Mapping Maternal Health Advocacy
A CASE STUDY OF ZAMBIA

FAMILY CARE INTERNATIONAL

TABLE OF CONTENTS

List of Boxes

List of Tables

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I. INTRODUCTION

In 2000, the adoption of the Millennium Development Goals (MDGs) marked the beginning of a renewed global commitment to improving the social and economic well-being of the world's population [1]. Of the eight goals, MDG 5 (Improve Maternal Health) is directly relevant to maternal health; a number of other MDGs, including those focusing on education (Goal 2), gender equality (Goal 3), child mortality (Goal 4), and HIV/AIDS (Goal 6), also have an impact on maternal health and well-being. In 2010, a review of countries' progress towards the MDGs revealed that many countries were falling short of achieving their targets [2]. A number of global and regional efforts now exist to help accelerate progress towards maternal health and the MDGs; these include the United Nations (UN) Secretary-General's Global Strategy for Women's and Children's Health, Countdown to 2015, the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) [3], and the 2001 Abuja Declaration on health-sector funding.

Advocacy can play a critical role in mobilising commitment and support for maternal health. At the global and regional levels, advocacy efforts have encouraged governments to sign commitments and set targets for maternal health. At the national level, civil society organisations (CSOs) utilise advocacy to hold governments and other stakeholders accountable to these commitments, and generate public demand for better maternal health services.

This report (Box 1) maps the current advocacy environment for maternal health in Zambia. It outlines systems of maternal health governance, identifies stakeholders working in maternal health advocacy, and analyses opportunities and challenges for maternal health advocacy organisations. It identifies the potential of engaging the Zambia private sector on maternal health issues, and concludes with a set of recommendations for strengthening maternal health advocacy efforts in the country. Although civil society organisations have not yet mobilised around maternal health issues in Zambia, there is a robust policy framework in place, and the country has signed a number of commitments to improve delivery, uptake, and outcomes of maternal health services. There are numerous opportunities for engagement, both with advocates and with the private sector, on maternal health in the country.

Data for this report were collected at the national level using a multidimensional qualitative model based on key informant interviews and a literature review. Respondents were identified via purposive sampling and included representatives from UN and government agencies, bi- and multi-lateral organisations, international and national non-governmental organisations (NGOs), health professional associations, advocacy coalitions, and private-sector organisations. Data were analysed using a thematic approach.

BOX 1: FAMILY CARE INTERNATIONAL'S (FCI's) MATERNAL HEALTH ADVOCACY MAPPING

Family Care International (FCI) completed a comprehensive mapping activity in Zambia in 2013 to gather information on the maternal health policy environment. The study assessed the organisations, partnerships, and networks currently and potentially engaged in maternal health advocacy, as well as the advocacy goals, strategies, resources, and core messages being used. The study also sought to understand the role the private sector currently and potentially has in maternal health in Zambia, and to identify points of engagement with potential private-sector partners.

II. MATERNAL HEALTH IN ZAMBIA

Zambia has been making good progress in meeting a number of its health-related MDGs. National measles and diphtheria, pertussis (whooping cough) and tetanus immunisation coverage is higher than regional averages, reaching 91% and 82% of children under five [4]. Zambia's HIV/AIDS prevalence is estimated to be 13.5%, down from 17.5% in 2008, and HIV/AIDS specific mortality has declined from 630 per 100,000 people in 2000, to 341 per 100,000 in 2009 [4]. Zambia has one of the highest rates of antiretroviral therapy (ART) coverage in Sub-Saharan Africa, with 72% of people with advanced HIV/AIDS having access to ART [4].[a] Zambia is one of only 11 countries in Africa with evidence of a greater than 50% decrease in malaria incidence cases between 2000 and 2011, and the country has seen a 30% decrease in under-five all-cause child mortality rates since 2000 [4].

Indicators for maternal health, however, have lagged far behind (Table 1). In 2002, Zambia's maternal mortality ratio was 720 per 100,000 live births. By 2010, the country had managed to reduce this number to 440 per 100,000, but the rate is still far off both the country's MDG target of 162, and the more ambitious target of 159 set by the National Health Strategic Plan 2011–2015 (NHSP) [4–6]. Skilled birth attendants are present at only 46.5% of all births [4]. The average fertility rate is 6.2 children per woman [6]. Many other maternal health indicators have failed to decline steadily since the mid-1990s, and vary greatly across provinces [7]. Leading causes of maternal death include haemorrhage, sepsis, obstructed labour, hypertensive conditions, abortion, malaria, and HIV [8].

Table 1: Key Maternal Health Indicators for Zambia and Sub-Saharan Africa

Indicators	Zambia	Sub-Saharan Africa
Maternal mortality ratio (per 100,000 live births)	440	480
Population growth rate (%)	2.7*	2.4
Antenatal care coverage (%) at least 1 visit	94	74
Antenatal care coverage (%) at least 4 visits	60	43
Births attended by skilled health personnel (%)	46.5	48
Nursing and midwifery personnel density (per 10,000 population)	7.1	9
Births by Caesarian section (%)	3	4
Post-natal care visit within two days of childbirth (%)	39	37
Total fertility rate (number of children per woman)	6.3	4.8
Pregnant women with HIV receiving antiretroviral medicines for PMTCT[b] (%)	75	50
Unmet need for family planning (%)	27	25
Contraceptive prevalence (%)	41	24

Sources: All statistics from World Health Organization. 2012. *World Health Statistics 2012*. Geneva: WHO, except * Government of Zambia. 2012. *2010 Census of Population and Housing: Summary of Findings*. Lusaka: Central Statistics Office.

[a] The regional average is only 49% [4].
[b] Preventing mother-to-child transmission of HIV

Zambia's progress has been impeded by number of supply- and demand-side barriers to accessing maternal health services. Barriers include the human resource crisis (e.g. lack of midwives, high level of staff turnover), lack of emergency obstetric services, low levels of contraceptive usage, cultural attitudes towards pregnancy, labour, and delivery, and high levels of malaria and anaemia [4]. Once evidence began to show that Zambia's MDG 5 performance was lagging, and that its targets would not be met by 2015, the Ministry of Health (MoH) began to redirect its attention towards maternal health. Following elections in 2011, a new ministry was created – the Ministry of Community Development and Mother and Child Health (MCDMCH) – to help guide implementation of programmes and direct service delivery closer to communities. MDG 5 is now prioritised as a performance indicator on the *Sixth National Development Plan 2011–2015* (SNDP). The country has been host to a number of large, donor-funded initiatives to address barriers to service delivery and utilisation, and to reduce high levels of maternal mortality. These initiatives include Mobilising Access to Maternal Health Services in Zambia (MAMaZ) and Scaling Up Family Planning (SUFP) (both funded by DFID[c]); as well as Saving Mothers, Giving Life (SMGL). MAMaZ ended in March 2013. The other two projects are ongoing.

III. THE MATERNAL HEALTH POLICY ENVIRONMENT

The health policy environment in Zambia is supportive of maternal health. Existing health governance structures are currently being strengthened and formalised. Strategic plans, policies, road maps, guidelines, and curricula are either already in place, in the process of being finalised, or in planning stages (See Box 2). Maternal health is one of the key areas in which health governance is being actively reviewed, expanded, and improved. Zambia is a signatory to many international maternal health commitments and these agreements provide a clear policy framework in the country (Table 2).

BOX 2: Key Guidelines, Curricula, and Frameworks for Maternal Health

GUIDELINES ON:
- Pregnancy, Childbirth, Post-Partum and Newborn Care
- Emergency Obstetric and Newborn Care
- Maternal Death Review
- Comprehensive Abortion Care
- Community Discussion Guide and Training Manual for Maternal/Newborn Care

OTHER RELEVANT PLANS AND POLICIES:
- Adolescent Health Strategic Plan 2011-15
- National Reproductive Health Policy
- National Health Worker Retention Scheme
- National Community Health Assistant Strategy 2011-15
- DRAFT 8-Year Family Planning Scale-Up Plan

CURRICULA ON:
- Emergency Obstetric and Newborn Care
- Family Planning
- Community-Based Distributors
- Safe Motherhood Action Groups

COMMUNICATION STRATEGIES FOR:
- Family Planning
- Adolescent Health
- National Gender Policy
- Reproductive Health Commodity Security Framework
- National Multi-Sector HIV and AIDS Policy and Strategic Plan
- National Food and Nutrition Policy
- DRAFT Newborn Health Framework

[c] Department for International Development, a cabinet-level department of the United Kingdom's government.
[d] Launched in 2012, SMGL is a collaborative partnership among public, private, and NGO sectors. The founding partners are: the U.S. government, the Government of Norway, Merck for Mothers, American College of Obstetricians and Gynecologists and Every Mother Counts.

Until recently, the primary policy document for maternal health in Zambia was the *National Health Strategic Plan 2011–2015.* This is the key strategic document for the MoH and is a component of SNDP. The NHSP underscores government commitment to the provision of **equitable access to cost-effective and quality health services as close to the family as possible.** The plan focuses on high impact interventions, and includes a costing analysis aimed at achieving high reductions in maternal, neonatal and under-five child mortality. It addresses barriers such as inadequate infrastructure, fragmented services, cultural issues and equipment shortages. It also supports the development of high impact nutrition interventions and the extension of intermittent preventive treatment in pregnancy (IPTp). The NHSP emphasises programming for antenatal and post-natal care, family planning, PMTCT, assisted deliveries by skilled health personnel, and advocacy. Advocacy messages are tied to specific accelerated actions.

CARMMA was launched in June 2010 and provides a critical framework for many of maternal health initiatives in Zambia. It has, however, not yet been effectively utilised as an advocacy tool; its advocacy messages are being deployed in various ways by many organisations working in maternal health, but often without the support of a clear advocacy strategy.

In April 2013, the *Road Map for Accelerating Reduction of Maternal, Newborn and Child Mortality 2013-2016* was launched by the first lady, Dr Christine Kaseba. This document will eventually serve as the primary strategy and advocacy framework for the reduction of maternal mortality in Zambia. The objective of the Road Map is to reduce maternal mortality to 162 per 100,000 live births over a 10-year period through the provision of skilled attendance across the continuum of care and levels of referral. The Road Map identifies the following priority areas:

- Prevention of pregnancy, especially among adolescents.
- Improved systems of referral.
- Health systems strengthening related to maternal, newborn, and child health.
- Community-centred interventions, sensitisation, and mobilisation.
- Scaling up high-impact health interventions (e.g. skilled birth attendance, emergency obstetric and newborn care, focused antenatal care and post-natal follow-ups).

Advocacy is a major element of this effort. The Road Map calls for:

- Increased budget allocation for maternal, newborn, and child health from both domestic and external financing.
- Revision of existing policies to ensure that maternal, newborn, and child health are effectively addressed.
- Improved health worker training, employment, deployment, and retention for better service coverage and delivery.
- Institutionalisation of maternal death reviews.

As the Road Map has only recently been launched, it remains unclear whether there are strategies in place to promote these goals, or whether stakeholders are working together to coordinate advocacy efforts.

IV. MATERNAL HEALTH ADVOCACY STAKEHOLDERS

The mapping identified 32 organisations that have planned, implemented, funded or served as a target for either maternal health advocacy or advocacy on issues closely related to maternal health. Organisations that only implemented maternal health projects, without including an advocacy or communications component, were not included. The research was unable to interview community-based and district-level organisations. Most organisations were based in the capital of Lusaka and, if they worked in communities, did so through project officers placed at district level, or through partnering with community-based organisations. Table 3 presents an abbreviated list of international NGOs, local NGOs, networks and coalitions, and academic institutions that have contributed to maternal health advocacy.[e]

[e] Private sector stakeholders are listed elsewhere in the briefing. A complete list of stakeholders – including government agencies, bilateral and multilateral organisations – is available in the full mapping report.

Table 2: Zambia's National, Regional, and International Commitments

Commitment	Targets and Resolutions Relevant to Maternal Health
Millennium Development Goals	• Reduce maternal mortality to 131 deaths per 100,000 live births by 2015. • Reduce infant mortality by two-thirds from 88.4 deaths per 1,000 live births.
Abuja Declaration	• Allocate 15% of the annual budget to the health sector.
UN Global Strategy for Women's and Children's Health (Every Woman, Every Child)	• Increase national budgetary expenditure for health from 11% to 15% by 2015 with a focus on maternal and child health. • Increase contraceptive prevalence from 33% to 58%. • Increase access to health services by bringing them closer to communities.
Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14: Health and Reproductive Rights	• Ensure the right of women to control their fertility, choose contraception, access family planning information, and protect themselves against HIV/AIDS and STIs. • Ensure the right to be informed of one's own and one's partner's health status. • Provide adequate, affordable, and accessible health services. • Establish and strengthen existing antenatal, delivery, and post-natal health and nutritional services.
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Article 12: Health	• Take appropriate measures to eliminate health-based discrimination against women. • Provide access to health-care services including family planning, pregnancy-related services, and nutritional support. • Provide free services where necessary.
SNDP 2011-2015	• Increase in deliveries by skilled attendants from 45% to 65% by 2015. • Increase in-facility deliveries from 28% to 50% for rural areas, and 79% to 90% for urban areas, by 2015.
Vision 2030 long-term plan	• To create a prosperous middle-income nation by 2030 based on seven key principles, one of which is gender-responsive sustainable development.
Termination of Pregnancy Act, 1972 (Amended in 1994)	• Stipulates that termination of pregnancy is legal when there is: a) risk of life or injury to the pregnant woman; b) evidence that the child will be born handicapped or continuation of pregnancy will put existing children in danger; c) evidence that pregnancy results from rape or defilement. • States that approval for abortion must be received by three registered medical personnel except in cases of emergency.
Anti-Gender-Based Violence Act, 2011	• Requires the state to provide protection and rehabilitation for victims of gender-based violence.

Table 3: Map of Maternal Health Advocacy Stakeholders

Category	Name of Organisation	Area of Interest
International NGOs	• Society for Family Health (SFH)	• Family planning, HIV/AIDS, social marketing, access to commodities
	• Program for Appropriate Technology in Health (PATH)	• Maternal and newborn health policy development, access to technologies
	• Planned Parenthood Association of Zambia (PPAZ)	• Sexual and reproductive health and rights, maternal health, human resources
	• Marie Stopes	• Sexual and reproductive health and rights
	• Tropical Health & Education Trust	• Human resources
	• Panos Institute Southern Africa (PANOS)	• Media and communications
National NGOs	• Afya Mzuri	• Communications
	• Youth Vision Zambia (YVZ)	• Sexual and reproductive health and rights, HIV/AIDS, adolescent health, gender-based violence
	• Women for Change (WfC)	• Health and human rights, maternal health
	• Women and Law in Southern Africa – Zambia	• Legal research, sexual and reproductive rights, gender-based violence
	• Comprehensive HIV/AIDS Management Programme (CHAMP)	• HIV/AIDS, private sector, workplace health
Coalitions/ Networks	• Zambia UK Health Workforce Alliance (ZUHWA)	• Human resources
Research	• Zambia Centre for Health Applied Research and Development (ZCHARD)	• Research, evidence for decision making
	• Centre for Infectious Disease Research in Zambia (CIDRZ)	• Research, evidence for decision making
	• Zambia Forum for Health Research (ZAMFOHR)	• Research, evidence for decision making
Professional Associations	• Zambian Association of Obstetricians and Gynaecologists (ZAGO)	• Human resources, sexual and reproductive rights, maternal health
	• Zambia Union of Nurses Organisation (ZUNO)	• Human resources
	• Midwifery Association of Zambia (MAZ)	• Human resources
Programmes	• Communication Sciences for Health (CSH)	• Communications, maternal health interventions
	• Maternal and Child Health Integrated Programme (MCHIP)	• Human resources, maternal health interventions
	• Zambia Integrated Systems Strengthening Programme (ZISSP)	• Human resources, maternal health interventions, family planning
	• Zambia Prevention, Care and Treatment II (ZPCT II)	• PMTCT, maternal health interventions, community-based advocacy

V. ADVOCACY GOALS, MESSAGES, AND DISSEMINATION STRATEGIES

Advocacy in Zambia has, for many years, been largely in response to the HIV/AIDS crisis and, increasingly, malaria. Other health issues have not benefitted from the sophisticated, sustained, and coordinated strategies deployed by AIDS and malaria advocates. While maternal health has a strong presence on the policy agenda in Zambia, stakeholders report that a harmonized set of maternal health advocacy goals is absent in the country. Instead, there exists a diverse array of messages that reflect shared priorities, but not shared strategies or objectives. These messages are often closely tied to existing government priorities and policies, or used to promote evidence from implementation research for the purpose of scaling up projects or programmes. Only one maternal health organisation had a clearly defined advocacy strategy (the DFID-funded MAMaZ's project), with a strategic plan focused primarily on dissemination of the project's interventions (e.g. emergency transport, budget tracking, and demand-led service provision). MAMaZ's dedicated budget for advocacy was also insufficient to implement activities.

Like the MAMaZ's project, other respondents did not clearly distinguish between "advocacy" and intervention-focused "promotion". A number of critical factors have driven the Zambian government's commitment to maternal health, (e.g. evidence on high mortality ratios, the availability of external financing, and the presence of key maternal health champions [8]), but advocacy itself is not generating action. Rather, the opposite is true: programmes, projects, and initiatives build advocacy into work plans, as part of their promotion and dissemination activities. Nevertheless, in both interviews and planning documents, government and other maternal health stakeholders support a number of key maternal health messages (Table 4). Some of these messages have not yet found their way into advocacy materials and campaigns, but could serve as launch points for potential advocacy work in the future.

Table 4: Messages and Targets for Maternal Health Advocacy

Message	Source	Dissemination	Target
No woman in Zambia should die while giving birth!	CARMMA	Posters, media campaigns, parliamentary briefings, community events	All stakeholders
Together, we can make a difference. Everyone is responsible and each one of us has a role to play.	CARMMA	Posters, media campaigns, parliamentary briefings, community events	All stakeholders
Every pregnancy faces a risk: Maternal deaths are preventable using proven and effective interventions. The challenge is to transform this knowledge into action.	CARMMA	Community events	All stakeholders
Healthy women contribute to the well-being of society.	CARMMA	Community events	All stakeholders
Safe termination of pregnancy is legal in Zambia and can be obtained from skilled providers.	PPAZ/ZAGO/Youth Vision Zambia	Media campaigns, parliamentary and cabinet briefings	All stakeholders
Progress in maternal health should not just focus on health impact indicators, but on aid effectiveness and accountability.	Government of Norway, MAMaZ, PANOS	Workshops, institutional mechanisms	Political leadership, donors, technical organisations
Services are important. Quality services are more important.	Saving Mothers Giving Life partners, MAMaZ, PPAZ, Women for Change	Workshops, institutional mechanisms	Political leadership, MoH, District Government
Community-based providers can provide critical maternal health services.	PPAZ, ZCHARD, ZUHWA, MAMaZ, MCDMCH	Workshops, institutional mechanisms, research conferences	Professional organisations, MoH

Messages in *italics* are direct advocacy messages. Messages in standard type represent ideas stakeholders wish to convey with advocacy, paraphrased from interview transcripts or literature.

Although advocacy activities have lacked coordination, a few organisations have found creative ways to disseminate information. For example, PANOS incorporated maternal health into a PMTCT project by supporting training and fellowships for journalists. PANOS also utilised listening clubs in rural areas to hold discussions following radio presentations on topics related to PMTCT and maternal health. The discussion itself would then be recorded and played back for district-wide dissemination on the same radio station. The intent of the listening clubs was to generate broader debate and create a platform within civil society for maternal health issues.

PPAZ also carried out advocacy both on behalf of the MAMaZ project and in support of the Termination of Pregnancy Act. Working with the Zambian Association of Obstetricians and Gynaecologists, they created memoranda to lobby for retention of the Act. They held parliamentary briefings, working luncheons, and field trips to Mother Shelters for parliamentarians, parliamentary health committee members, and political candidates. PPAZ targeted Safe Motherhood Action Groups (SMAGs), Neighbourhood Health Committees (NHCs), and traditional and religious leaders with outreach activities to promote maternal health messages at the community level.

The evidence base on maternal health is growing in Zambia, with a number of organisations carrying out maternal health research, especially in relation to the Saving Mothers, Giving Life (SMGL) initiative. Respondents often mentioned the dissemination of evidence as a primary means by which to affect policy change in Zambia. However, when describing channels of influence, respondents frequently cited institutional bodies embedded within government ministries (e.g. technical working groups, Inter-agency Coordinating Committee for Health), as opposed to naming, for example, the media or civil society. Moreover, while stakeholders also mentioned budget tracking as a critical tool for advocacy, they provided no evidence that budget tracking is happening in relation to maternal health.

There have been a number of other missed opportunities for maternal health advocates. While World AIDS Day and World Malaria Day are vital platforms for advocacy in Zambia, maternal health has been unable to leverage similar events (e.g. National Safe Motherhood Week, International Women's Day). Indeed, during interviews, national-level advocacy respondents did not mention National Safe Motherhood Week – an event established in 2010 – as an opportunity for maternal health in Zambia. While a number of districts did hold activities, the outcomes and impact of such events are unknown. Maternal health advocacy is not being monitored, measured, or evaluated in Zambia.

VI. OPPORTUNITIES, CHALLENGES, AND PRIORITIES

Opportunities

There are a number of opportunities for maternal health advocacy in Zambia. The country has a favourable policy environment and a strong evidence-based decision-making ethos in government. The presentation of evidence is a primary tool for advocacy to government and provider associations. If credible evidence demonstrates the effectiveness of a particular intervention, approach, or policy, the Zambian government will adopt or, at the very least, approve a pilot study. Similarly, there are clear institutional channels for advocates to follow upwards to government (e.g. technical working groups, the Parliamentary Health Committee, ZAGO) and downwards to communities (e.g. SMAGs, NHCs, health centres, community health assistants). Maternal health also has a high-level champion in the form of the first lady, Dr Kaseba, an obstetrician and gynaecologist.

Additionally, maternal health is prominent on the policy agenda in Zambia. Maternal health initiatives are being rolled out and maternal health issues are frequently part of parliamentary briefings and Q&A Sessions. Maternal health programmes are strengthening SMAGs, as well as targeting traditional leadership. Both SMAGs and traditional leaders serve as important grass-roots platforms for advocacy. While many organisations are primarily focused on project implementation, there are a handful of organisations that clearly understand and think creatively about advocacy, although they often struggle for funding, capacity, and coordination. Respondents view advocacy as a critical tool for improving maternal health outcomes in the country, and acknowledge that advocacy needs better funding, planning, and monitoring and evaluation.Finally, the media sector is growing

in Zambia and becoming more sophisticated. There are more media outlets, including television stations, radio, newspapers, and magazines. A number of journalists are keen to report on health, and health is a topic to which the media is paying more comprehensive and analytical attention.

Challenges

A lack of attention to maternal health advocacy in the past, as well as organisations' inability to clearly distinguish between advocacy and health-intervention promotion, means that stakeholders frequently leave advocacy work until late and fail to provide it with a dedicated budget line. This has hampered a number of recent advocacy initiatives. While respondents emphasised the importance of partnership and coordination, in reality, harmonisation often exists "in name only", as each organisation has its own agenda and wants separate recognition. Additionally, there are no dedicated health desks at media outlets, and therefore it is easy for health stories to be dropped quickly or redirected. Windows of opportunity close as the media lacks the capacity to follow themes and maternal health stakeholders fail to capitalise on openings in public discourse. As a consequence, there is no consistent, sustained, synchronised means for ensuring maternal health advocacy in Zambia. This often results in missed opportunities for advocacy (Box 3).

BOX 3: A MISSED OPPORTUNITY

In May 2009, *The Post* newspaper published a graphic photo of a woman giving birth in the parking lot of University Teaching Hospital during a nurses' strike. *The Post* hoped that the picture would force the government to end the strike by calling attention to the maternal health consequences of the strike and the health worker conditions that prompted it. Instead, the editor of *The Post* was arrested on obscenity charges. The report made the international press and was quickly transformed from a story about the inadequacies of the hospital's maternity wing and the general state of maternal health services in the country, into a debate on freedom of the press and government overreach. In the words of one respondent: "Moments that can shake the country need to have follow-through." In the absence of a robust maternal health advocacy climate, there was no sustained follow-through by either the media or by advocates, and the story lost momentum.

Moreover, while stakeholders are often successful at moving maternal health programmes forward in Zambia, this does not mean that these programmes are efficiently implemented or, if they are implemented, that they have any long-term sustainable impact. It is fairly easy to get maternal health ideas and initiatives on the policy agenda in Zambia. It is far harder making them work. As advocacy is not being measured, it is unclear what impact advocacy efforts are having.

VII. THE PRIVATE SECTOR AND MATERNAL HEALTH

Over the past 10 years, regulatory barriers to the establishment of private business have been gradually loosened. These barriers had made it difficult for medical practitioners to operate outside the public system, blocked the establishment of private practice by doctors, nurses, and midwives, and acted as a disincentive to the growth of other health-related enterprises [10]. A series of private-sector initiatives and reforms – within and outside of the health sector – have laid the groundwork for a more receptive policy and investment climate. Since the mid-1990s, the MoH has been open to the idea of public-private partnerships (PPPs), even if the larger regulatory and taxation climate has remained restrictive. All NHSPs since 1995 have called for an enhanced role for private providers [10]. The last two NHSPs have singled out the creation of PPPs as a key strategy in the development of the health sector, and list the private sector as a critical stakeholder across a number of areas of their work plan [6]. However, there is still no explicit private-sector policy or strategy within the MoH, nor is there a designated office for PPPs within the ministry.

At present, the relationship of most private-sector stakeholders to maternal health is not obvious. Many of the projects engaging the private sector in Zambia have sprung up in relation to HIV/AIDS and malaria, diseases that have had the greatest impact on the Zambian workforce (e.g. mining, commercial, agricultural). Additionally, the private sector is often wary of engaging the public sector due to past experience with punitive regulation and taxation [8]. Private-sector stakeholders have also experienced numerous disappointments with time-bound, donor-financed projects that come to an end before any clear benefit can be seen. Even though the sector is growing, private health service provision and pharmaceutical manufacturing is still small in Zambia compared to other countries, and concentrated almost entirely in Lusaka and the Copperbelt region. Finally, there is sometimes a tendency for the public sector to treat corporate partners as simply a source of financial support, without understanding why the private sector might be interested in investing in PPPs, or health in general [11].

In spite of these barriers, there has been an expansion of private hospitals and clinics in urban areas, as well as a number of innovative partnerships – often associated not with service delivery, but with financing, essential medicines supply, and health communication – piloted in Zambia with interest from both government and donors. Most of these have not focused on maternal health. Nevertheless, there are indications from the not-for-profit and the for-profit private sectors that they are eager to invest more in maternal health if provided objectives, guidance and, in the case of for-profits, a strong business case for doing so. Additionally, several organisations – including ZAGO and PPAZ – have been eager to provide in-service training to private providers in order to bring them up to date on maternal and reproductive health services. A comprehensive mapping of private-sector maternal health services, and a strategic assessment of training, managerial, and financing gaps, would help provide clarity on areas of engagement, as would aid the development of a country-specific business case for maternal health.[f] Finally, there are institutions in place through which to create networks with the private sector. For example, the Zambia Health Alliance works with private-sector companies, associations, and federations to establish sustainable, long-term links between Zambian business, NGOs, and government. Table 5 outlines key private-sector health stakeholders.

Table 5: Key Private-Sector Stakeholders

Organisation	Category
Churches Health Association Zambia	Non-governmental health provider, advocacy, programme management
Mining sector hospitals/clinics	Non-governmental health provider
Non-mining employer-based providers (e.g. Zambia Sugar)	Non-governmental health provider
Medical Stores Limited	PPP, supply-chain management
First Quantum Minerals Limited	Health-sector financing, Lower care programme management, PPP
Sweden-Zambia Health Cooperation (SWECARE)	PPP
Zambia Health Alliance	PPP
Zambian Private Providers Association	Health provider organisation
Private Hospitals Association	Health provider organisation

[f] A number of mappings reports have been commissioned for the general health sector, but none specific to maternal health.

VIII. CONCLUSION AND RECOMMENDATIONS

The policy window for engaging both maternal health and the private sector for health is wide open in Zambia. There are key maternal and private-sector health stakeholders on the ground, along with a wealth of experience from which to draw. However, the two issues – maternal health and private sector – have not yet been brought together, nor is the advocacy climate for maternal health presently strong. Based on the mapping results, maternal health advocacy is not being planned, budgeted for, or measured in a sustainable or coordinated way. Maternal health advocacy follows from existing programmes, projects, and funding; it does not lead the way forward. Similarly, PPPs are not being established with regard to their long-term viability, but rather in reference to short-term opportunities. Nevertheless, respondents in Zambia are quite keen to address these challenges. This report offers the following recommendations:

1. **Leverage existing advocacy and private-sector health organisations and networks** rather than create new ones. There exist in Zambia a number of national networks and alliances, such as the Zambia UK Health Workforce Alliance (ZUHWA) and the private sector Zambia Health Alliance (ZHA), which can be strengthened and made more effective in coordinating maternal health advocacy.

2. **Support maternal health advocacy organisations** in the development of tools, indicators, and mechanisms for measuring advocacy outcomes and impact. At present, advocacy is not measured in a coordinated and systematic way. Organisations need to build their capacity for monitoring and evaluation.

3. **Engage health provider organisations as key partners** in advocacy work. It is critical to provide technical and resource support to provider organisations that are new or inactive such as the Midwives Association of Zambia in order for them to support advocacy on behalf of human resources for maternal health.

4. **Engage local advocacy organisations,** including those that may be struggling or operating under capacity, and build their administrative, management, and planning capabilities in order to ensure maternal health advocacy is locally owned.

5. **Target local media organisations and encourage them to establish or strengthen health desks** to create institutionalised points of contact. Building institutional capacity for health reporting will help to ensure that maternal health remains on the policy agenda.

6. **Seek to harmonise maternal health messaging** and tie advocacy messages to a strategic platform with specific, measurable outcomes, and impact. Maternal health advocacy stakeholders need a forum to share advocacy experiences, and build common objectives, messages, tools for planning and budgeting, and indicators of impact.

7. **Focus on private-sector engagement across all components of the health system,** not simply the private provision of services. Potential partners should look "outside the box" at the creative PPPs already on the ground in Zambia (e.g. in supply-chain management and health communications) and strive for innovation.

8. **Partnerships with the private sector in Zambia** should consider private-sector priorities: particularly the need for long-term, trust-based relationships. There is a need to create materials and tools to help guide public-sector and NGO partners to more productively engage the private sector in maternal health.

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