Global Learning Laboratory
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Action Brief*: Promoting Respectful Maternal Health Services in rural Zambia

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Audience	Healthcare providers, policy makers, district health managers, health programme implementers
Key Message	The interventions proposed in this brief were developed with national and district partners to empower rural communities in Zambia and enable them to address the many household and community level barriers that prevent timely access to and uptake of quality maternal health services. The work with front-line health providers aimed to improve teamwork and morale within the health facilities, reducing the poor communication that can affect clients' experience of or willingness to use health services. It also focused on increasing health providers' awareness of the most vulnerable and least-supported women and girls, and what can be done to reach and support them.
Background	It is well known that mortality and morbidity are clustered in sub-sections of populations that are particularly vulnerable. Yet, many health programmes fail to reach the women and families who carry this disproportionate burden. Even if services are available, such individuals often lack self-esteem and social support which are major factors in influencing their access to the formal health sector. And when they do manage to access services, they are often treated with a lack of respect by healthcare providers, thus reducing the chances of their subsequent attendance.
Objective/goal	The objective of this action brief is to share how interventions on social inclusion and orientation of health care providers on essential preventive and curative maternal and newborn health services led to reaching most vulnerable individuals and families in rural Zambian communities.
Period covered	2014-2016
Impact	Attendance at health facilities increased following the orientation and training received by the health care providers and the related community mobilization work on reaching under-supported women. Overall, the programme achieved the following increases: • First trimester and 3+ ANC visits, from 37% to 53%; • Skilled birth attendance, from 46% to 78%; • Use of modern family planning, from 24% to 38%; • Knowledge of at least three maternal danger signs by men, from 19% to 70%. While it is difficult to attribute changes to one particular input, recipients of the training described how transformative the process had been for them as individuals and how the training had made their work more satisfactory and valued. Specifically, it helped them: • to understand why they communicated badly only with some patients, • to appreciate that it was important to hide their frustrations from clients, • to realize that reviewing their experiences with other staff made communication easier. These effects are very likely to have contributed to the recognition by health facility staff and community workers of women who need more moral and social support by relatives (including husbands) and communities, as well as recognition by communities of improved communication and trust in health services.
What did you do?	The training methodology and orientation of health workers worked well as it was relevant to the context of the health workers. Specific features include the following aspects: • all training focused on participants' own experiences in their homes and at work • it encouraged internalisation of their own communication and when it goes wrong • it facilitated internalisation of their own experiences of support and its impact on their mental health and ability to cope in life

	• it helped participants understand the impact on themselves when people are rude, dismissive or contemptuous and the impact on their clients • it highlighted the importance of encouraging women to join groups Other programme interventions included community mobilization discussion groups and home visits by volunteers, the establishment of community support systems, including emergency transport, food banks, saving schemes and mothers helpers, and community level monitoring and coaching.
What worked well?	Participants reported that the training transformed their relations with other staff, resulting in improved staff morale and better team work, as well as better communication with the district health team. It also helped them to pay better (and more rewarding) attention to women who seemed insecure, worried, frightened, or distressed and it resulted in better relations with community leaders and community health workers too.
What did not work so well?	Not all health workers responded positively to the training and consequently did not show significant changes in behaviour, requiring further support from their colleagues. Some individuals in these communities continue to avoid using health services, perhaps due to apprehension or a previous bad experience, or failure by volunteers or others to include them in supportive systems. These people need to be continually encouraged to engage socially and with the health sector. Community volunteers can support this process.
Could this intervention/action be adopted and adapted to other settings?	These interventions have the potential for adoption on a larger scale and in other settings through a number of actions, such as: • including in pre- and in-service training a focus on how social exclusion within families and communities is a factor influencing health behaviour; • including in health providers' pre- and in-service training a focus on how frustration and anger influence communication and clinical outcomes, and how these can be controlled in clinical settings; • improving liaison between community services and health services so that under-supported individuals can achieve better social inclusion and support; • altering protocols for performance assessments and technical support with personnel in clinical settings to address the importance of improved communication and attention to social factors; • including appraisal of team cohesion in clinical settings; • strengthening existing monitoring systems to ensure socially excluded and under-supported individuals are included and welcome in health services and community-based programmes; • investing in national baseline surveys to determine the level of clustering of poor health access and outcomes by level of social support in rural areas (to inform and help operationalise the current emphasis on universal health coverage within the SDGs). Social exclusion cuts across geographical, cultural and political settings, thus, interventions to address it are relevant for all countries. However, they need to be embedded in the local context with actions tailored to address specific challenges in each particular situation.
Next steps	Proposed next steps to build on this action: 1. Further dissemination of the experience to ensure broader awareness among key audiences such as health facility managers, district health teams, policy makers and implementers; 2. Additional research on adapting the methodology and assessing its impact in other settings; 3. Collaborations with health training institutions and ministries of health to support implementation of the recommendations listed above to scale up and sustain actions.
Further information	1. MORE MAMaZ Presentation on social factors and communication. 2. Addressing social exclusion and gender-based violence as key strategies for improving maternal and newborn health. Summary for Busy Managers and Policy Makers. 3. C Green et al (2015). Increasing access to rural maternal health services in Zambia through demand-side interventions, Development in Practice, 25:4, 450-464 4. MORE MAMaZ programme. Social Inclusion & the Poor-Poor Divide, Policy Brief for PRRINN-MNCH, Tony Klouda December 2012