbst, H.C., and D. Gijsbrechts (2007) 'Comprehensive and Accurate Data on Stock, Profiles, and Distribution of HRH in Zambia: Analysis of the Health Facility Survey Data' Summary Findings Sheet (Washington, D.C.: World Bank).

Ireland, Megan; Paul, Elisabeth; and Dujardin, Bruno (2011) 'Can performance-based financing be used to reform health systems in developing countries?', *Bulletin of World Health Organisation* 89: 695-698.

McPake, B.; Witter, S.; Ensor, T.; Fustukian, S.; Newlands, D. and Martineau, T. (2011) 'Removing Financial Barriers to Access Reproductive, Maternal and Newborn Health Services: The Challenges and Policy Implications for Human Resources for Health', Working Paper (Edinburgh: Queen Margaret University).

Ministry of Health (MoH) (2008) *National Reproductive Health Policy* (Lusaka: MoH).

Ministry of Health (MoH) (2011) *National Human Resources for Health Strategic Plan 2011-2015* (Lusaka: Ministry of Health).

Ministry of Health (MoH) (2012) *National Health Strategic Plan, 2011-2015. Towards Attainment of Health Related Millennium Development Goals and Other National Health Priorities in a Clean, Caring and Competent Environment* (Lusaka: MoH).

Ministry of Health, Republic of Zambia; University of Zambia; World Bank; and Swedish International Development Agency (2006) *Zambia Public Expenditure Tracking and Quality of*

Service Delivery Survey in the Health Sector: Findings and Implications (Lusaka: Ministry of Health).

Okonofua, F.; Lambo, E.; Okeibunor, J. and Agholor, K. (2011) 'Advocacy for Free Maternal and Child Health Care in Nigeria - Results and Outcomes', *Health Policy* 99, 131-138.

Pitt, Catherine; Greco, Giulia; Powell-Jackson, Timothy; and Mills, Anne (2010) 'Countdown to 2015: Assessment of Official Development Assistance to Maternal, Newborn and Child Health, 2003-08', *The Lancet* 376: 1485-96.

Rowe, Alexander K.; de Savigny, Don; Lanata, Claudio F. and Victora, Cesar G. (2006) 'How Can We Achieve and Maintain High-Quality Performance of Health Workers in Low-Resource Settings?', *Lancet* 366: 1026-35.

Shiffman, J. (2007) 'Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries', *American Journal of Public Health* 97:5, 796-803.

Shiffman, J. and del Valle, A. L. G. (2006) 'Political History and Disparities in Safe Motherhood Between Guatemala and Honduras', *Population and Development Review* 32:1, 53-80.

Shiffman, J. and Smith, S. (2007) 'Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality', *The Lancet* 370:1370-1379.

Shiffman, Jeremy and Ved, R. R. (2007) 'The State of Political Priority for Safe Motherhood in India', *BJOG: An International Journal of Obstetrics and Gynaecology* 114:785-790.

Stekelenburg, J.; Kyanamina, S.; Mukelabai, M.; Wolffers, I. and van Roosmalen, J. (2004) 'Waiting Too Long: Low Use of Maternal Health Services in Kalabo, Zambia', *Tropical Medicine & International Health* 9:3, 390-398.

UNFPA (2005) *Reaching Out in Zambia: A Country Programme Update* (Lusaka: UNFPA).

Usher, Ann Danaiya (2010) 'Donors Lose Faith in Zambian Health Ministry', *The Lancet* 376:9739, 403-404.

Vujcic, M.; Ohiri, Kelechi; and Sparkes, Susan (2009) *Working in Health: Financing and Managing the Public Sector Health Workforce, Directions in Development* (Washington, DC: World Bank).

World Bank (2009) *Zambia Health Sector Public Expenditure Review: Accounting for Resources to Improve Effective Service Coverage* (Washington: The World Bank).