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### ***Political settlements and the implementation of maternal health policy in the developing world: A comparative case study of Rwanda, Ghana, Uganda and Bangladesh***

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## Abstract

Maternal health, and in particular the issue of reducing maternal mortality, has been a prominent feature of the global health policy agenda for the past three decades. However, maternal health has rarely become a political priority at national levels, with policy uptake and implementation proving relatively disappointing. In this paper, we compare the experience of Rwanda, Bangladesh, Uganda and Ghana in reducing maternal mortality, relating policy uptake and, in particular, implementation to the underlying balance of power and institutions, or *political settlement*, on which these countries' politics is based. Rwanda's 'dominant-developmental' political settlement has enabled a vigorous, joined-up approach to maternal mortality reduction, while, at the other end of the spectrum, Ghana's inclusive-competitive settlement has been less effective in matching policy commitment with implementation. Uganda and Bangladesh's more intermediate settlements present a more mixed experience. The paper argues that policy reformers should try to optimise their maternal mortality reduction strategies within the context of the political settlement in which they operate. That implies a government-supporting strategy in more dominant developmental settlements, while engaging non-state actors or building out from pockets of effectiveness in other types.

**Keywords:** healthcare, LMICs, politics political economy, political settlements, maternal health, maternal mortality

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## Introduction

Maternal health, and in particular the issue of reducing maternal mortality, has been a prominent feature of the global health policy agenda for the past three decades. However, maternal health has rarely become a political priority at national levels, with policy uptake and implementation proving relatively disappointing (Shiffman, 2007). Existing studies highlight a number of features of the policy process that can enable or disable uptake, but relatively little work has focused on the matter of implementation (Shiffman, 2007). In this paper, we compare the experience of Rwanda, Bangladesh, Uganda and Ghana at reducing maternal mortality, relating policy uptake and, in particular, implementation to the underlying balance of power, or *political settlement*, on which these countries' politics is based.<sup>1</sup>

Previous work on political settlements has posited that 'dominant' settlements, that is, polities in which the ruling group or coalition has a reasonably assured grip on power, will have better capacity to design and implement successful policies than 'competitive' settlements, viz ones in which the ruling group is weak and facing a credible threat of imminent removal (Khan, 2010; Levy, 2013). By choosing two cases that seemed to fit the dominant category (Rwanda and Uganda) and two that fit the competitive category (Ghana and Bangladesh), we aimed to test that thesis. We also selected and conducted fieldwork in better and worse performing districts within each country, the aim being to gather insights into how to get better than average results, even in less auspicious political contexts.

We find that existing theory is largely confirmed. Rwanda has the best record of reducing maternal mortality – a fact that can be attributed to its dominant, developmental political settlement, which drives effective policy implementation through hierarchical performance mechanisms, complemented by 'diagonal' and 'bottom-up' approaches. Ghana, by contrast, has the worst record, explained by the way in which its competitive political settlement encourages undisciplined public sector expansion and populist policymaking, prioritising visible infrastructural investments over functioning systems. Uganda and Bangladesh turn out to be less clear cases of a more intermediate type, yet the relationship between a non-dominant political settlement and a largely ineffective public sector still holds.

The picture in the three less dominant settlements is not all gloomy, however. Pockets of effectiveness can be found in each, where visionary political or health leaders, sometimes with multistakeholder support, are able to encourage and enforce performance measures.

## Background to the politics of maternal mortality

In the decades following World War II, maternal health ranked relatively low on the list of global health priorities (Shiffman, 2007). However, in 1985 an influential article

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<sup>1</sup> The research on which this paper is based draws on four previous ESID working papers on maternal health: Abdulai (2018), Bukenya and Golooba-Mutebi (2019), Mahmud et al. (2020) and Golooba-Mutebi and Habiyonizeye (2018).

in the *Lancet*, entitled 'Maternal mortality – a neglected tragedy', heightened awareness of the issue. An international conference was held in 1987 in Nairobi, which saw the launch of the Global Safe Motherhood Initiative, which aimed to cut maternal deaths in half by the year 2000. Subsequently, an Inter-Agency Group for Safe Motherhood was formed to maintain momentum, and a series of UN-sponsored conferences affirmed the importance of the target throughout the 1990s. Maternal health was also recognised in Millennium Development Goal 5, which included a commitment to reduce maternal mortality by 75 percent (Shiffman, 2007). In 2005, a new global Partnership for Maternal, Newborn and Child Health was created to accelerate efforts to reach MDGs 4 and 5, followed in 2010 by the UN secretary general's Global Strategy for Women's and Children's Health. Despite these efforts, and an accelerating downward trend, the maternal mortality ratio fell by just 45 percent worldwide, 1990 to 2015 (independent Expert Review Group, 2012).

The reasons for these disappointing results are at least partly political. Shiffman, for example, has argued that global maternal health advocates have failed to provide a clear problem framing, that policy networks around the issue have lacked cohesion, that no single organisation or compelling individual has taken the lead on the issue, that there has been disagreement about the appropriate policy solutions, and difficulties obtaining clear data (Shiffman, 2007).

These problems have also been apparent, to greater or lesser extent, at country level, together with country-specific factors that have aided or retarded the issue's prioritisation. In the case of Nigeria, for example, a democratic transition created a political opening for maternal health issues, while in Indonesia, it undermined a relatively effective existing programme. Other country-specific factors include the severity of competing health priorities and the availability of external resources – as in the case of the large amounts of funding available for HIV/AIDS through the US President's Emergency Program for AIDS Relief (PEPFAR) (Shiffman, 2007).

By 2014, many of these problems had been resolved at global level, with numerous multistakeholder commitments to the Global Strategy and financial pledges of almost \$60 bn – yet country-level uptake has remained variable (McDougall et al., 2015). Moreover, as Shiffman recognises, placing an issue on the policy agenda is only one of multiple factors that stand behind policy effectiveness. Implementation is also 'a politically infused process', yet this subject has received relatively little academic attention (Shiffman, 2007: 802). Exceptions can be found in Smith's work, which explains differential prioritisation and performance of maternal health in two Indian states by reference to a variety of features of the political context, including the nature of the coalitions that took power upon these states' formation (Smith, 2013). Our research is in a similar vein, showing how a country's deep politics influences not just the way in which an issue appears on the political agenda, but also how successfully the problem is addressed.

## **Conceptual framework**

The papers in this collection all analyse the processes around the adoption and implementation of maternal health policy using the concept of a 'political settlement'. The term has been defined in various ways in the literature, but common to most is the idea that a political settlement is the underlying balance of power and institutions on which peaceful politics is founded and based (DFID, 2010; Di John, 2009; Khan, 2010). Thus political settlements theorists typically look at the relative organisational strengths of elite and non-elite actors and factions (international actors included), as well as the basic rules of the game, common understandings or orientations around how and to what ends power is exercised, all of which serve to prevent a country descending into generalised violent conflict or war (DFID, 2010; Di John and Putzel, 2009; Khan, 2010; Laws and Leftwich, 2014). This distinguishes political settlement theorists from regime-type theorists, who are more interested in the characteristics of formal political institutions and their relationship to development outcomes (see Kelsall, 2014, for a review). While the first wave of political settlements theory placed considerable emphasis on the role of material resources and in particular economic rents in sustaining political settlements (Khan, 2010; North et al., 2009), more recent research has stressed that ideas are also significant, and may be essential to explaining how settlements endure or change over time. Indeed, Lavers and Hickey have gone so far as to argue that 'paradigmatic ideas' constitute a vital third dimension to political settlements, alongside institutions and factional power (Hickey, 2013; Lavers and Hickey, 2015).

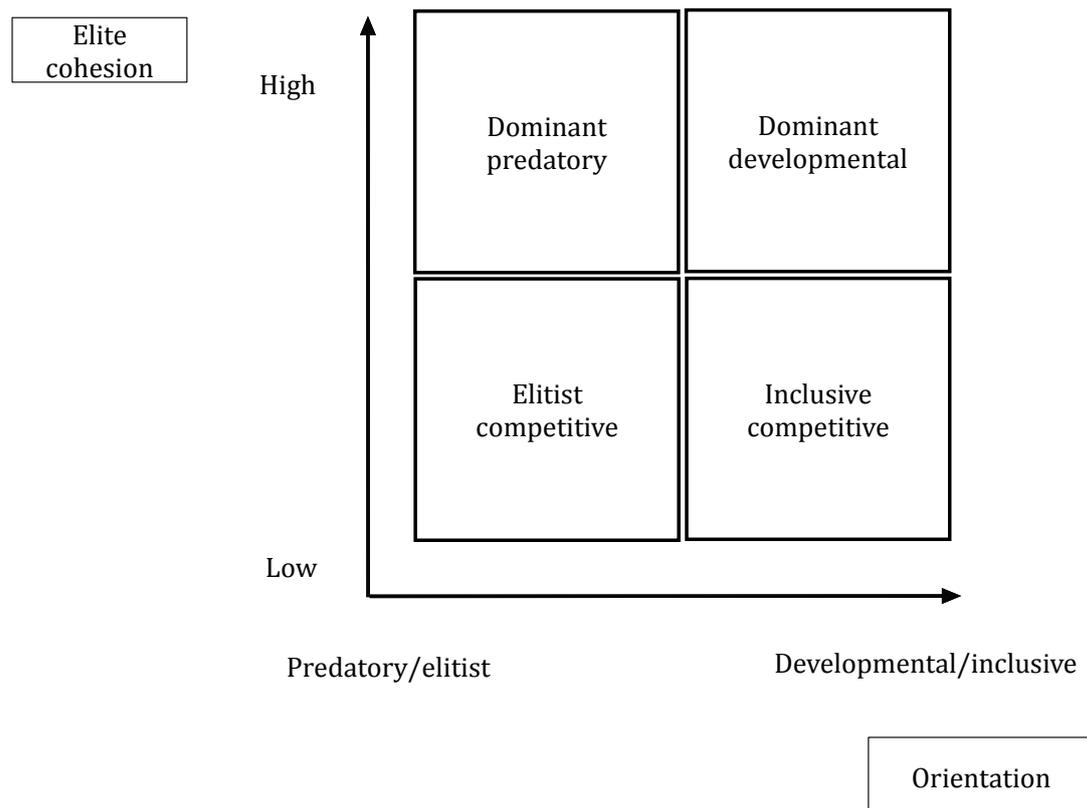
Understood in this way, political settlements analysis can be used to frame very rich accounts of individual country contexts: actors and factions can be described in intricate detail, thick descriptions of institutions can be constructed and ideas discussed with considerable nuance. However, political settlements theorists have also been keen to reduce this complexity to a set of simple variables congenial to model building. For example, in the work of Mushtaq Khan, ruling factions or coalitions can be either 'strong' or 'weak', while for Brian Levy, the elite can have 'high' or 'low' cohesion. Institutions in low-income countries are typically 'clientelistic' or 'personalised', while ideas, to the extent that they enter the picture at all, can be reduced to questions of whether the ruling group is 'developmental' or 'predatory', 'inclusive' or 'elitist' (Khan, 2010; Levy and Walton, 2013).

These basic distinctions can be used to generate some predictions about political settlement type and progress on policies like maternal health. Developmental or inclusive ruling groups, for example, are more likely to prioritise such policies than groups that are predatory or elitist. Dominant ruling groups, meanwhile, are likely to have a longer time horizon, and thus a greater propensity to design and plan policy for the long term than ones that face a shorter time horizon due to a higher level of political competition. They are also more likely to be able to implement policies successfully, since they have more political space in which to create an effective bureaucratic machinery, and face fewer challenges from political opponents or, indeed, their own supporters. This allows them to focus on developmental goals,

rather than patronage hand-outs, even if a degree of personalised administration endures (Kelsall, 2016; Levy and Walton, 2013; Lavers and Hickey, 2015). That said, we should be wary of falling into simplistic generalisations, such as 'dominant, good', 'competitive, bad'. Although it is possible that long-term relationships between settlement types and outcomes will be observable over time, evidence for this has yet to be tested. In the meantime, political settlements typologies are perhaps better thought of as diagnostic frameworks that draw attention to salient features of the political context, to which good policy should adapt.

The diagram below represents an adapted version of the main political settlement 'types' Brian Levy envisages for low- and lower middle-income countries (LMICs). On the vertical axis, settlements are categorised according to the degree of elite cohesion, or how easy it is for opponents to remove the ruling group from power, while on the horizontal axis, settlements are categorised according to their basic orientation: predatory and/or elitist on the one hand; developmental and/or inclusive on the other.<sup>2</sup>

**Figure 1: Political settlement types**



Source: Adapted from Levy and Walton (2013).

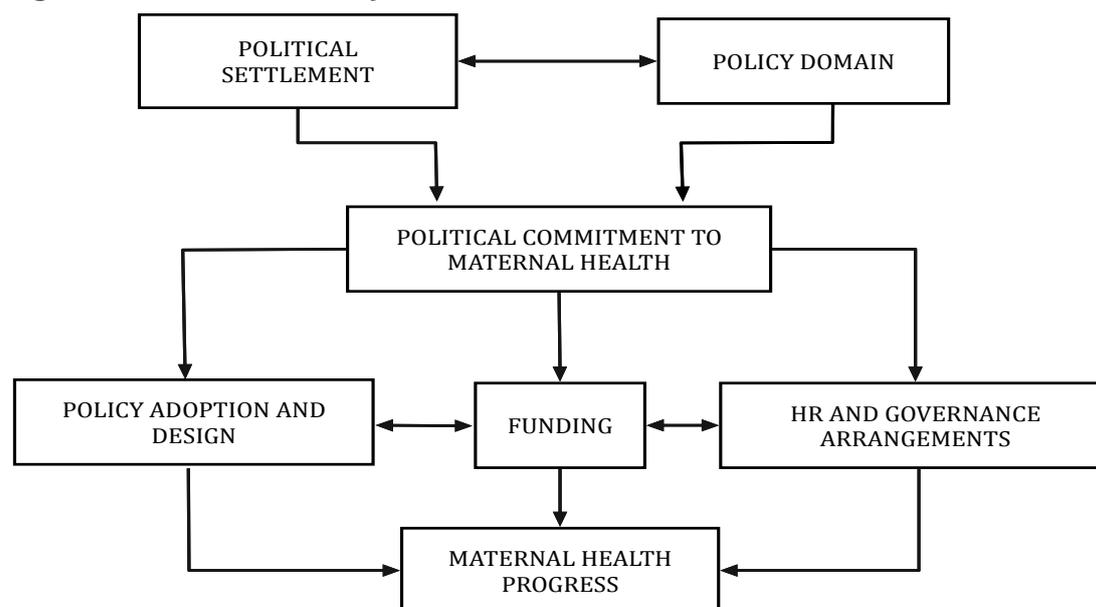
<sup>2</sup> Note that in Levy's original model, which covers the entire spectrum from conflict-ridden less-developed societies to stable, advanced societies, the X-axis measures the degree of institutional impersonalisation in the polity. However, since all 'early-stage' settlements are at the personalised end of the spectrum, it makes more sense to use the X-axis to differentiate them according to orientation

Note that in Levy's original formulation, both elitist and inclusive competitive settlements are labelled 'clientelist', on account of the personalised nature of their institutions (Levy and Walton, 2013). We think the label misleading, however, since low-income 'dominant' settlements are equally likely to be clientelistic, albeit in a more top-down way (with relations in dominant developmental settlements possibly evolving into a more impersonal form). Consequently, we discard the clientelist epithet here.

It is important to stress that although we believe the nature of the political settlement influences progress on maternal health, it does not determine it in any straightforward way. This is because the deep forces of the political settlement interact with the more contingent aspects of what we call the 'policy domain'. The policy domain is the arena of ideas, actors, and interest groups concerned with health issues. Semi-autonomous of the political settlement, it encompasses actors such as the global partnerships around maternal, newborn and child health referred to above, as well as other international and domestic actors, some of them more interested in maternal health issues than others. The political dynamics of this arena, in combination with those of the political settlement itself, will co-determine the level of political commitment devoted to the issue. For example, it is possible to imagine countries in which there are few forces endogenous to the political settlement pushing for priority to be given to maternal health, yet where a very favourable balance of forces in the policy domain stimulates some degree of commitment nonetheless. Conversely, there may be strong forces in the political settlement sympathetic to the issue, but an unfavourable balance of factors in the policy domain may mean that progress remains rather slow. Whatever the effect of this combination of forces, we believe it will manifest itself in three key areas: policy design and choice; funding levels; and whether human resource and governance arrangements are appropriate to effective implementation. Figure 2 below outlines what we believe to be the main causal mechanisms.

In normal circumstances, external actors have little ability to change the political settlement. They are more likely to exert influence through the policy domain. According to Levy, their influence is likely to be most beneficial when it 'fits' or 'works with the grain' of the political settlement (Levy, 2014). The best way to improve services in dominant developmental settlements, for example, is to provide technical support and funding to what are likely to be already well-functioning public administrations, with what he calls 'multi-stakeholder solutions' possibly adding value at the margin. In inclusive competitive settlements, by contrast, much of the state apparatus is likely to be dysfunctional, and the services sector characterised by a somewhat chaotic interest group and private sector politics. External actors are most likely to improve services by helping connect the more pro-poor members of these different spheres, encouraging the emergence of successful reform coalitions. In predatory or elitist settings, prospects for improvement are less good, but even here it may be possible to create parallel structures or islands of effectiveness, either

**Figure 2: Political causality in maternal health**



outside or inside the state, providing the ruling group is not actively hostile (Levy, 2014; Levy and Walton, 2013). In their research into political settlements and pathways to universal health coverage, Kelsall et al. find tentative support for the hypothesis that in dominant settlements the optimal strategy will be *government-supporting*, that in predatory and elitist settlements it will be *government-substituting*, while in inclusive competitive settlements it will be *government-connecting* (Kelsall et al., 2016).

### Methodology and data sources

Our research was guided by two main questions. How do political settlements influence progress in maternal health? And how can better results be acquired under different types of political settlement? Our primary method was case-based process-tracing, which is increasingly recognized as a powerful means to reveal complex causal processes (George and Bennett, 2005). For each of our country cases, academic literature, policy documents, media reports and key informant interviews were reviewed to ascertain who were the most powerful individuals and groups in society and how they interacted to sustain relatively peaceful political coexistence, focusing on the material, institutional and ideational sources of systemic legitimacy or continuity. Against that background, we also examined the political dynamics of what we have called the ‘policy domain’, and how these have interacted with the political settlement to shape policies, funding and de facto governance arrangements for maternal health. Note that the studies were qualitative in nature and did not attempt to operationalise variables in a quantitative way. Rather, they sought to tell convincing analytical stories about the relationships among variables.

We supplemented process-tracing with cross-case and within-case comparison. As mentioned above, we selected countries on the independent, political settlement variable, to give us two ‘dominant’ (Rwanda and Uganda) and two ‘competitive’

(Ghana and Bangladesh) cases, based on what we knew about the strength of those countries' ruling coalitions (remaining open-minded, at this stage, about how predatory or inclusive each country was). Within-country, local sites were selected on the dependent variable, that is, better and worse maternal health outcomes. This approach provided two sources of leverage over our research question: cross-case comparison allowed us to assess whether some types of political settlement were more associated with better outcomes than others, while within-case comparison allowed us to make judgements about how to get better performance even in less-favourable contexts or types of settlement. The process of comparison not only strengthens the internal validity of our conclusions, but provides some indication of external validity, that is, the extent to which findings can be generalised.<sup>3</sup>

As already noted, our study focused on maternal health in general, with a particular focus on maternal mortality. The causes of maternal mortality are complex, related to epidemiological, educational and nutritional factors, child spacing, access to safe abortion, skilled birth attendance, antenatal and routine and emergency obstetric care (Chou et al., 2015; Temmerman et al., 2015; Rasanathan et al., 2015). Our research focused in particular on the success of governments in getting pregnant women to have antenatal check-ups and facility births, and in providing appropriate staff and facilities for routine and emergency obstetric care. It is common for developing countries to experience difficulties in supplying adequate financial and human resources for public health, and in ensuring that those resources are used equitably and efficiently, while private services are often poorly regulated and inaccessible to the poor (World Bank, 2003). We were interested in knowing how the political settlement helped overcome or reinforce these problems across our case studies.

Before diving into our case studies, it is worth comparing some indicators pertinent to maternal health. The numbers are provided for illustrative purposes, providing some detail on the context and some food for thought for the ensuing discussion. However, they have been compiled ex post and were not used to inform the field research.

Of our countries, Ghana spends the most money per capita on health and has the highest percentage of public expenditure, closely followed by Rwanda, then Uganda, with Bangladesh bringing up the rear (see Table 1 below). As a percentage of GDP, Uganda actually spends the most, and also has the highest external component to its health spending, followed by Rwanda, then Ghana and Bangladesh (note that Ghana is considerably richer than the other countries in our sample). Bangladesh has the highest levels of out-of-pocket expenditure, followed by Uganda, Ghana, and then Rwanda. Rwanda, meanwhile, has had the biggest increase in official development assistance (ODA) for maternal, newborn and child health policies.

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<sup>3</sup> Note that case selection did not control for potentially confounding variables in a rigorous way. However, the two Uganda cases were contiguous, while in Ghana, the better performing district was actually poorer than the worse performing one, suggesting that its good results were not attributable to income. However, Bangladesh and Rwanda are more ambiguous here.

**Table 1: Health finance indicators 2013**

| Country        | Health expenditure per capita (US\$) | Health expenditure as % GDP | External resources as % health expenditure | Annual increase in ODA for MNCH | Public health expenditure as % of total | Out-of-pocket expenditure as % of total |
|----------------|--------------------------------------|-----------------------------|--|---------------------------------|---|---|
| Bangladesh     | 32                                   | 7.8                         | 8.6  | 11.5                            | 35.3                                    | 60.2                                    |
| Ghana          | 99                                   | 10.6                        | 13.2                                       | 11.6                            | 60.6                                    | 36.2                                    |
| Rwanda         | 70                                   | 22.3                        | 38   | 29.5                            | 58.8                                    | 18.4                                    |
| Uganda         | 59                                   | 24.3                        | 45.5                                       | 9.7                             | 44.4                                    | 38.4                                    |
| All low income | 37                                   | NA                          | 31.7                                       | NA                              | 41.5                                    | 40.7                                    |

Source: World Data Bank, 17 February 2016 and Arregoces et al. (2015).

When it comes to health services directly relevant to maternal health (see Table 2), Rwanda has the highest percentage of women receiving prenatal care and skilled birth attendance, closely followed by Ghana, Uganda a little way behind, and Bangladesh lagging considerably. When it comes to contraceptive prevalence, however, Bangladesh is out in front, followed by Rwanda, with Ghana and Uganda lagging far behind.

**Table 2: Maternal health indicators**

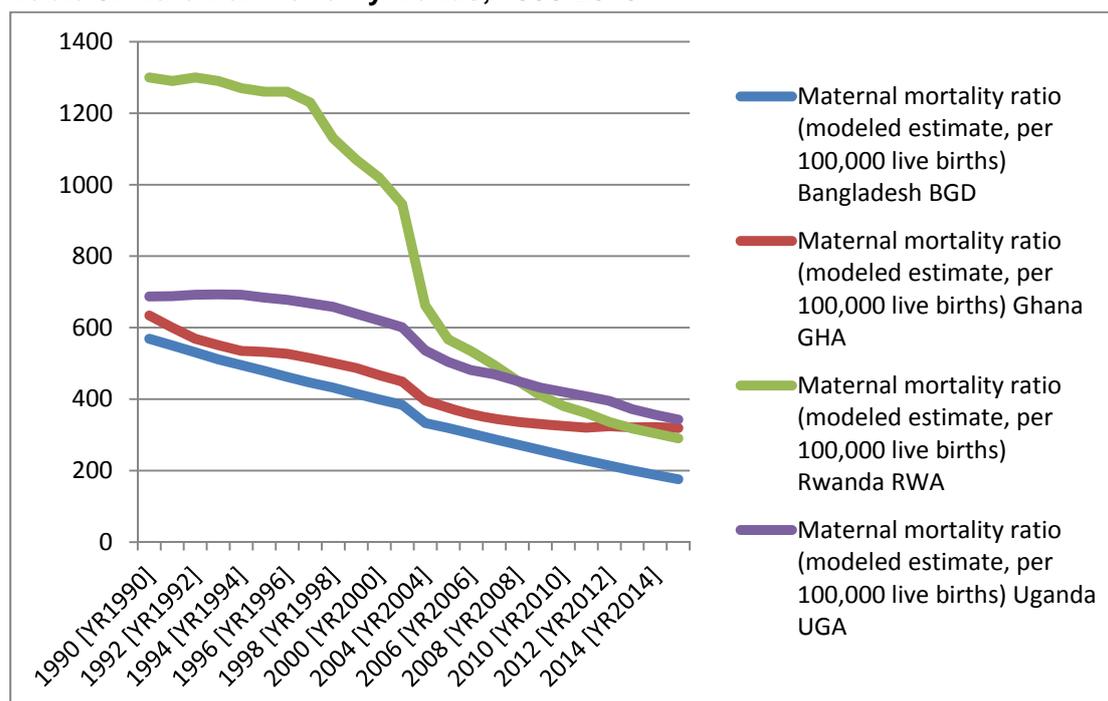
| Country        | Pregnant women receiving prenatal care % (2011) | Skilled birth attendance (2011) | Contraceptive prevalence % (ages 15-49) (2011) | Maternal mortality ratio (MMR) (modelled estimate 2011) | MMR reduction % 1990-2015 |
|----------------|---|---------------------------------|--|---|---------------------------|
| Bangladesh     | 54.6  | 31.7                            | 61.2   | 228   | 69                        |
| Ghana          | 96.4  | 68.4                            | 34.3   | 320   | 49                        |
| Rwanda         | 98*   | 69*                             | 51.6*  | 361   | 78                        |
| Uganda         | 93.3  | 57.4                            | 30   | 408   | 50                        |
| All low income | 77  | 51.8                            | 29.6   | 570   | 41                        |

\*2010

Source: World Data Bank, 17 February 2016.

Table 3 shows the maternal mortality ration (MMR) trajectory for 1990-2013. Bangladesh still has the lowest absolute figures, but the decline in Rwanda is by far the steepest. Indeed, by 2015, Rwanda had overtaken Ghana and had exceeded the MDG 5 target of reducing maternal mortality by 75 percent. Bangladesh (69 percent) had just missed the target, while Ghana (49 percent) and Uganda (50 percent) had missed it by a considerable margin (although they still performed better than the low-income average).

**Table 3: Maternal mortality trends, 1990-2015**



Source: World Data Bank, 17 February 2016.

There appears to be no direct relationship, then, between *overall* health spending and success in reducing maternal mortality. However, a relationship may exist between targeted ODA for maternal, newborn and child health and maternal mortality, since Rwanda, with the best progress, has received the largest increases. There is not much of a relationship between women receiving prenatal care, skilled birth attendance, and maternal mortality: perhaps the effects of these interventions have been exaggerated, maybe because their efficacy very much depends on the quality of care (see Temmerman et al., 2015). There does appear to be a relationship between contraceptive use and maternal mortality, which may partly explain why Rwanda and especially Bangladesh perform better than Ghana and Uganda. Unfortunately, however, we lack comprehensive data on other likely determinants of maternal mortality, such as access to education, nutrition, infectious disease prevalence, quality of emergency obstetric care and safe abortion services, to say anything with confidence here. We stress that our fieldwork did not try to isolate all the different causal contributors to maternal mortality. Rather, it focused mainly on the commitment of public authorities to tackle maternal mortality, assessed according to the presence and functioning of public health facilities, staff and systems pertinent to routine and emergency obstetric care.

If we look at the shape of the curves for maternal mortality reduction, Rwanda shows a very steep decline between the mid-1990s and mid-2000s (perhaps the result of a peace dividend), and then a fairly steep decline thereafter, while Bangladesh shows a fairly steady, moderately steep decline across the period in question. Uganda, by contrast, is more or less flat-lining until the early 2000s, when the pace of decline picks up a little, while the reverse is the case in Ghana. Reliable maternal mortality

data is difficult to collect, so it is important not to read too much into these fluctuations; nevertheless, in the analysis to come we will tentatively suggest some explanations.

## **Rwanda**

Since 1994, Rwanda has been governed by a coalition of parties dominated by the Rwanda Patriotic Front (RPF), which swept to power following the genocide of that year. Although facing a strong threat from opposition groups outside its borders, it has acquired an impressive level of dominance within them, having symbiotic links with the Rwandan military and business elite, and being returned to power with overwhelming majorities in every election since coming to office. Originally dominated by a mainly anglophone Tutsi elite exiled in Uganda, the RPF has since broadened its base, to include many Hutu in authority positions (Booth et al., 2014).

From an early stage the party recognised that to govern effectively it would need to win the support of the Hutu masses. It has consequently made a determined effort to try and transform the historical legacies of the past, focusing not on patronage hand-outs to ethnic favourites, but on broad-based economic and social development. As part of this project, it has also taken steps to improve the position of women in society, and is widely recognised as one of the most gender-conscious governments in the entire developing world (Booth et al., 2014).

Institutionally, the RPF has chosen to govern in combination with smaller pro-regime parties, among whom great care is taken to generate consensus. Apparently robust policy debates occur behind closed doors, but once decisions have been made, the focus shifts to implementation, with little tolerance for dissent. The party has established hierarchical governance structures characterised by strong top-down accountability measures, more common in states at much higher levels of income. These are given a personalised flavour, however, by the individual performance contracts based on a pre-colonial warrior oath (imihigo), that key officials sign with the president (Chambers, 2012; Chambers and Golooba-Mutebi, 2012).

Like many other developing countries, Rwanda has undergone a decentralisation process, including in its health sector, yet the centre has retained significant powers, preventing the phenomenon of local elite capture so common elsewhere. Another distinguishing feature of the Rwandan political settlement is its near-zero tolerance for corruption, a policy reinforced by the abstemiousness of President Kagame and the swift action taken against officials suspected of erring in this regard (Booth et al., 2014).

Despite being politically stable for the past 20 years, the country remains poor and donor dependent. Indeed, it is fair to say that development partners are an important part of the political settlement, since aid is integral to the RPF's legitimisation strategy. Unlike in other aid-dependent countries, however, the government is firmly in the driving seat in donor relations (Booth et al., 2014). For example, in order to improve

donor efficiency, it has insisted on a 'donor division of labour', with donors being directed into sectors in which they enjoy comparative advantage. In addition, NGOs are also strictly regulated and directed to work only in those areas where there are gaps to fill (Golooba-Mutebi and Habiyonezeyeye, 2018).

The health policy domain is dominated by the president and the Ministry of Health, scrutinised by the Rwandan Patriotic Front's Commission on Welfare, generously funded by development partners. Local authorities are the main implementing agents, under the watchful eye of local RPF cadres. Unlike in our other cases, neither professional associations nor the private sector emerged as significant actors (Golooba-Mutebi and Habiyonizeye, 2018).

Despite excellent performance, it was not apparent that maternal health was accorded special status within the health policy domain, or at least not relative to other MDGs, which the RPF tends to make a point of trying to exceed. Rather, a focus on maternal health appeared to be a by-product of two main factors: first, a general determination to earn political trust by delivering benefits to the population, leaving no-one behind; and, second, to lay the foundations for middle-income status by creating the conditions for a healthy workforce (Golooba-Mutebi and Habiyonizeye, 2018).

It is conceivable that the augmented role of women in Rwanda's post-genocide political settlement, including that of Agnes Binagwaho, the influential former minister for health, has cemented this emphasis, but informants did not make this point. Rather, both the elevated role of women and good performance with respect to maternal health appear to be concrete manifestations of the RPF's inclusive philosophy (Golooba-Mutebi and Habiyonizeye, 2018).

As Golooba-Mutebi and Habiyonizeye's research shows, the strong top-down accountability measures noted above are clearly evident in health. The president signs performance contracts with local mayors, who in turn sign them with local health officials, all the way down the line to community health workers, employed to encourage expectant mothers to seek antenatal care and have facility births. There are strict reporting requirements, salaried staff are paid bonuses related to performance, while community health workers have access to grants and other perks. In addition, health indicators are regularly monitored and localities ranked in local or national performance. This has engendered a spirit of competition among districts, with mayors and local health officials conscious of the fact that good performance will cause their careers to blossom. Conversely, 'the prospect of identification as a non-performer and being held to account for performing below expectation compels lower-level officials to take their obligations seriously' (Golooba-Mutebi and Habiyonizeye, 2018).

Health facility inspections are regular and frequent. In addition, the ministry periodically sends inspectors to conduct thorough audits that cover general hygiene, staff punctuality, prescription and management of medicines, and the use and

management of assets such as equipment – including furniture, power generators, vaccine refrigerators, beds in wards, vehicles and other things.

The health sector has also responded creatively in a problem-solving way to aspects of the local context. For example, traditional birth attendants were banned, but then trained and encouraged to become community health workers. They have been given mobile phones and use SMS services to alert health workers to cases requiring emergency response within communities. Before women had been sensitised to the importance of facility births, they were fined for delivering at home; and to reduce the probability of women giving birth before they are able to reach a facility, special wards have been created where pregnant women close to their due date can stay free of charge.

Bottom-up accountability measures are also significant, with local citizens represented on health centre management committees, well used suggestion boxes present in health centres, and health officials' photographs and phone numbers prominently displayed. That most Rwandans are locked into the public health system through community health insurance, together with the comparative dearth of private facilities, contributes to local people voicing their health concerns.

As a result of measures such as these, health units open their doors to users promptly at the designated times, are clean, and under normal circumstances well stocked with drugs and sundries. Facilities have all the equipment they need to carry out their allotted duties, including vehicles and fuel. Reports of misconduct by health staff are rare. These factors have contributed to an upsurge in facility births and to improvements in emergency obstetric care, which have surely contributed to the country's rapidly declining maternal mortality ratio.

## **Ghana**

In contrast to Rwanda, Ghana has a highly competitive political settlement. Since it returned to multi-party competition in 1992, the National Democratic Congress (NDC) and New Patriotic Party (NPP) have alternated in power every eight years, with elections won sometimes by the narrowest of margins (Whitfield, 2009; Nugent, 2001). As a result, the country has been lauded as one of the most vibrant multi-party democracies in Africa.

Typically, the NDC has been seen as a left-of-centre party inheriting the Nkrumahist tradition of Ghana's first president, which represented the interests of some of Ghana's more deprived ethno-regional and social groups, while the NPP has been regarded as more right-of-centre, following the Danquah-Busia liberal tradition, which represented more prosperous ethnic areas and elite interests. In reality, however, ideology does not count for much. Both main parties broadly accept the neo-liberal status quo, which includes a large role in the economy for international capital, and depend for their financial wellbeing on contributions from politically connected businessmen. Access to power is dependent on victory in a large number of swing

constituencies, and for this each party mobilises its local-level supporters in colourful and sometimes rowdy election campaigns. Both parties have based their political strategies on awarding contracts to friendly businessmen, channelling rents to party 'footsoldiers', keeping public sector pay and employment as high as possible (while soft-peddalling performance-based reforms), and making technically ill-considered, populist policy gestures (Kelsall, 2013; Abdulai, 2018). Meanwhile most senior public sector bureaucrats are said to be 'appointed by presidential fiat, largely on the basis of partisan political criteria rather than merit' (Gyimah-Boadi and Yakah, 2012).

As Abdulai's research shows, the health sector has not been immune to these trends. To give a few examples, there were seven different ministers of health between 2009 and 2015, disrupting policy continuity, while many senior officials are kept in 'acting positions', making them increasingly vulnerable to political interference and pressure. Reports indicate that over 90 percent of the government's health budget is spent on staff salaries, with much of the remainder disappearing into individuals' pockets. Despite there being a hierarchical system of performance management in place, rewards and sanctions are rarely enforced. According to one informant: 'Have I been ever called and asked, "Director, this is your contract with me what have you done?" No! There is no follow through. You sign, and you take pictures and they sign, but then what else? Nothing!' (Abdulai, 2018). Promotion is largely dependent on seniority or political connections.

Large numbers of health staff have been trained: Ghana exceeds internationally recommended midwife/nurse-to-population ratios, yet maldistribution of resources means that many facilities remain chronically understaffed. Some doctors and nurses remain on the central payroll even though they never show up to their official place of work, with schemes to remedy this, such as putting salaries under the control of local assemblies, vigorously resisted by the Ghana Medical Association. There has been, and continues to be, a huge drive to build highly visible community health planning and services (CHPS) compounds, yet many are lacking basic equipment and staff, while an initiative to expand massively the number of ambulances in the country has not been matched by resources to equip emergency rooms (Abdulai, 2018).

Another populist policy is the National Health Insurance Scheme. Introduced to great fanfare in 2008, an election year, it was rapidly expanded on the insistence of the president, against technical advice. Its financial problems have all but crippled some health facilities, leading them to reintroduce unofficial user fees that deter poorer patients. Expert recommendations to scale back the scheme to target the most underprivileged contradict political imperatives, which are to spread resources as widely as possible (Abdulai, 2018).

In this context, progress in maternal health has been disappointing. Yet it is not because the issue fails to resonate. President Nkrumah introduced free antenatal care services as early as 1963, and in 2008, the NPP government declared maternal mortality a national emergency. The NDC was equally enthusiastic, with President Mills declaring in 2010 that 'no woman should die while giving life'. A special fund

has been created to reduce the MMR, and in 2013, the government announced a 10 percent voluntary pay cut in the salaries of the president and other members of the executive, with the objective of constructing 'special purpose CHPS compounds focusing on maternal and neonatal health' (GoG, 2013: 5). Indeed, since 2000, Ghana has adopted numerous initiatives aimed at reducing maternal mortality, the most recent being the *2010 MDG Acceleration Framework (MAF) – Ghana Action Plan*. All have been laudable on paper; implementation has been lacking in practice.

Despite these problems, some local districts have made good progress in the face of adversity. A case in point is Upper East District, one of the most impoverished regions of the country, with one of the worst doctor–population ratios. Whereas one doctor served 3,178 people in Greater Accra in 2013, the corresponding figure for Upper East was 33,896. Traditionally known as a hardship posting, between 2007 and 2009, only one of 13 doctors posted to the region actually reported. Since 2008, however, the district has begun to turn its fortunes around.

Most of the changes can be attributed to the creation of an island of excellence under the dynamic leadership of the regional director for health, who inspires others with his vision and conduct. To give a few examples, the region strictly enforces a 'bond system', under which health workers who have trained in the region must stay there for a minimum of three years. Staff are deployed to areas of greatest need, often remote locations, but good performance here can earn a transfer to a better connected location within the space of one or two years. CHPS compounds have been made more attractive by being equipped with creature comforts, such as television, and staff in remote locations are frequently visited by senior officials and praised for their hard work. The region makes regular use of personalised letters of commendation for good work, and holds regular meetings, in which the performance of health facilities is compared. As in Rwanda, this creates a competitive spirit among staff, driving better performance. Not only are facilities subject to regular inspections, any case of maternal death is followed by a rigorous audit. All health staff are aware that the regional director treats every maternal death as a preventable tragedy, and are motivated accordingly (Abdulai, 2018).

Whereas the Upper East Region had the worst nurse-to-population ratio in 2007, it now enjoys the most favourable in Ghana (MoH, 2014: 10). The problem of emergency transport has been addressed via a multistakeholder initiative called the 'Motor King Ambulance system', in which local three-wheeled motorbikes are adapted for carrying women in labour. Partly as a result, the probability for a woman to deliver at a health facility was 74 percent in Upper East Region, compared to 45 percent in the much more prosperous and better resourced Volta Region (MoH, 2015: 33). Indeed, our research in the Volta Region showed that many of the same systems as in Upper East were in place, but they failed to function because of poor supervision and monitoring. One positive story, however, concerned a local NGO/multistakeholder initiative, in which traditional queen mothers have been enrolled in raising awareness about maternal health. Thanks in part to its efforts, the

Ho Municipal Hospital for the first time recorded zero maternal deaths for one full year (from June 2013 to June 2014), down from 14 deaths in 2012 (Abdulai, 2018).

## **Uganda**

If Rwanda is an almost archetypal dominant developmental settlement, and Ghana an inclusive competitive one, Uganda is somewhat more mixed. The current political settlement traces its origins to 1986, when Yoweri Museveni's National Resistance Army (NRA) triumphed on the battlefield after years of conflict. In an attempt to heal the rifts of the past, the leadership suspended competitive adversarial multi-party politics and established an inclusive 'no-party' (National Resistance Movement (NRM)) system. The restrictions allowed the NRM to consolidate its hold on power and establish a hegemonic dominance. Nevertheless, the regime's political base, built on alliances with guerilla fighters, traditional leaders and ordinary peasants, remained the south of the country. The north, which had dominated post-independence politics, was less well represented and insurgencies soon reignited, both there, and, less seriously, in the west of the country.

In 2001, the leadership also came under strong electoral pressure, when a faction of the ruling elite, whose members had exited the coalition, attempted to unseat President Museveni. In 2005 the pressure increased further, with a hotly contested referendum to abolish presidential term limits, designed to allow Museveni to stand again as president in multi-party elections in 2006. Since then, the president has faced increasing demands, not just from the opposition, but from lower-level members of his own party, whose bargaining position the move to multi-partyism has enhanced.

On coming to power, Museveni espoused a left-of-centre, pro-poor ideology, and the regime was lauded for some early successes in social sector provision, and decentralisation. Financial management has also been fairly sound, with strong economic growth and a reasonable record of poverty reduction. However, as competitive pressures within the system have increased, politics has arguably become more patrimonial and policies more populist.

The health sector is reflective of these tendencies. Although early on in Museveni's tenure, the Ministry of Health was a locus for relatively effective policy implementation, especially in the field of HIV/AIDS, it later became a vehicle for rent-seeking. This shift was related to Museveni's bid to extend presidential term limits in 2005 and win re-election to the presidency in 2006, both of which required substantial resources to distribute as patronage. Around this time, high-performing politicians and technocrats in the Ministry of Health were replaced by close Museveni associates, some of whom already had a track record of being implicated in corruption, and in 2005 a major scandal erupted over the management of the Global Fund and GAVI. The scandals seriously damaged Uganda's relationship with donors, placed both corrupt and upstanding officials under suspicion, and caused many of the latter to leave the ministry. By 2010, it had had four different permanent

secretaries in the previous five years. Another significant development related to the increasingly competitive nature of the political settlement was the proliferation of local district councils. Between 2002 and 2011, over 50 new districts were created, providing a significant outlet for clientelist pressures. In many cases the effect on health services was extremely damaging, as new health authorities with untested structures and staff were hurriedly brought into being. The problems were compounded by grand corruption in the National Medical Stores, which often led to drugs being diverted from their intended use (Croke, 2012).

As in many other developing countries, Uganda's Health Sector Strategic Plan includes a commitment to reducing maternal mortality, encompassing policies in emergency obstetric and newborn care, access to skilled attendance at birth, family planning and antenatal care services. Despite these policies, progress in reducing maternal health has been no better than average, with the country missing MDG 5 by a significant margin. This generally average performance, however, does mask some interesting local differences. Bukenya and Golooba-Mutebi's (2019) paper shows how these can be partly explained by differences in local-level political settlements, which become particularly salient in a context of decentralisation and weak dominance at the centre.

The paper compares two adjacent districts. In the first, Sembabule, local politics is intensely divided between two members of President Museveni's inner circle, whom he seems unwilling or unable to discipline. Among other things, this has created a stalemate at the district headquarters, where between 2006 and 2010 the district could not recruit, confirm, promote or retire health staff. Moreover, the standoff has bred public service indiscipline, as political godfathers shield individuals from being held to account. Even health unit management committees have been infected by factional politics, rendering them practically useless. The district has also been shunned by NGOs, partly because of the unhealthy political atmosphere. Reflecting this, our research found that operating theatres in both the district's health centre IV (HC IV) units lacked anaesthetists and blood transfusion equipment, so did not carry out caesarean sections, a key component of emergency obstetric care. Its ambulances had been grounded for years. Meanwhile the in-patient department at Sembabule HC IV was in a dilapidated state and the grounds overgrown. Not a single patient was admitted during the team's five-day visit. Deficiencies such as these are reflected in national health performance figures, in which Sembabule ranks 107 among Ugandan districts, with only 11.4 percent of deliveries taking place in health facilities.

The situation could hardly be more different in neighbouring Lyantonde. In 2013-14 it ranked fourth in national performance figures, with 74.4 percent of births occurring in health facilities. Although health services are far from perfect, the district has a well developed, solar-powered health infrastructure with two functioning ambulances to facilitate referrals. One HCIV facility has been upgraded to hospital status.

Lyantonde is a relatively new district, created in 2006 in response to a popular demand, which built on local perceptions of political marginalisation dating to the colonial era. United around the goal of better service delivery and development, its leadership has leveraged a combination of personal connections and performance mechanisms to achieve this. For example, helped by the fact that one of the district's two MPs is a minister for health, it has lobbied hard for improvements to health infrastructure, using the argument that the district is situated on one of Uganda's main transport arteries (en route to the president's constituency) and therefore requires better emergency facilities. In addition, the permanent secretary in health is a district 'son of the soil'; according to one informant, 'all the money that comes here is in one way or another linked to him' (see Bukenya and Golooba-Mutebi [2019: 30]). The district leadership has also been proactive in seeking out NGOs and CSOs.

Donations of money and equipment are not sufficient to sustain a good health service, however, and the political leadership also strictly monitors performance. For example, when in 2013 the district fell outside the country's top ten health performers for the first time, the district health officer was required to give regular accounts to the council of what he was doing to address the matter:

'When we were ranked 17th, I had a hard time. I was bashed throughout that year... I was made to write reports to explain why we performed poorly and what we needed to do to improve. We made action plans to help us improve. I felt relieved when we improved in 2014.' (see Bukenya and Golooba-Mutebi (2019: 28)

The political leadership also works with the technical staff in a symbiotic way. As one health worker explained, 'We the health workers deliver the services and they take the credit. In return they help us to mobilise communities and get the materials and equipment we need to deliver' (see Bukenya and Golooba-Mutebi (2019: 28)). The local community is also involved, and there have been various innovations to encourage participation, for example availing toll-free telephone complaint numbers. Indeed, in some interviews, health staff felt that local people complained 'too much'.

Given the narrative above, the shape of the longitudinal maternal mortality curve in Uganda is surprising. The decline begins to accelerate slightly, right around the time that serious patrimonial pressures begin to engulf the ministry. Bearing in mind that the data may not be entirely representative, and that maternal mortality is a complex issue, with multiple direct and indirect determinants (Chou et al., 2015) two possible political explanations suggest themselves. One is that increasing decentralisation in the health sector has begun to bear fruit. Although there may be no shortage of horror stories like Sembabule, on balance, more local districts might approximate the situation in Lyantonde. Another is that the declining effectiveness of the Ministry of Health may have been compensated for by the increased commitment of other actors, including external partners, in the maternal health policy domain. More research would be required, however, to determine whether either of these explanations is correct.

## **Bangladesh**

Bangladesh is also something of an intermediate case. Its current political settlement dates from 1990, when today's two main political parties, the Bangladesh Nationalist Party (BDP) and the Awami League (AL), collaborated to oust a military dictatorship from power. Since then, aside from a short military interregnum, there have been regular turnovers in power, as one or other of the main parties has governed in coalition with a combination of smaller parties. Politics has been highly fractious, with most of the country's formal institutions, including the judiciary, arenas of political contestation, and the parliament becoming almost non-functional. Since 2008, moreover, the AL has held onto power, with the BDP boycotting the most recent elections (Hassan, 2013; Hossain and Osman, 2007). The settlement may then be in transition towards dominance.

The orientation of the political settlement is also somewhat hybrid. The leadership of the main political parties tends to be elitist, but the ideology they espouse is pro-poor; socialism and democracy are embedded in the country's constitution, leading some to describe Bangladesh as a 'South Asian welfare state'. This may be partly due to the weight in the political settlement of several large NGOs, including BRAC and Proshika. Instrumental in helping rebuild the country after the 1971 war and secession from Pakistan, they have continued to be influential players, especially in the field of social provision, including health. Bangladesh has also been at the forefront of the developing world when it comes to addressing gender disparities, having had a female head of state for more time than any other country.

Several large players interact in the health policy domain. The minister of health and family welfare is one; top ministry officials, well organised and active professional bodies, such as the Bangladesh Medical Association and the Obstetrical and Gynaecological Society of Bangladesh, development partners and the aforementioned NGOs are others. Maternal health has been a long-standing concern, and was originally addressed through the country's innovative low-cost primary health care approach. However, by the mid-1990s, it became clear that the high rate of maternal deaths could not be tackled through this approach alone, and that more complex arrangements with specialised equipment, supplies and medically trained human resources would be required. In 2001, further impetus was provided by the National Strategy for Maternal Health, under which the government declared its commitment to the MDG5 target of cutting the MMR by 75 percent by 2015.

Despite this commitment, our research found that Bangladesh experiences many of the same problems of visible infrastructure bias, human resource maldistribution, and staff indiscipline that we have seen in Ghana and Uganda. This can be explained by the exigencies of competitive politics and the unwillingness or inability of the centre to impose its will on competing interest groups and centres of power. To give a few examples, there has been a massive expansion in community clinics, a flagship initiative for addressing maternal health issues, but most remain ill-equipped to provide emergency obstetric care. Here and in other local health organs, a major

issue is the retention of qualified staff. As Mahmud and Mahzab (2020) argue, 'This can be partly attributed to an implicit "elite consensus" around the issue of doctor absenteeism at the local level'. Meanwhile, initiatives to try and address HR gaps, such as the short-term training of junior consultants and assistant surgeons in anesthesiology and obstetrics, have faced resistance from senior doctors, and implementation of task sharing of responsibilities between non-specialist doctors and lower-level health cadres has been opposed by doctors' associations (Arifeen et al., 2014). Linked to the culture of absenteeism and indiscipline, it is common for informal fees to be charged in public facilities, or for staff to be found working in nearby private facilities, which far outnumber public ones.

Another problem is that maternal health policy implementation is often undermined because of conflicts of interest between the two main agencies for field implementation, the Directorate General for Health Services and the Directorate General for Family Planning. Local-level research by Mahmud and Mahzab (2020) found evidence of all these trends, more severe in some locations than others. In these cases, the main determinants of better and worse performance appeared to be geographic isolation, which exacerbated human resource allocation and supervision issues, and the idiosyncratic interest that some local political leaders took in health issues.

Bangladesh, then, appears to be something of an enigma. Maternal mortality has declined at a comparatively fast rate, despite experiencing many of the problems also present in the Ghana and Uganda cases, especially in the public sector. A number of explanations are possible. First, Bangladesh may perform better than Uganda and Ghana for indirect reasons, such as women's education, better nutrition, a lighter endemic disease burden, and highly successful NGO programmes in community health, including family planning (Mridha et al., 2009; Arifeen et al., 2014; Sikder et al., 2015). There is also evidence of some successful NGO initiatives in distributing drugs that prevent post-partum hemorrhaging, a significant cause of maternal mortality. It may also be the case that while Bangladesh scores poorly on indicators such as facility births and antenatal check-ups, the quality of the interventions that do take place may exceed that in Ghana and Uganda, perhaps because of a better skilled health workforce. Finally, it is highly likely that some maternal deaths are being reduced by the presence of comparatively high quality private and NGO obstetric care, although in the case of the former, this comes with worrying equity implications. Bangladesh, it should be noted, has the highest percentage of out-of-pocket expenditures of all our cases.

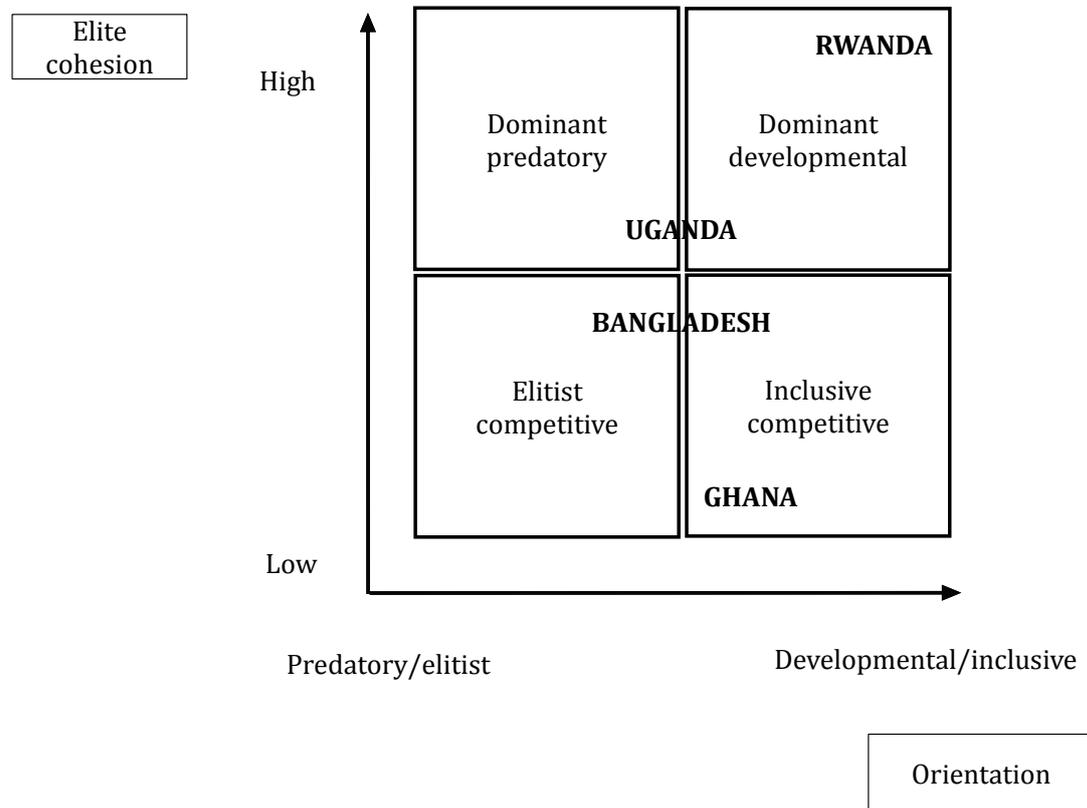
## **Discussion**

We can turn now to a comparative discussion of the causal factors underlying better and worse performance on maternal health.

To refresh our memories, Rwanda has a stable political settlement, with a dominant ruling group, an absence of powerful local-level groups, and an inclusive

developmental vision. The last of these can be related to the historical legacy of genocide and the new regime's determination to transcend it, an element of which involves the promotion of women. Partly as a result, the ruling group has taken strong charge of the health sector, resulting in a clear policy vision (complemented by a problem-solving approach), with little evidence of interest group mobilisation. It

**Figure 3: Political settlements typology with countries**



has driven performance gains through top-down and impartial hierarchical (and diagonal) governance norms, buttressed by elements of bottom-up participation.

Ghana, by contrast, although also having a stable political settlement, lacks a dominant coalition *and* has powerful lower-level groups. Although there are traces of Nkrumahist socialism in NDC ideology, the orientation of the two most powerful parties is best described as populist or even patrimonial, focusing not on impartial public goods provision, but instead on providing state employment and highly visible local infrastructure investments. Political leaders have professed high commitment to maternal mortality, but words have not been matched by deeds. For the most part, top-down performance mechanisms are weak, and doctors are a powerful interest group, sometimes impeding more effective personnel management. Policy vision, as expressed in official documents, is clear enough, but neither human nor financial resources are allocated in such a way as to realise it. There is also little evidence of a problem-solving approach, except in local pockets.

In Uganda, the political settlement is less stable, insofar as the ruling group around President Museveni (on which the settlement itself is based) faces strong challenges. Although ostensibly dominant, the ruling group in fact faces strong competition, both from opposition groups and from lower-level NRM factions. The pro-poor orientation with which Museveni came to power has since been diluted by patronage pressures, as the president has chosen to rule in an increasingly patrimonial way. Although in some domains this has been consistent with relatively good development performance, this is not the case in health. Whatever the policy vision, effective implementation has been undermined by a lack of impartial governance norms or hierarchical performance mechanisms, as the sector has been captured by patrimonial pressures.

Bangladesh is another settlement experiencing an element of uncertainty, although the direction of travel is the opposite to that in Uganda. Nevertheless, like Uganda, it seems reasonable to say that the ruling group is not particularly dominant and that lower-level groups *are* strong. The political settlement is founded on an inclusive developmental vision, but the actual modus operandi of elite political factions is more predatory. As in Ghana (and to a lesser extent Uganda), there is a policy commitment to maternal health, but hierarchical performance mechanisms and impartial governance norms are notable by their absence – a problem, as in Ghana, to which strong professional interest groups contribute. One notable difference between the countries is the comparatively greater role for national NGOs, which have often been at the forefront of innovative and problem-solving service delivery – a legacy, in part, of the important role these organisations played during the period in which the Bangladeshi state was created. The private sector is also better developed than elsewhere.

Our cross-case comparative analysis points then to the considerable similarities between Ghana, Uganda and Bangladesh, and the exceptionalism of Rwanda. Rwanda is different from the other countries in terms of the dominance of its ruling group, the weakness of lower-level groups, and the inclusiveness of its development vision.<sup>4</sup> Analytically, Rwanda is arguably more different on the first two of these variables than on the third, and for this reason dominance and the lack of internal challenges ought perhaps to be at the heart of our answer as to how political settlements affect development outcomes. Ontologically, however, all three variables are interdependent and difficult to disentangle, at least in the Rwandan case. It is the combination of vision, dominance and lack of internal opposition (which is itself partly due to Rwanda's unique consensus-building approach) that drives the policy, funding, and governance arrangements that result in better outcomes.

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<sup>4</sup> A sceptic might argue, of course, that Rwanda is also exceptional in other respects: for example, it has a much higher population density that allows it effectively to 'broadcast' power. Our study was not rigorous in controlling for such differences when it came to case selection. At the same time, the within-case comparisons suggest that population density is not a good predictor of state capability for addressing maternal health, and in general we believe there is enough evidence in our causal stories to build a plausible case for the importance of political settlement dynamics in this respect.

Interestingly, some of our within-case comparisons also validate this point. In Lyantonde, Uganda, the local ruling group was dominant, had a vision for the district, and demonstrated some ability to impose hierarchical performance mechanisms. In Upper East Ghana, a particularly charismatic and visionary local health director was able to do the same, with multistakeholder initiatives strengthening his impact in areas such as the ambulance service. Even in the poorly performing Volta Region, a local multistakeholder initiative had made a difference in one district hospital. 'Diagonal' accountability measures utilising local, national, and international league tables were also a powerful incentive to good policy implementation in some places, supporting other evidence from Zambia (Bevan et al., [2018]).

What does the research tell us about our overall conceptualisation of how political settlements affect elite commitment to better development outcomes? Readers will remember that our working causal model hypothesised that political commitment was co-determined by the political settlement and the policy domain. Our research has not led us to doubt that hypothesis, and may have shed some light on the nature of the interaction between settlement and policy domain. In Rwanda, the political settlement and policy domain were aligned, and converged on strong political commitment and good outcomes. In Ghana, by contrast, clear policies around maternal health in the policy domain appeared to be undermined by competitive populist and patronage pressures emanating from the political settlement. The lesson is that where political settlement and policy domain conflict, political settlement dynamics dominate. In Bangladesh and Uganda, the story is a little less clear. One might argue that in Bangladesh, the deficiencies of competition were mitigated by the strong pro-poor commitment of NGOs in the policy domain. But, in truth, NGOs are also influential in the national-level political settlement, so one could argue that political settlement dynamics still reign. Uganda at first glance also presents a picture of an increasingly patrimonial national-level political settlement undermining the effectiveness of actors in the policy domain. What gives us pause for thought, however, is the slight improvement in maternal mortality outcomes from the early 2000s onwards. Although more research is needed, it may be that the politics of the policy domain, and in particular the role of external actors therein, was able to compensate for damaging political settlement trends.

## **Conclusions**

Our research appears to confirm earlier work, which argued that the nature of the political settlement makes a difference to service provision, and that, generally speaking, dominant developmental settlements are more likely to be able to design and implement effective policies (Levy and Walton, 2013). This is also supported by wider evidence. For example, of ten 'fast-track' countries that in 2012 were on course to meet MDGs 4 and 5 (Mishra et al., 2015), seven (Cambodia, China, Egypt, Ethiopia, Laos, Rwanda and Vietnam) lay closer to the dominant, and only three (Bangladesh, Peru, Nepal) to the competitive end of the spectrum.

One conceivable policy implication is that development partners should try to encourage the emergence of more dominant developmental political settlements. However, we would urge caution here. Political settlement dynamics are often difficult for external actors to influence, let alone transform, and, where settlements *are* transforming, the outcomes are often uncertain and the risks that a prolonged period of conflict will ensue, high (quite aside from the fact that dominant settlements often, if not always, involve a trade-off with political freedoms).

A less risky strategy is to try and optimise results within the context of the settlement that already exists. We have seen in the case of Rwanda that for dominant developmental settlements this largely implies lining up behind and generously supporting the government's development strategy. In the other three cases, the implications are different. Here, external actors may be best advised to work on narrower issue areas, or at sub-national levels, leveraging state, NGO and private actors to build channels or islands of effectiveness in or around otherwise poorly performing administrations.

This advice, it should be noted, could be interpreted as going against the current fashion for eschewing vertical and parallel programmes and focusing instead on general health system strengthening. However, this need not necessarily be the case – as long as one recognises that the entry points for health system strengthening will vary according to context. Rather than focusing on national-level systems, external actors in competitive and intermediate settlements should be focusing on pockets of effectiveness, with a view first to supporting them in smart ways, then connecting them or expanding them from wheresoever they are found. Progress is likely to be slower than in countries like Rwanda, and reaching the most vulnerable people in locations with entrenched poor governance will be particularly difficult, but progress is possible nonetheless.

In September 2015 the international community embarked on a new updated Global Strategy for Women's, Children's and Adolescents' Health, which acknowledged the centrality of effective leadership, partnerships, accountability and collective action (Mishra et al., 2015). However, the precise nature and most successful configuration of these variables is likely to vary by context, and, as we hope to have shown in this paper, political settlements analysis provides a useful starting point for thinking about why, how, and where.

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