MORE MAMaZ
Mobilising Access to Maternal Health Services in Zambia

Scaling up Safe Motherhood Action Groups in Zambia

EVIDENCE BRIEF

"Our community is happy now. With the SMAGs here, women are delivering at the health facility and babies are no longer dying."

This comment, from a community member living in a remote, rural part of Zambia captures the significant changes that have occurred in communities where Safe Motherhood Action Groups (SMAGs) are operational. Launched as a national programme in 2008, SMAGs are a key part of the Zambian government's safe motherhood policy response.

The Mobilising Access to Maternal Health Services in Zambia programme (MAMaZ) and its successor programme, MORE MAMaZ, supported the scaling up of the national SMAG initiative between 2010 to 2016. Government efforts to roll SMAG activities out to new areas (horizontal scale-up) and to build institutional ownership, thereby placing the initiative on a sustainable footing (vertical scale-up) were supported. These scaling up experiences are highly relevant in a context where current global health policy gives high priority to accelerated implementation of evidence-based initiatives to ensure the survival of every newborn, mother and child.

Summary

- Safe Motherhood Action Groups in Zambia are helping to change health-seeking behaviour in favour of improved maternal and newborn health.
- MAMaZ and MORE MAMaZ supported the scale-up of Safe Motherhood Action Groups to 14 districts. The two programmes trained over 6,000 community volunteers.
- It is vital that the national scale-up of Safe Motherhood Action Groups is built on solid evidence of effectiveness. On-going review to continue incorporating good practice will be important.
- Significantly higher priority needs to be given in the national and district health budgets to demand-side activities that empower communities to address poor maternal and newborn health.

Female SMAGs in Serenje District

Background and context

Funded with UK aid from the UK government, MAMaZ (2010-2013) tested different ways to increase the effectiveness of the national SMAG approach. In the programme's intervention districts, an empowerment approach built community capacity to address the range of household and community level barriers that prevented timely use of maternal and newborn health (MNH) services. This supplanted a more narrowly focused awareness-raising approach. As a demonstration programme, MAMaZ's key objective was to generate robust evidence to inform future scale-up of the national SMAG initiative. Funded by the UK charity Comic Relief, MORE MAMaZ (2014-2016) worked with government to take the evidence-based SMAG approach to scale. The programme worked in five core intervention districts and supported wider expansion through a national scale-up component.

When MAMaZ began, a small number of SMAG volunteers had already been trained in some of the programme's intervention districts. However, many of these volunteers lacked the capacity to effectively carry out their role. District Health Management Teams (DHMTs) lacked an agreed system to support and supervise the SMAGs. Health plans and budgets prioritised supply-side over demand-side interventions, and did not cater for the support or expansion of the SMAGs. Moreover, DHMTs lacked the technical capacity and resources to oversee and effectively manage a community-based, demand-side MNH intervention. Hence there was a lot of work to do to fully institutionalise the national SMAG initiative at district level and prospects for rolling out the approach to achieve scale were low.

Strategy

MORE MAMaZ adopted a number of strategies to support vertical scale-up of the SMAG initiative:

Technical capacity building: A capacity building approach built expertise within the district health teams to support a demand-side MNH approach. District Programme Officers (DPOs) with a community development background were embedded within the DHMTs, creating opportunities for exchange of ideas and experience. The DPOs were, in turn, supported by the programme's technical team based in Lusaka. District health teams were involved in all aspects of the programme, including design, training and monitoring and evaluation activities. An emphasis on 'learning by doing' provided opportunities for sustained exposure of the district health team to effective ways for supporting demand-side interventions as a contribution to improved MNH.

District Programme Officers with a community development background were embedded within the DHMTs

Encouraging use of data and evidence: Proud of the results achieved in MAMaZ, DHMTs in the programme's intervention districts were encouraged to use and share evidence of the added value of SMAGs. Capacity building efforts reinforced the importance of using evidence for decision-making. Health facility staff were trained to oversee the community monitoring system managed by the SMAGs and to use the data to inform their decision-making. The involvement of district health staff in routine SMAG monitoring meant that implementation bottlenecks could be quickly identified and addressed, and informed decisions made about how and where to allocate resources.

A mechanism for measuring institutionalisation: DHMTs were encouraged to undertake their own assessment of the extent to which they led and owned the SMAG work using a District Performance Assessment Tool (DPAT). Gaps in ownership, whether this manifested as lack of budgetary provision, or inadequate supervision, were identified through this process and steps taken to address these.

Building support for evidence-based programming: At national level, the programme's vertical scale-up strategy focused on building consensus around the need for a community empowerment approach which extended beyond awareness-raising to address all MNH barriers simultaneously. Participation of the MORE MAMaZ Programme Director in the national Safe Motherhood Technical Working Group created opportunities to share the work and results of the two programmes. Staff of the Ministry of Community Development, Mother and Child Health (MCDMCH) and Ministry of Health (MOH) participated in programme design, monitoring and review activities. This provided opportunities to see the work of the programme first-hand.

Horizontal scale-up strategies included:
District-wide scale-up: MORE MAMaZ's intervention districts were supported to identify priority geographical areas for expansion of the SMAG initiative. Scale-up plans were devised and districts supported to implement these.

National scale-up: The programme adopted a flexible, responsive approach to national scale-up, stepping in to support MCDMCH's scale up plans on request. Support was provided for provincial level training of trainers activities, and in one province, MORE MAMaZ supported geographical scale-up using a 'demonstration district' approach.

SMAGs demonstrating a maternal danger sign ('long labour')

Male SMAG in Mongu demonstrating maternal danger sign ('hand and foot come first')

Results

Scale of work: MAMaZ and MORE MAMaZ supported 14 districts in four provinces. 587 community intervention sites in the catchment area of 78 health facilities were reached.

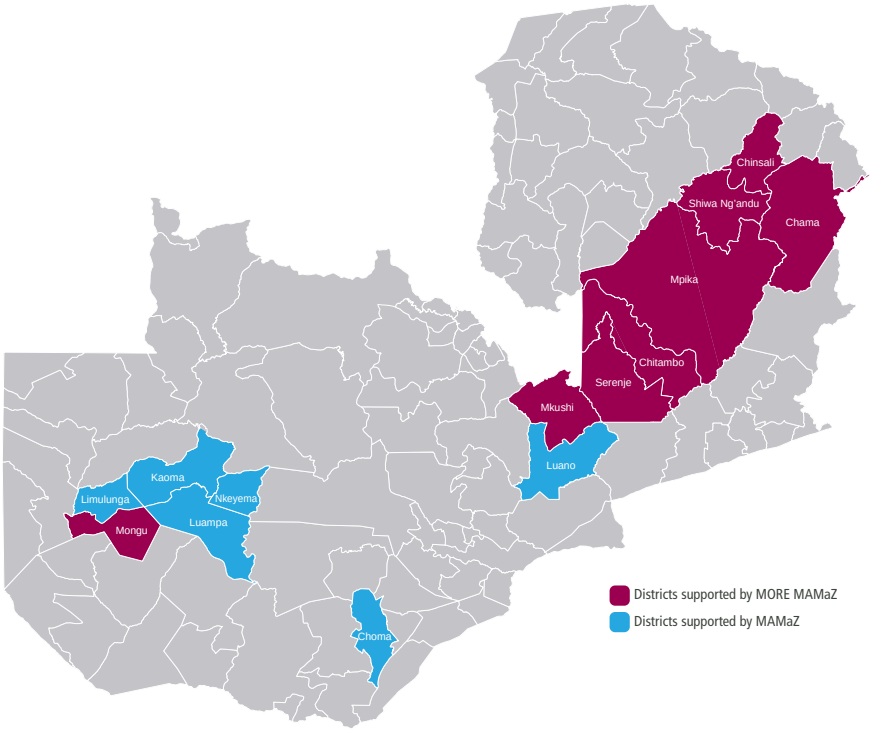
MAMaZ and MORE MAMaZ supported the roll-out of the national SMAG initiative in 14 districts:

Western Province: *Mongu, Kaoma, Limulunga, Nkeyema, Luampa*

Central Province: *Serenje, Chitambo, Mkushi, Luano*

Muchinga Province: *Chama, Chinsali, Mpika, Shiwa Ng'andu*

Southern Province: *Choma*



An additional 12 districts in Eastern and Central province were reached through MORE MAMaZ's national scale-up component. The activities in Eastern Province were jointly implemented with Peace Corps volunteers, funded through the Saving Mothers Giving Life initiative. In both cases, the support focused on training district master trainers on the content of the National SMAG Training Manual.

District level population coverage: While MAMaZ achieved 25% population coverage, MORE MAMaZ's five core intervention districts achieved between 61% and 94% population coverage. Priority was given in all districts to hard to reach rural areas. Districts with large urban populations (areas that tended to have higher institutional delivery rates) achieved lower coverage. The total population coverage was 669,000 people.

Scale of community interventions: All 587 intervention sites were supported to establish community safety nets for pregnant and newly delivered women (e.g. emergency savings schemes, food banks, mother's helpers). 41% (241) sites, usually those with the greatest physical access barriers, established community-based transport schemes to improve MNH. A total of 5,573 SMAG volunteers were trained (3,002 by MAMaZ and 2,571 by MORE MAMaZ) and 500 emergency transport scheme riders (264 by MAMaZ and 236 by MORE MAMaZ).

MAMaZ and MORE MAMaZ trained more than 6,000 community volunteers, thereby making a major contribution to the national SMAG effort.

Institutionalisation at district level: Significant steps towards institutionalisation were taken in MORE MAMaZ's five core intervention districts. By 2016, DHMTs recognised the importance of investing in the community health system in a way that was not evident in 2010 when MAMaZ began. Each DHMT could draw on a pool of individuals with SMAG training experience, and who understood and could support a broader demand-side MNH intervention. DHMTs actively shared their experience and learning with other districts. They used the funds available to them to reinforce and help sustain the SMAG initiative. There was strong evidence that the demand-side interventions helped to leverage supply-side improvements in the intervention districts (e.g. improved staffing levels). Each DHMT took steps to put in place a supervisory system for SMAGs, although these systems had not been fully institutionalised by the end of MORE MAMaZ.

Institutionalisation at national level: MORE MAMaZ contributed significantly to the National SMAG Training Manual. This helped ensure national level adoption of significant elements of the MAMaZ and MORE MAMaZ approach, including: adoption of a new training module on community systems for MNH, integration of a focus on social inclusion, a stronger focus on gender-based violence, and inclusion of training tools that had proved to be highly effective in low-literacy settings.

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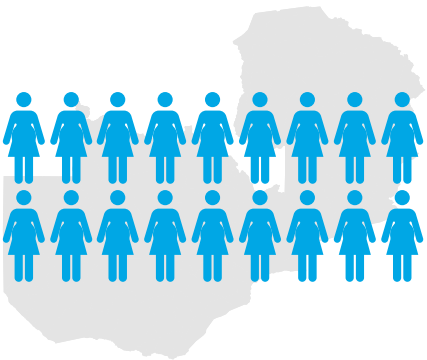

Lessons learned

MAMaZ and MORE MAMaZ made a significant contribution to the geographical scale-up of the national SMAG initiative in Zambia. With a combined budget of GBP 4.5 million, the two programmes worked in more districts and trained many more community health volunteers than other volunteer training programmes with substantially larger budgets. A retention ratio of 82% among volunteers trained five years ago is evidence of the effectiveness of the approach.

Key lessons learned from the two programmes' scaling up experiences include:

- The support and leadership of District Medical Officers in the MORE MAMaZ intervention districts was vital to the progress made.
- The process of embedding a District Programme Officer with community development experience into the DHMTs built district capacity and greatly assisted the process of institutionalising the SMAG initiative.
- The flexible approach to national scale-up adopted by MORE MAMaZ enabled the programme to align appropriately with, and be responsive to, the national agenda.
- The priority given to supply-side activities within national and district health budgets creates a funding gap for demand-side, community-based health interventions. This undermines DHMT capacity to put these initiatives on a sustainable financial footing. Larger investments such as community-based emergency transport cannot currently be funded by districts and are likely to require external investment, at least in the short- to medium-term.
- Although the National SMAG Training Manual shifts the focus of the SMAG effort away from a primary focus on awareness-raising, national and district level capacity to implement a broader approach is limited. Priority needs to be given to building this capacity at every level of government going forward.

Bicycle ambulance in Mkushi District

Policy implications

Implications for Zambian policy makers include:

- At district level, planning and budgeting to secure the future of the SMAG effort is undermined by resource constraints. It is critical that more is done to balance investments in supply- and demand-side interventions in support of improved MNH.
- More work needs to be done to fully institutionalise and appropriately fund routine supervision of SMAGs and other aspects of the community-based MNH response. Current efforts to provide this support at health facility level need to be backed up with capacity building support and increased funding.
- It is recommended that the MOH considers trialling a new position at DHMT level – a post that oversees efforts to strengthen the community health system. This will allow the DHMT to provide focused support to community interventions, taking the pressure off other staff who are already over-loaded.
- The gains achieved so far in the national SMAG effort are unlikely to be sustained unless DHMTs put in place robust, routine supervisory and monitoring systems for these activities.
- Regular review and revision of the content of the National SMAG Training Manual to incorporate on-going implementation experience will be important. All aspects of the manual need to be based on solid evidence of effectiveness.

It is recommended that MOH considers establishing a new DHMT post, one that focuses on strengthening the community health system

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