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Amplifying Accountability by Benchmarking Results at District and National Levels

This multi-level ethnography of the Zambian health system illustrates the importance of top-down accountability, and how it has emerged in a historically neglected sector. Maternal health care indicators are prioritised when they are benchmarked, at district and national levels. The realisation that Zambia was lagging behind African countries making progress towards MDG 5 (to reduce the maternal mortality ratio by three quarters) appears to have invoked reputational concerns and revealed inspirational possibilities. Growing prioritisation also stems from a change in incentives, with some partner funding being conditional on the proportion of deliveries attended by skilled health personnel.

Keywords: Zambia; maternal health care; accountability; Overseas Development Assistance; Millennium Development Goals; benchmarking; ideas; norm perceptions.

1. Introduction

Of all the Millennium Development Goals, it is MDG 5 (to reduce the maternal mortality ratio by three quarters) where global progress lagged furthest behind agreed targets (UNDP, 2015). As has been widely recognised, this intransigence largely stems from insufficient political prioritisation, rather than unknown technical solutions. Accordingly, this article seeks to ascertain the factors accounting for increased prioritisation of maternal health care in Zambia. It considers the relative importance of perceived self-interest, norm perceptions and normative beliefs, as shaped by institutional practices (such as top-down and bottom-up accountability). In answering this empirical question, this article seeks to contribute to broader debates about what motivates greater attention to a historically neglected issue – at district and national levels.

There are two relevant bodies of literature here: one focuses on service providers' motivation; the other examines agenda-setting within central government. Important examples of the former include qualitative and quantitative research on safe motherhood in Rwanda, indicating the significance of performance-based management (Basinga et al., 2011; Chambers and Golooba-Mutebi, 2012). Poor health care elsewhere in Africa is often attributed to inadequate incentive structures, which is arguably resolvable through top-down performance monitoring (Picazo and Zhao, 2009; Wild et al., 2013). The *World Development Report 2004: making services work for poor people* emphasises top-down and also bottom-up pressure, particularly the latter (World Bank, 2003). These analyses imply that health policies are more likely to be implemented when doing so aligns with managers' and service providers' own interests, through performance-based incentives. But they differ in emphasising different kinds of self-interest: whereas the World Bank (2003) exclusively stresses economic self-interest, Chambers and Golooba-Mutebi highlight the additional importance of reputation and prestige, as Rwandan local authorities compete over rankings. Similarly, in England, Bevan and Wilson (2014) show how performance has been improved by 'naming and shaming' poorly performing schools and hospitals. Grindle (1997), Therkildsen and Tidemand (2007) also emphasise performance disciplines in the public sector. However, unlike the World Bank (2003), they do not exclusively stress 'incentives' and self-interest. Instead they illustrate the significance of organisational culture: appreciation, local autonomy, collective problem-solving and the sense of a shared mission. In an interesting turn, however, the *World Development Report 2015: Mind, Society and Behaviour* recognises the importance of ideas (see World Bank, 2014: 155 on health workers in particular). Though, this could just be a blip, as the subsequent World Development Report reverted to the usual focus on incentives (World Bank, 2016).

The specific domains in which top-down accountability is enforced reflect national policy-makers' normative

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beliefs, norm perceptions, perceived interests as well as the institutional context. But what amplifies accountability? The WHO-established, independent Expert Review Group on Information and Accountability for Women's and Children's Health (2014: 9) notes that '[a]lthough accountability is gaining strength as a powerful means to accelerate political action, there is very little reliable evidence to guide us as to the appropriate mechanism of accountability to adopt'. Some envisage that momentum for women's reproductive health might be galvanised by supporting local advocacy, as well creating monitoring and accountability mechanisms, bringing together and informing a diverse range of stakeholders (PMNCH, 2012; Ravindran and Kelkar-Khambete, 2007; WHO, 2004:27). However, such technical modifications may not secure increased accountability in practice. Drawing on research in Guatemala, Honduras, India, Indonesia and Nigeria, Shiffman (2007) attributes differing degrees of political prioritisation of maternal mortality to the extent of transnational influence (i.e. norm promotion and resource provision), domestic advocacy (policy community cohesion, political entrepreneurship, focusing events and credible indicators), as well as the kind of national political environment. Through a comparative study of Tamil Nadu and Karnataka, Smith (2014) likewise emphasises the significance of political context, leadership and commitment to improved health care, as well as the normative belief that government must drastically reduce maternal mortality. Similar catalysts appear to have been important in Argentina. Here, Lopreite (2012) argues that policy-makers became more receptive to transnational normative beliefs about reproductive health and rights (attached to World Bank funding) in the wake of the 2001-2002 economic crisis, which triggered budget shortages at both national and family levels. Changing patterns of resource access led otherwise conservative forces to regard family planning as in their self-interest. Also significant was domestic advocates' reframing of transnational ideas, making them more compatible with local normative beliefs.

These studies raise a number of important questions. How exactly do global development agendas shape national priorities? Is it primarily due to donor pressure and aid dependence or a shift in normative beliefs (through transnational networking, information-sharing and persuasive framing)? What has been the impact of the MDGs? As Fukuda-Parr et al. (2014:105) note, '[d]espite [their] newfound prominence… the ways in which global goals achieve their influence in shaping priorities and actions of the key stakeholders, and the ensuing consequences, are not well understood'. This is a concerning lacunae, going into the post-2015 process.

Are credible indicators sufficient to make maternal mortality visible in a country with an endemic HIV/AIDS burden (unlike Shiffman's case studies?) Also, what form of 'focusing event', to use Kingdon's (2003) term, might foster greater attention to maternal mortality? Can domestic 'policy entrepreneurs' (identified as important by Shiffman, Smith and Lopreite) be created by donor-driven interventions? Furthermore, how important are any such individual agents, relative to their political context?

This paper seeks to ascertain the relative significance of these factors in Zambia, where there has been substantial improvement in maternal health outcomes. The data is analysed in terms of normative beliefs, norm perceptions and perceived self-interest. The normative beliefs considered in this paper are individuals' moral convictions about maternal health care, i.e. whether it ought to be prioritised. 'Norm perceptions' are individuals' perceptions of attitudinal and behavioural norms in their societies (Tankard and Paluck, 2016). Individuals develop (and update) their norm perceptions through their idiosyncratic experiences (ibid), such as by seeing service users, managers and politicians demand improved maternal health care; by observing the permissibility of tardiness and absenteeism; as well as performance cultures; and the power of the executive relative to the legislature. 'Perceived self-interest' relates to that which a person considers instrumental to achieving their desires, e.g. for economic security, career promotion, reputation or political legitimacy. Thus conceptualised, interests are subjective and their content cannot be assumed *a priori*. A person's perceived self-interest is not only shaped by their material circumstances but also their norm perceptions, i.e. how they expect to be perceived and treated by others. For a more detailed exposition of constructivist institutionalism see Hay (2011).

These concepts enhance the analysis of the growing prioritisation of maternal health care in Zambia because they create competing hypotheses: does increased government attention to maternal health care primarily stem from a shift in interests (such as growing donor pressure), norm perceptions (the potentially invigorating effects of collective commitments) or normative beliefs (i.e. the Government's newfound belief in its importance)? Besides their comparative significance, this paper also examines *why* interests, norm perceptions and normative beliefs matter. For example, to the extent that increased attention has been motivated by service providers' self-interest, is this largely due to top-down or bottom-up pressure? Alternatively, if change is more due to the normative belief that maternal health *should* be prioritised, what accounts for the growing endorsement of this belief? In answering these questions, this article contributes to broader debates on accountability and priority-setting in health systems (and the public sector more broadly), as well as the effectiveness of different forms of overseas development assistance. By differentiating between internalised normative beliefs and norm perceptions, it also seeks to fine-tune our analysis of how and why norms/ ideas matter for inclusive development (thereby building on Fukuda-Parr and Hulme, 2011; Gauri et al, 2013; Hickey et al, 2015; Hudson

and Leftwich, 2014; Rodrik, 2014). While most work in this field conceptualises norms as properties of societies, I focus on individuals' perceptions of them because it is only through individual psychologies that macro-level phenomena become causally efficacious, influencing behaviour. This conceptual modification then allows us to connect micro and macro-level phenomena.

The structure of this paper is as follows. Section 2 introduces the Zambian case study and presents data showing improvement in maternal health outcomes. Section 3 sets out the methodology, prefacing the subsequent results and discussion. Then, focusing on district level (i.e. health facilities and management), Section 4 compares the motivational impact of: bottom-up accountability, in-service managerial training and top-down accountability. The latter seems most significant – according to my participants, observations and the existing literature. Among health workers and district level managers, it appears to have fostered both the self-interested concern and also the normative belief that maternal health care indicators must be radically improved. Absent this top-down pressure to improve maternal health care, technical interventions (such as formally-mandated community participation in planning, in-service training and awareness-raising activities) seldom seem sufficient to motivate attention to maternal health care.

Given the particular significance of top-down accountability, Section 5 tries to understand its emergence by examining national level processes in Zambia. The normative belief in the unacceptability of maternal mortality appears to have been reinforced by the realisation that Zambia was trailing behind African countries making greater progress towards MDG 5. Collective resolve has been further enhanced by a growing sense of shared mission with co-operating partners, in which the Ministry of Health maintains ownership. Prioritisation also seems to reflect a shift in incentives, with some donor funding being conditional on the proportion of deliveries attended by skilled health personnel. Meanwhile, there is little evidence that awareness-raising events have been motivational. A consistent theme of this article is the importance of benchmarking results, at both district and national levels. This fosters a shift in norm perceptions (influencing both normative beliefs and interests), and has important implications for the post-2015 process.

2. The Zambian Context

Maternal health has recently attracted growing attention at all levels in the Zambian Ministry of Health – according to health care workers, district administrators and senior managers interviewed by the author. Additional indicators of increased government prioritisation include institutionalisation of MDG Target 5.2 as the Ministry of Health's own Performance Assessment Indicator; a national programme to strengthen Emergency Obstetric and Neonatal Care (launched in 2007); a National Reproductive Health Policy (2008); Maternal Death Reviews in all districts (2009); a separate budget line for reproductive health and commodities (2009); direct funding to institutions training health professionals (2009); an annual 'Safe Motherhood' week and obligatory inclusion of MNCH activities in district action plans (2010); increased government expenditure on family planning commodities (MoH 2008; Mukonka 2012; Mukonka et al. 2014); the 'Eight-Year Integrated Family Planning Scale-Up Plan, 2013-2020' (2012); and the 'Road Map for Accelerating the Reduction of Maternal, Newborn and Child Mortality 2013-2016' (2013). Its launch was attended by the First Lady (an obstetrician) as well as the Minister and Permanent Secretary of the Ministry of Community of Development, Mother and Child Health.

There has also been improvement in health outcomes. After rising from 577 (in 1990) to 596 (in 1995), the estimated maternal mortality ratio decreased to 541 (in 2000), 372 (2005), 262 (2010) and 224 (2015) (WHO et al, 2015: 77). This constitutes a 61% reduction from 1990 to 2015 – missing the MDG, but nonetheless being one of the largest declines and lowest contemporary ratios in Sub-Saharan Africa (ibid). Further, between 2007 and 2014, skilled birth attendance increased from 47% to 64% (CSO 2015:127). The percentage of women using family planning has also steadily increased over the past two decades: 15 (1992), 26 (1996), 34 (2001-2002), 41 (2007), to 49.0 (2013-2014) (CSO 2015:93). Additionally, the total fertility rate has reduced: from 6.2 in 2007 to 5.3 in 2013 (CSO 2015:70). However, progress is not uniform across Zambia. Curiously, '[g]eographic patterns in intervention coverage [a]re not highly correlated with socioeconomic status, and further investigation is needed to understand what is driving such heterogeneity at the district level' (Colson et al, 2015). This paper responds to that call.

3. Methodology

This paper draws upon four months of ethnographic research in Zambia, undertaken in 2012, 2014 and 2015. In order to understand why only some parliamentarians come to champion maternal health care, the means by which they do so and constraints faced, I interviewed former Ministers of Health, Members of the Committee on Health, Community Development and Social Welfare (which had recently presented a report on

maternal health), as well as those in the All Party Parliamentary Group on Population and Development (currently focusing on maternal health). A further purposive sample of fifty participants was invited to reflect on if, how and why health care priorities had changed over the past decade. They included health care workers, health managers, staff from non-governmental organisations (such as the Churches Health Association of Zambia) and co-operating partners (including UKAID, USAID, SIDA, the World Bank, the European Commission, WHO, UNFPA and UNICEF).

Most participants were interviewed over several days – often in Bemba (a local language in which I am fluent). My ethnography also comprised observation of everyday institutional practices and living with a number of key informants: this enabled further inquiry about the comparative importance of various influences. Equally critical was the triangulation of data sources, through listening to multiple informants (with different experiences, perspectives and agendas) as well as reviewing district-level statistics and health budgets, media statements, donor agency reports and government policy documents. However, policy documents are not the focus of this paper, since creating policy documents on maternal health does not entail implementation (as UNFPA 2012 note of Zambia). Instead, a key form of triangulation was to observe meetings and workshops (on clinical care, planning and policy formulation, at both district and national level) as well as the routine activities (e.g. community outreach, planning and technical support) of three contiguous rural District Health Management Teams.

These three districts were chosen because they have similar socio-economic and geographic profiles. Accordingly, the World Bank's Results-Based Financing team in Zambia was, at the time of fieldwork, preparing to use them to compare the effects of different interventions, as part of a nationwide study. Despite socio-economic similarities, these districts differ in maternal health care indicators: the proportion of supervised deliveries, as well as antenatal and postnatal visits. Variation in their prioritisation of maternal health care was also evident from interviews with provincial health managers and other participants. Additionally, I observed that managers in better-performing areas spent more time self-critically reflecting upon how to improve maternal health care indicators. Furthermore, in their budgets, they prioritised activities widely recognised as effective in improving maternal health.

To preserve participants' anonymity, the three districts' maternal health, demographic and economic statistics are not revealed here. While this does limit transparency, I consider it ethically essential. Names of people and places have also been changed. Ethical approval was obtained from the London School of Economics and Political Science, the University of Zambia, the Ministry of Community Development and Mother and Child Health, as well as the relevant Provincial Officer in the Ministry of Health.

Data was coded using themes that emerged from the research. While the purposive (rather than statistically representative) nature of my sample does limit external validity, my findings were widely corroborated by senior personnel at the Ministry of Health, who read earlier versions of this paper.

3. District-Level Variation in Attention to Maternal Health Care

This section examines what drives attention to maternal health care at district level. It assesses the relative importance of civil society activism, in-service trainings for health managers and workers, as well as supportive supervision.

Civil society activism

Great confidence has been expressed in the potentially transformative power of bottom-up accountability. The World Bank (2003:64) rationalises this endorsement by claiming that as a result of regular interactions with service providers, '[c]lients are usually in a better position to see what is going on than most supervisors in government hierarchies'. Community participation in district-level health planning has also been endorsed in post-2015 discussions (Kickbusch and Brindley, 2013) and by the World Health Assembly (WHO, 2011). It is hoped that communities will voice their concerns, assert their rights and thereby incentivise service providers to improve service delivery – as has resulted from the White Ribbon Alliance for Safe Motherhood in India (Campbell et al., 2013). Encouragingly then, the Zambian 'health sector has established structures for participation of stakeholder at all levels, which include Village Health Committees, committees at health facilities and District Health Boards… [All of which] provide an opportunity to capture views and sentiments from the community' (MoH, 2012:37).

Although communities' participation is formally mandated, interviewed Zambian health workers and managers strongly denied they exerted any pressure. 'In some [rural] areas, even if outreach is not done for a year they [the community] will just keep quiet until the health worker decides to resume' – surmised one District Maternal and Child Health (MCH) Coordinator. These norm perceptions were consistent with my observations of 'community participation'. Neighbourhood Health Committees in rural areas have largely been trained to

disseminate health education. Their participation in planning and accountability appears constrained. Ngulube et al. (2005) suggest this is partly due to community representatives' limited understanding of the health system, and intimidation by District Health Management Teams. To quote one of their participants, "[w]e are also intimidated by these people because whenever we complain they always tell us that we should remember that we are just volunteers" (Ngulube et al., 2005: 17). Civil society activism does not appear to have improved maternal health care (as observed of Zambian civil society more broadly – Chigunta and Matshalaga, 2010; Omar et al., 2010). This is partly because there has been no change in norm perceptions: communities seldom think that *they* can shape health care priorities or practices; and providers do not anticipate any such pressure.

In-service trainings

An alternative hypothesis emphasises trainings – addressing limited managerial knowledge and skills. This idea is implicit in the Ministry of Health's (2011:34) prediction 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'. My evidence provides some support for this expectation: participatory discussions, horizontal learning (from peers in similar situations) and clinical training incorporating practice were identified as particularly useful by participants (see also Bluestone et al. 2013; Seims et al. 2013).

Besides disseminating technical information and cognitive skills, it is possible that workshops on maternal health care cultivate the normative belief in the importance of this issue. However, implementation of the cognitive and normative beliefs promoted during in-service training appears conditional upon workers' pre-existing motivation. While participatory trainings were often appreciated by those eager to improve their maternal health care indicators, they rarely fostered self-critique or behavioural change amongst their less interested colleagues (as De Sardan, 2009 likewise observes of civil servants in West Africa). Even when encouraged to consider 'management weaknesses', workshops participants tended 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 District Health Officer privately remarked to another that 'for us to address these things you need to bring us resources'. No matter how participatory the workshop, the tendency is to blame government for inadequate support and/or the community for low demand, rather than recognising (let alone addressing) one's own role – as a health manager or worker – in dampening demand by providing poor quality of care. Participants' motivation to apply taught content seemed strongly shaped by the institutional context in which they worked (as Cook, 2010 and Grindle, 1997 suggest of public sector reform more generally).

A further problem with trainings is their underlying assumption that participants will return to their workplaces, share information with colleagues and then collectively implement best practices. This technocratic conception of knowledge dissemination overlooks group dynamics. Both managers and health workers envisaged difficulties in persuading their colleagues to adopt 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.*
> District Medical Officer[2]

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), (contrary to cognitive theories of performance) service delivery also depends on motivation, as well as available resources (see also Rowe et al, 2005; UNFPA, 2005:21). The question then is how to enhance concern for safe motherhood?

Supportive supervision

[2] A much broader, global study similarly emphasises that 'peer learning is fundamentally about exchange between individuals', not necessarily achieving impact at scale (Andrews and Manning, 2015: 20).

Some managers inspire and motivate staff through their own prioritisation of safe motherhood. In one rural locality (with comparatively high maternal health care indicators), midwives and the Maternal Health Co-ordinator emphasised the support provided by their District Health Officer. They explained that through prioritised allocation of resources, he provides material assistance and also nurtures the normative belief that maternal health matters. Other health workers and managers similarly emphasised supportive, empathetic supervision, 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. Their narratives revealed the importance of norm perceptions: believing that work on maternal health is both valued and scrutinised by their institutions. The more thorough the monitoring and unannounced visits, the more health workers and managers feel pressured to improve performance and also take pride in their *recognised* accomplishments (as also found by Rowe et al., 2005; Bradley et al., 2013; George, 2009).

By contrast, and as noted in Zambia's 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 lead nurses to feel that no one cares about what they are doing (as Gilson et al., 2004; Topp and Chipukuma, 2016 similarly observe in South Africa and rural Zambia). Such norm perceptions curb workers' enthusiasm, dampening their incentive to improve maternal health care. As one senior hospital midwife explained,

> Kunda: *He [our previous supervisor] 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...*
> Author: *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.*

Supervision was often said to be superficial and inadequate. Many interviewed health care workers and managers further maintained that they felt minimal pressure to improve. Even the Ministry of Health characterises itself as having 'a lax attitude to poor performers' (2011:26, as also observed by Herbst et al. 2011; Duncan et al., 2003:47-48). Meanwhile, high-performing individuals and institutions complained that the current system provides insufficient recognition of their efforts.

However, norm perceptions are changing, shifting perceived interests. In order to satisfy managers at provincial level Many District Health Officers increasingly evaluate performance on the basis of maternal health indicators. Being held accountable for their district's performance, desiring career progression and believing in the meritocracy of that system seem to incentivise otherwise uninterested District Health Officers to focus time and resources on maternal health, becoming more open to criticism. As one Maternal and Child Health Co-ordinator explained:

> *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 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.*

In summary, supportive supervision was widely emphasised by participants. Such institutional practices appeared to impact health care workers and administrators' norm perceptions, perceived interests, self-conceptions and normative beliefs. While *geographical variation* in the extent of supportive supervision reflects idiosyncratic differences between District Health Officers (some being more intrinsically motivated than others, i.e. varying normative beliefs), provincial-wide changes *over time* reflect a shift in norm perceptions and thus perceived interests. Top-down accountability seems to have increased because maternal health has been identified as a 'national health priority' (MoH, 2012:47).

4. Increasing Attention to Maternal Health Care at National Level

This section explores why there has been increasing attention to maternal health care at national level. It considers the relative significance of global development agendas, and how they might have influenced domestic priorities. Is it by increasing resources for maternal health care; benchmarking results and inflicting reputational damage; or generating maternal health champions through awareness-raising activities?

Global development agendas

One hypothesis for amplified attention to maternal mortality is transnational influence (i.e. donor pressure and/or resources). This explanation appears plausible to some extent, given that more co-operating partners have come to prioritise maternal health. As a former Minister of Health reflected,

> *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.*
> *Mr 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!*

Two points are raised here: historically, less funding was available for maternal health and (partly as a consequence of that) such indicators were less scrutinised – even though they were technically part of monitoring and evaluation forums. Although the above-quoted perspectives were corroborated by others, they obfuscate heterogeneity within the donor community. Some agencies, like UNFPA, felt they were previously pushing the safe motherhood agenda, with limited support from Government. However, divergent priorities on the part of most donors meant that even if *some* Zambian civil servants and politicians sought to promote maternal health, they found it difficult to secure external support (on the displacement effects of global attention to HIV/AIDS see also Biesma et al., 2009; Shiffman, 2008). Going back to the quotations, the reference to women giving birth on the floor may be hyperbole, but it does reflect frustration with some co-operating partners' previous priorities.

However, donors have increasingly prioritised safe motherhood and health systems strengthening. In Zambia, aggregate official development assistance to maternal, new-born, and child health per live birth increased from US$24.7 in 2003 to US$46.1 in 2008 (Pitt et al., 2010). More recently, $24.0 million for family planning for 2012-2016 was announced by DfID (2012) and a further $60.3 million for mother and child health by the EU (2013), for 2013-2017 – dwarfing their previous funding in this area, explained with reference to the proximate MDG deadline. The World Bank (2014) has similarly approved $52 million credit and $15 million grant to accelerate progress towards MDGs 4 and 5. The MDGs were mentioned by all donors, parliamentarians and senior civil servants when explaining their attention to maternal health (as also observed more globally by Shiffman, forthcoming: 8). Importantly, this reference to the MDGs was volunteered by participants, *not* introduced by me. Additionally, the vast majority of district and national action plans commence with a commitment to attaining the MDGs.

However, setting these global targets did not increase attention immediately. Focus only sharpened more recently (circa 2006/7), with the realisation that Zambia was lagging behind other similar African countries, more likely to meet international targets. Separately interviewed senior managers in the Ministry of Health commonly expressed their keenness to avoid the embarrassment of trailing behind other countries making rapid progress:

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 is a shame [points to sharing rankings with conflict-afflicted states].

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

International benchmarking and consequent awareness of Zambia's *comparatively* poor performance appears to have catalysed attention to maternal health indicators within Ministry of Health. Benchmarking results led Zambian politicians and civil servants to see that other African countries were successfully making progress and manifestly prioritising maternal health care – thereby shifting norm perceptions. This appears to strengthen normative beliefs (that maternal mortality can and *must* be radically reduced), providing external legitimisation. A shift in norm perceptions also shapes interests. Reputational concerns and the desire to be 'developing' (i.e. achieving shared socio-economic targets) on a par with other African countries appear to have fostered greater support for maternal health within the Ministry of Health – an institution already working towards this objective (as indicated by successive Poverty Reduction Strategy Papers, National Development Strategies and National Health Strategic Plans).

While studies of Nigeria and India likewise suggest that the MDGs galvanised attention to safe motherhood (Shiffman and Okonofua, 2007; Shiffman and Ved, 2007), Zambian narratives reveal specific mechanisms. Benchmarking appears to have shifted norm perceptions, revealed inspirational possibilities and triggered reputational concerns. The significance of reputational concerns is also observed by Fukuda-Parr (2014:123), who suggests that '[c]ountries are keen to present their MDG records in international fora to bolster their standing. Countries prepare MDG progress reports for international consumption, some for this purpose only rather than for national development planning and monitoring. The Prime Ministers of India and China have come to present and showcase their MDG reports at high-profile UN events'. Sarwar (2015:10) likewise finds that the Indonesian and Mexican governments belatedly came to prioritise the MDGs due to reputational concerns: to position themselves as regional leaders. Reputational concerns are also emphasised in Kang's (2015) explanation of Niger's introduction of a gender quota, exemplified by Boureima Gado MP:

We in Niger we have to avoid being put at the bottom of the class… Today the situation is such that everywhere we go, we do not feel comfortable with having just one female MP. Let's try to correct that.

Importantly, to the extent that the MDGs have fostered greater attention to maternal health in Zambia, this seems more due to comparisons with other African countries than directives from New York. Research in social psychology likewise suggests that people are more likely to conform to the norms of a group with which they identify (Tankard and Paluck, 2016: 196; see also Htun and Weldon, 2012 on the importance of regional effects). Furthermore, the Zambian Government's increasing attention to maternal health is not perfectly correlated with increased donor MCH funding, which fell between 2008 and 2010, from $99.1 million to $62.2 million (Hsu et al., 2012:8).

However, regional benchmarking cannot fully explain Zambia's particularly rapid progress on MDG 5, compared to other African countries (since this is a continent-wide process). The remainder of this article thus examines the relative significance of the additional processes, leading to the domestication and prioritisation of MDG 5: accountability, collective commitment, reputational concerns, awareness-raising events and political context. Ideally this analysis would be complemented by comparative research from other African countries.

Indicators, accountability and collective commitment

MDG Target 5.2 (the proportion of deliveries attended by skilled health personnel) has become institutionalised as a Performance Monitoring Indicator of the Ministry of Health. Traditional Birth Attendants were excluded from the indicator, as a result of discussions in the Monitoring and Evaluation Technical Working Group and also the Sector Advisory Group, and in line with international consensus about their ineffectiveness, as reflected in MDG 5. This revision shifted government and donor attention to human resource constraints. As two senior managers at the Ministry of Health explained, in separate interviews,

These were the indicators looked at in the Joint Annual Review. 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. 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.

The disbursement of European Union funding for health depends on two conditions. Fixed funding depends on process indicators of public financial management; variable tranche 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 Zambia did not meet its target for the proportion of deliveries attended by skilled health personnel. This conditionality may have incentivised greater attention to (and funding for) human resources.

The increased significance of this indicator is also due to a shift in norm perceptions: a growing sense of shared mission. This emerged through regular interactions (e.g. the quarterly Inter-agency Committee Meetings on maternal, new-born 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 Zambian launch of the 'Countdown to 2015' in 2008, the 'Campaign for the Accelerated Reduction of Maternal Mortality in Africa' (CARMMA) in 2010 and the London Summit on Family Planning According to a 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' (this chimes with Shiffman's 2007:799 emphasis on 'policy community cohesion'). Seeing others striving to improve maternal health care seems to have shifted norm perceptions: invigorating and amplifying commitments to maternal health. The significance of domestic prioritisation and ownership cannot be over-stated. For example, some interviewed senior civil servants in the Ministry of Health had a negative view of an ongoing maternal health programme due to their perceptions of World Bank ownership and control.

Awareness-raising activities

There have been numerous donor-funded awareness-raising events to amplify support for maternal health care. Shiffman (2007:800) suggests that such conferences have 'agenda-setting power… bringing visibility to hidden issues'. But my research suggests that effectiveness varies according to workshop format, discursive framing and participants' normative beliefs.

In terms of format, maternal mortality is more commonly recognised as a problem in need of (and amenable to) policy solutions when comparative data demonstrates that it is not inevitable. For instance, some interviewed managers recalled how glaring regional differences in maternal mortality rates had revealed the avoidability of such deaths (shifting their norm perceptions). This realisation enhanced their confidence in their on-going efforts to promote safe motherhood. Further, exposure to neighbouring country data often inflicts reputational damage: 'No, Zimbabwe can't do better than us!', exclaimed one Maternal and Child Health co-ordinator. Similarly so for parliamentarians: once shown regional statistics, they promptly introduced a separate budget line for this end.

To some extent, my research suggests that – by facilitating information-sharing – international conferences can amplify attention to maternal health care (as observed in Honduras and Nigeria by Shiffman et al., 2004; Shiffman and Okonofua, 2007:131). But this is with the caveat that such networking only seems significant for those already motivated (e.g. those already holding normative beliefs in the importance of maternal health care, see also Tankard and Paluck, 2016: 198).

Some interviewed parliamentarians and civil servants extolled the benefits of collectively deliberating and developing an 'African' agenda, on how to tackle shared constraints relating to safe motherhood. 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 Health Minister insisted that safe motherhood was not a donor-driven agenda but instead developed through such continental meetings.

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.

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. This norm perception seemed to have strengthened his personal commitment to maternal health care. However, another (separately interviewed) former Health Minister dissented, denigrating regional meetings as mere 'talkshops'.

The Zambian launches of 'Countdown to 2015', CARMMA and the London Family Planning Summit were also emphasized. However, this was primarily by those closely involved in their organisation, such as one former director in 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. When issues came in, everyone in management was very supportive and wanted to be involved. When 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.*

This speaker may have had a heightened sense of the event's significance, since its planning had consumed so much of his time. Interviewed outsiders (including colleagues in the Ministry of Health, a former Minister of Finance and other parliamentarians) indicated little or no recollection of these events. The vast majority of policy-makers downplayed the significance of such advocacy. This could be because such 'talkshops' do not shift norm perceptions: they do not provide concrete evidence that others are prioritising or making progress on maternal health care. The limited impact of donor-financed workshops is also noted in a UNFPA (2012: 27-32) evaluation:

> *The mostly logistical and financial support provided by UNFPA to the launching of CARMMA and the development and revision of the Zambian Maternal and Newborn Health Road Map did not translate into a coordinated and coherent push to strengthen the integration of maternal health into the Zambian health policy framework… Although UNFPA support of these initiatives has helped to generate a lot of national attention at the time of their launch… it has not translated into any significant and concrete new commitments to maternal health.*

The impact of awareness-raising events was also strongly downplayed by concerned Zambian parliamentarians, who more typically attributed their motivation to experiential knowledge, such as guided tours of health clinics. These provided first-hand evidence of (and empathy for) the difficulties pregnant women face in rural areas. Such sentiments were shared by one former Minister of Finance who explained his increased resource allocation to health as follows:

> *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.*

Leaders' interest in the ideas and information presented in workshops also seems to depend on their concern for gender inequalities (i.e. their normative beliefs). While collective discussions on reproductive health were sometimes cited as inspirational and informative by those already interested in this topic, uninterested others largely remain so, even when a range of innovative discursive frames are used.

A major constraint here is the overwhelming multiplicity of workshops. They are the default means by which co-operating partners seek to influence government policy and practice – on malaria, tuberculosis, HIV/AIDS etc. As one senior manager in the Ministry of Health explained, 'we have so many awareness campaigns'. Single issues are rarely the subject of sustained attention. As noted earlier, there is a tendency to perceive workshops as 'IGAs': Income Generating Activities.

Political Context

Most important perhaps is the broader political context. Workshops for parliamentarians on maternal mortality

or health expenditure in general[3] do not seem to address what Barrientos et al (2005: 35) term 'the chronic weakness of [the Zambian] parliament' (see also Burnell, 2003). Limited support for health spending amongst backbench parliamentarians does not seem to be the binding constraint:

> *If the focus is on parliamentarians, they* [donors] *are wasting their money… As regards the budget, the MP has an 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.*
> Former Minister of Health

Interviewed backbench MPs commonly portrayed themselves as 'powerless' to affect the budget. Some donors have long lobbied for increased health expenditure, through information-dissemination and advocacy workshops, yet government expenditure on health as a proportion of total government expenditure did not exceed 9% between 2006 and 2009 – far below the 15% Abuja target.

Allocation increased in 2011, following national elections. As detailed in the National Health Strategic Plan 2011-2015, '[t]he MTEF [Medium Term Expenditure Framework] projects that government funding for health services will grow from USD 160 million in 2011 to USD 370 million in 2011 (MoH, 2011:68). One health advisor of a co-operating partner commented, 'it was all done by the Government. It caught us by surprise. We hadn't imagined they would increase it by that much'. Health has been identified as one of four priority sectors by the new administration. One senior party leader explained of the then President, 'he was previously Minister of Health, so he understands the problems and is easily convinced that they need more money'. At that time the First Lady, Dr Christine Kaseba, was a practising Obstetrics and Gynaecology doctor, who regularly speaks publicly on maternal health and recently launched a video documentary on abortion (Nkonde, 2013). In addition, a number of ministers and permanent secretaries are health professionals, with particular expertise in maternal and child health. As one senior manager at the Ministry of Health commented:

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

Similar sentiments were expressed by donors when asked about the Government's expressed commitment to double its allocation for family planning, announced at the 2012 London Family Planning Summit. Given the power of the executive in shaping policy priorities in Zambia, a critical mass of support for health and maternal health care may be significant (on the influence of policy elites in Zambia see also Gilson et al. 2003). Further, Zambian elites' normative commitment to maternal health care may have made them particularly sensitive to shifts in norm perceptions (induced by regional benchmarking): not wanting to be outdone on something they cared deeply about.

Increased government expenditure on health may also be due to a structural change in perceived interests. Arguably, recent increases merely trail the previous administration's announcement of a 30% increase in domestic contributions (Musokotwane, 2010). This followed the suspension of budget support from donors, resulting from Government's disclosure of corruption in the health sector in 2009 (MoH, 2011). The incentive to amplify domestic financing may have also been strengthened by democratic pressures: widespread dissatisfaction with health services was clearly vocalised before the 2011 national elections (see also Armah-Attoh et al, 2016: 16). Popular dissent and high-level political attention have also been catalysed by private media, exposing instances of inadequate maternal health care.

5. Conclusion

This paper began by examining what drives attention to maternal health care at district level. Supportive supervision seems particularly significant. When performance is evaluated on the basis of maternal health care indicators, improvement is in the self-interest of health care professionals. But (contrary to the implications of World Bank, 2003), health care professionals are not merely self-interested. They are also motivated by norm perceptions: that their work is valued, as part of an important collective endeavour, and that maternal health care is strongly prioritised by the Ministry of Health. These norm perceptions appear to be strengthened by supportive supervision, benchmarking and top-down accountability. In institutions where improved performance is neither recognised nor rewarded, awareness-raising activities and in-service training only

3 Some co-operating partners, such as the WHO have sought to increase support for regional agreements like those made in 2001 in Abuja, where Africa Union countries pledged to increase government expenditure on health to at least 15%.

stimulate momentary attention. The effectiveness of these interventions seems strongly conditional upon accountability pressures. Maternal health care indicators need to be scrutinised in order to shift health care professionals' norm perceptions and normative beliefs about their importance, as well as self-interested concerns for improvement.

Maternal health seems to have become the subject of increasing concern and resource allocation at district level due to changes within central government. This seems partly due to a shift in norm perceptions. Benchmarking has revealed that other African countries are making progress and prioritising maternal health care, thereby revealing inspirational possibilities, legitimising normative beliefs and also triggering reputational concerns. The perceived unacceptability of maternal mortality has been further strengthened by growing collective commitment among co-operating partners, where the Ministry of Health maintains ownership. This has been reinforced by new incentives, with some partner funding now being conditional on the proportion of deliveries attended by skilled health personnel. Importantly, this is not to deny the potential power of social movements or to imply that benchmarking results is unproblematic; but, of the existing processes in Zambia, this seems to have been most effective.

Although service provider motivation and agenda-setting in central government tend to be examined separately, this multi-level analysis of Zambia reveals their shared drivers. Benchmarking results can shift norm perceptions and amplify accountability, at both district and national levels.

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