ePact
Strengthening evaluation effectiveness and impact

Evaluation of the DFID Zimbabwe Maternal, Newborn and Child Health Programme

Baseline report for the evaluation of the 'Strengthening Community Participation in Health' programme in Zimbabwe

Final Version

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e-Pact is a consortium led by Oxford Policy Management and co-managed with Itad

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Preface

This report constitutes the baseline report of the evaluation of the 'Strengthening Community Participation in Health' programme in Zimbabwe, a pilot programme funded by the UK Department for International Development (DFID) and the European Union (EU).

The programme is being implemented by Save the Children (SC) and Community Working Group on Health (CWGH) in 166 health facilities in 21 districts across eight out of Zimbabwe's 10 provinces (Harare and Bulawayo are excluded). 14 districts are funded by DFID and the remaining seven by the EU. The programme is part of DFID's broader Maternal Newborn and Child Health (MNCH) Programme in Zimbabwe.

The programme was originally called 'Strengthening Voice and Accountability for Improved Maternal, Newborn and Child Health Services' but SC and CWGH have renamed it as they felt that the original name might be contentious.

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Executive summary

This report constitutes the baseline report of the evaluation of the 'Strengthening Participation in Health' programme in Zimbabwe, a pilot programme funded by DFID and by the EU.

The Strengthening Participation in Health Programme

The programme is being implemented by SC and CWGH in 166 health facilities in 21 districts (14 funded by DFID and seven by the EU) across eight out of Zimbabwe's 10 provinces (Harare and Bulawayo are excluded). The programme is part of DFID's broader MNCH Programme in Zimbabwe.

The aim of the programme is to strengthen citizen engagement in the monitoring of MNCH services in order to improve their quality and utilisation, and hence improve MNCH outcomes. The programme will also contribute to national level advocacy to strengthen accountability mechanisms in order to increase the visibility of MNCH issues.

The programme's work centres on establishing Health Centre Committees (HCCs) where they do not already exist, and training and providing ongoing support to the HCCs. Activities also include the provision of training to Health Literacy Facilitators (HLFs) on how to educate community members about MNCH issues and to Community Monitors (CMs) on how to administer community score cards.

Prior to this programme, there has been ongoing work looking at HCCs and their impact on health systems in Zimbabwe. Between 1989 and 2002, CWGH was setting up or revitalising HCCs and by 2001 the organisation covered 21 districts. Studies provide evidence of better service delivery and better quality of services in Rural Health Centres with an HCC than in those without.[1] For example, in three districts with well-functioning HCCs, clinics with HCCs on average had more staff, larger allocation of funding from MoHCC, more expanded programme on immunisation (EPI) campaigns, and greater drug availability (even if overall availability of drugs was low) than clinics without.[2] However, these studies neither investigate whether this relationship is causal, nor do they provide a clear hypothesis of change that connects the presence of HCCs in communities and improved health outcomes in those same communities. As described in below, this evaluation will aim to address this issue.

The programme is important given the national rollout of a results-based financing (RBF) model in the health sector in Zimbabwe, and the role that HCCs are expected to play in that model. The World Bank and the UN Children's Fund (UNICEF), through funding from multi-donor trust funds, are helping the Government of Zimbabwe to implement a national RBF programme. This began in late 2014. Under the RBF model, HCCs have a responsibility to prioritise expenditure at health facilities and they therefore affect how effectively RBF funds are used. HCCs are responsible for deciding how the money received at the health facility is spent; if the HCCs are well governed, funds will be prioritised according to community health needs. HCCs will thus have an instrumental role in improving the allocation of RBF funds – with funds prioritised according to the specific needs of a community. Conversely, poorly governed or poorly working HCCs may cause inefficient allocation of RBF funding if their

[1] Training and Research Support Centre (TARSC)/CWGH, 2004. 'Assessing the impact of Health Centre Committees on health system performance and resource allocation'.
[2] TARSC/EQUINET, 2005. 'The impact of HCCs on health outcomes in Zimbabwe'.

prioritisation of expenditure is not aligned to that of the communities they serve. HCCs thus have an allocative role in the spending of RBF finances.

Another key role of the HCCs, in the context of the RBF, is improved health governance. RBF requires that health facilities develop annual operating plans, and HCCs are an integral part of this planning process. The involvement of HCCs in planning can be expected to help communities understand better what RBF is, how it works, and some of its benefits. If understanding the nature of interventions in a particular community is linked to greater ownership and support for such programmes, then HCCs may well serve as a communication and dissemination platform for RBF, and could lead to better engagement by communities.

The evaluation

The main objective of the evaluation is to estimate the impact of the programme, whilst also considering the other Organisation for Economic Co-operation and Development (OECD) – Development Assistance Committee (DAC) evaluation criteria of relevance, effectiveness, efficiency (including value for money (VfM)) and sustainability.

In this report we will describe the baseline situation for indicators that are expected to change as a result of the programme (impact), assess the strength and weakness of the programme design (relevance) and give an analysis of the current status of major factors that are likely to influence the achievement or non-achievement of the objectives of the programme (effectiveness). As this is a baseline report, we will not comment on the efficiency or sustainability the programme, but we will describe how we will assess efficiency and sustainability at endline.

The evaluation takes a theory-based approach and uses mixed methods. A theory-based approach makes explicit use of the theory of change (ToC) to draw conclusions about whether and how an intervention contributed to the observed results. The evaluation uses mixed methods in that it employs both quantitative research and qualitative research. The quantitative research will use a quasi-experimental method to assess, at endline, whether the intervention worked, and the qualitative research will look at how and why the intervention worked, or did not work.

The quantitative part of the evaluation uses a propensity score matching design to identify a comparison group, and this will be used to measure the impact of the programme at endline. The quantitative part of the evaluation uses a health facility survey of 147 health facilities, including interviews with 1400 antenatal care (ANC) users and 1400 carers of under-fives being treated at the facilities, and various secondary data sources.

At endline, the qualitative component will complement the quantitative survey by addressing the effectiveness, relevance and sustainability of the programme interventions within the overall context, in addition to providing data on impact, both in terms of changes that have occurred (particularly those not measured through the quantitative survey) and the reasons why change has or has not occurred.

Key baseline findings

Here we summarise the baseline situation of all key outcomes that are expected to change as a result of the programme.

Quality and functionality of HCCs

Almost all facilities (99%) have some kind of a health committee, but they are not always called an HCC. The country is presently in a period of transition, as it is transferring responsibilities from Ward Health Teams/Committees and Sub-Health Committees to HCCs. In some cases this merely involves a change of name, but in other cases the change has affected operations as well. This has arisen following the introduction of the RBF model, which imposes requirements regarding the way a committee is formed and operates, including the need to elect committee members, which was not always required by Ward Health Teams/Committees or Sub-Health Committees.

The HCCs have an average of 8.7 members, of which 4.7 are men and 4 are women. The nurse in charge is represented on almost all HCCs, as well as 'ordinary community members'. It is also very common to find community health workers, traditional community leaders and councillors/local political leaders on the committees. The average age of the HCC is 6.5 years and the average number of years since the most recent HCC election is 1.6 years

There is significant variability in the quality and functionality of HCCs. Most, though not all, HCCs meet regularly between themselves and with their communities. Despite the relatively high proportion of HCCs meeting with communities, there is a significant lack of awareness in the communities about the existence and function of the HCCs (only about one-quarter of ANC patients and carers of under-fives know of the HCC in their community). There is a reasonable level of minute keeping across HCCs, though there is room to bring all HCCs up to the same level. The level of engagement with the District Health Executive (DHE) is low.

The initiatives that HCCs most commonly report undertaking are providing new infrastructure, conducting repairs, buying supplies, providing security or improving the environmental sanitation of the facility. 30% of committees raise money for the facilities and the average amount raised is about US$879, which is quite a significant proportion of the facilities' income. The funds are used for new infrastructure, repairs and security of the facility.

Knowledge of rights and entitlements

Even though few people are aware of the Patient's Charter *per se*, there is reasonable knowledge about rights and entitlements. The main source of information regarding patient rights are facility staff and general knowledge shared amongst community members. Approximately three-quarters of ANC patients and carers of under-fives know that services are meant to be free. This information is most commonly obtained from facility staff or friends and relatives rather than HCC/HLF/community health workers. There is no difference in the level of understanding of patient rights in communities with high and low functioning HCCs, which is consistent with the view that information is obtained most frequently from facility staff or friends and relatives.

Decision-making regarding community and health facility resources

The vast majority of facilities have an operational plan and almost all HCC members report that their HCC was involved in the development of the current operational plan for the health facility. The health facilities are regularly visited by the HCC (approximately once a fortnight) and the DHE (approximately one a month). The health facilities' staff and the HCC are the primary decision-makers regarding spending of facilities' income, and most HCC respondents said that they feel the health facility expenditure is in line with their priorities. All expenditure is approved at district level. The facilities' income is most often (by 92% facilities) used to buy supplies, drugs or equipment, and it is also frequently used for repairs and new infrastructure. However, not all facilities have a bank account and of those that do about one-fifth have trouble accessing it.

Complaints and monitoring mechanisms at health facilities

Only about half of all facilities have a formal mechanism (such as client surveys, complaints or suggestions box) to collect patient feedback, and these are not used very much. Furthermore, if they are unhappy about something at the facility, only 59% of ANC patients and carers of under-fives report that they would complain. If they would, it would mostly be to the nurse in charge. Both qualitative and quantitative data shows that if ANC patients would not complain it is generally because they do not know where to go to make a complaint, or because they are afraid of reprisals from health facility staff if they do. There is no difference in the likelihood that an ANC patient or carer of an under-five would complain when comparing those living in communities with high and low functioning HCCs, suggesting there is significant scope for the HCCs to improve in this regard.

Technical quality of health facilities

The evaluation primarily relies on secondary data sources to measure the quality of health facilities, but these were not available in time for this report. However, we have a small number of indicators in our quantitative survey which measure the quality of facilities, and which show some promising signs. For example, all ANC patients interviewed had an ANC card and almost all facilities are now not charging for MNCH services. However, most facilities still have poor infrastructure, including a lack of staff accommodation, lack of water and electricity, and a lack of transport. Some small facilities do not have any/enough maternity beds

Perceived quality of care

This section aims to measure whether or not community members believe the services provided at the health facilities are of good quality. How one perceives the quality of services depends on one's expectations of quality. Therefore, perceived quality changes when expectations change, and perceived quality can change even when the actual quality of the services do not change. Perceived quality is important for this programme because the programme aims to increase community members' expectations of the quality of services to which they are entitled, and to increases the community members' voice in the governance of the health facilities. It then seeks to enable community members to use their increased expectations to demand better services, and it is hoped that this will lead to an improvement in the technical quality of the services, and that this, in turn, will lead to increased utilisation of services. Therefore, over the life of this programme we could expect that perceived quality will initially fall as expectations are raised, and then the perceived quality will rise if the quality of services improves.

Despite the significant problems commonly mentioned regarding the quality/availability of basic infrastructure at the health facilities, community members report very high levels of satisfaction with the health care provided at the primary health care centres: community respondents largely describe health facility structures as being ‘adequate’, and report high levels of trust in the health workers. There is a sense that facilities’ staff are doing their best within their means, though there were some reports of negative staff attitudes in the qualitative interviews. The satisfaction levels are lowest when service users were asked about the convenience in terms of getting to the facility, the amount of time they had to wait to be seen and the ease of obtaining medicines.

MNCH service utilisation

Based on Zimbabwe’s Health Management Information System (HMIS) data, utilisation of antenatal and postnatal services increased steadily from early 2013 to mid-2014, while the number of children being vaccinated has remained approximately constant. Some service providers and decision-makers attribute the increase in ANC and postnatal care (PNC) visits to Health Transition Fund (HTF) and RBF funds and improved community participation and outreach.

The main barriers to utilisation of MNCH services identified by the baseline qualitative interviews are cultural barriers, mainly within certain segments within the Apostolic church (in total, members of Apostolic churches constitute 33% of Christians in Zimbabwe). Distance to the facility is also a key barrier. Of less importance in terms of increasing utilisation is the quality of facilities. While staff attitudes are often cited as a reason for non-use, poor physical infrastructure is not. While it is often reported that there is poor physical infrastructure (lack of a mothers’ shelter, electricity, water etc.) or a shortage of staff, this is not often given as a reason for not attending. There is a sense of resignation that the facilities are doing the best with the resources they have, and a recognition of the fact that quality has improved significantly since the low point in 2008. As services get better, non-quality barriers become more important.

Implications of the baseline findings for the programme

The findings outlined above show that perceived service quality is not reported as a major factor in determining utilisation levels. We have also found that most users report satisfaction with the quality of current services, often ‘factoring in’ an allowance for the circumstances in which they are delivered. These findings undermine two key assumptions in the programme ToC and raise the very real concern that, even if outputs are delivered as planned, service utilisation levels will not increase as a result.

We recommend that the programme consider whether it should address other barriers to service utilisation in addition to those addressed in the current design. This may mean more consideration of factors other than knowledge of rights and processes in order to increase the community's voice. It might also mean giving more attention to the role of HLFs in addressing these areas, in addition to the HCCs.

Key areas for consideration, identified in this baseline evaluation, include:

- Cultural barriers: the programme can further support HLFs and HCCs in their role of informing community members about the importance of using MNCH services instead of relying on traditional medicines or religious practices.

- Religious barriers: as an objection to the use of MNCH services is a powerful barrier, reinforced by deeply held beliefs among some groups of the Apostolic church, the programme could consider if there are ways to transform the levying of punitive sanctions by chiefs and traditional leaders into positive motivations to utilise MNCH services.

- Distance: the programme is not able to provide short-term solutions to the issue of distance, though this may be a subject addressed in the longer-term, as advocacy for MNCH needs make those needs more widely known and enable information about those needs reaches higher level decision-makers. In the meantime, the programme could support greater outreach by existing facilities into the communities.
- Negative staff attitudes: the programme is well placed to improve the relationship between frontline service providers and community members, using HCCs to minimise tensions between nurses and community members who bring complaints; HCCs can also play a role in monitoring the occurrence of reprisals against service users who bring grievances/lodge complaints. The programme could design interventions to raise awareness among service providers of the benefits of critical feedback, so that they view it as a learning mechanism rather than a threat.

For the programme to improve community participation in health facility governance it needs to:

- focus on providing community members with knowledge that has practical value, which they can act on in order to assert their right to access quality services;

- improve community awareness of the existence and roles of the HCC and clarify the distinction (or non-distinction) between Ward Health Teams/Committees and HCCs so that community members know who to give feedback to, as awareness of both these points is currently low;

- train HCCs and CMs to better understand their roles. Whilst HCCs are largely aware of their role as mobilisers, the baseline evaluation found that greater understanding is needed about their role in terms of bringing grievances to the health facility, of meeting with communities (not just village heads), and also requesting and contributing more substantially during meetings with the DHE. It would also be worthwhile to reinforce efforts to make sure the HCCs are not captured by influential elites, but are representative of the diverse communities they serve;

- train HCCs to put in place complaints mechanisms, respond to fear of victimisation/reprisal, and train community members on how, where and with whom to register their complaints. Most people said they would not complain because they do not know where to go to make a complaint and they are worried about what might happen if they do, and those that do complain usually do so to the nurse in charge;

- there does not appear to be a significant difference between HCCs that have already been trained and those that have not been trained, when comparing our HCC outcomes of interest, so either the previous training did not cover the areas of interest, or, if it did, the training does not appear to have had a significant effect. The programme implementers should consider if their HCC training needs to do anything differently in order to have a sustained effect on key areas of interest.

Implications of the baseline findings for the evaluation

About 20% of ANC patients and carers of under-fives have already received training (mostly from staff at the health facility), while 80% of HCCs have received training (mostly from the District Health Team, other Ministry of Health and Child Care (MoHCC) staff and staff at the health facility). Furthermore, implementation of some elements of the programme began in some districts before the baseline study could be conducted. Yet despite both these factors, there do not appear to be any significant differences between the baseline and comparison groups. This means that we have a good comparison group for the evaluation. It also means that, especially in the case of HCCs, the evaluation will be measuring the effect of additional HCC training, rather than of some HCC training compared with none.

The preliminary verification process in respect of the health management information system (HMIS) data has revealed the existence of considerable discrepancies between what we observed in the facility registers, what is written in the facility level tally forms and what is the official HMIS database. Given that our ability to measure impact at endline will be highly dependent on the reliability of our data sources, we will mitigate the risk that the HMIS database is not accurate by again conducting the same HMIS verification survey, which will provide us with an alternative measure of the trends in utilisation of MNCH services in the facilities of interest.

We have found that some of the assumptions underpinning the ToC do not hold. We will discuss these and the implications of the baseline findings with SC and CWGH. We propose to work together to revise the ToC diagram, descriptions and assumptions following the analysis of our baseline data. At endline, we will assess the programme against the revised ToC.

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List of abbreviations

ANC	Antenatal care
ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CWGH	Community Working Group on Health
CM	Community Monitor
DAC	Development Assistance Community (OECD)
DFID	Department for International Development (UK)
DHE	District Health Executive
DHIS	District Health Information System
DHS	Demographic and Health Survey
DNO	District Nursing Officer
EPI	Expanded Programme on Immunisation
EQUINET	Regional Network for Equity in Health in East and Southern Africa
EU	European Union
FGD	Focus group discussion
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HCC	Health Centre Committee
HLF	Health Literacy Facilitator
HMIS	Health management information system
HTF	Health Transition Fund
HTFE	HTF Evaluation
ILO	International Labour Organization
IMF	International Monetary Fund
ISP	Integrated Support Programme
M&E	Monitoring and evaluation

MICS	Multiple indicator cluster survey
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MoHCC	Ministry of Health and Child Care
NGO	Non-governmental organisation
NIHFA	National Integrated Health Facility Assessment
OECD	Organisation for Economic Co-operation and Development
OPM	Oxford Policy Management
PNC	Postnatal care
RBF	Results-based financing
SC	Save the Children
ToC	Theory of change
TARSC	Training and Research Support Centre
TOR	Terms of reference
UDACIZA	Union for Development of the Apostolic Churches in Zimbabwe Africa
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
Zim-Asset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZimStat	Zimbabwe National Statistics Agency

1 Introduction

1.1 Objectives of the report

This report constitutes the baseline report of the evaluation of the ‘Strengthening Participation in Health’ programme in Zimbabwe (henceforth referred to as ‘the programme’), a pilot programme funded by DFID and the EU.

The programme is being implemented by SC and CWGH in 166 health facilities in 21 districts, across eight out of Zimbabwe’s 10 provinces (Harare and Bulawayo are excluded). 14 districts are funded by DFID and seven by the EU. The programme is part of DFID’s broader MNCH Programme in Zimbabwe. The programme was originally named ‘Strengthening Voice and Accountability for Improved Maternal, Newborn and Child Health Services’ but it was renamed by SC and CWGH as the originally name was thought to be politically contentious.

The main objective of the evaluation is to estimate the **impact** of the programme whilst also considering the other DAC evaluation criteria of **relevance**, **effectiveness**, **efficiency** (including VfM) and **sustainability** of the programme.

At this baseline stage, in this report we will describe the baseline situation for indicators that are expected to change as a result of the programme (impact), assess the strength and weakness of the programme design (relevance) and give an analysis of the current status of major factors that are likely to influence the achievement or non-achievement of the objectives of the programme (effectiveness). As this is a baseline report, we will not comment on the efficiency or sustainability the programme but we will describe how we will assess efficiency and sustainability at endline.

The report is organised into eight sections:

Section 2 describes the programme in more detail, including its activities, outputs and intended outcomes, and its ToC.

Section 3 discusses the overall design of the evaluation, including the design and methodology of the quantitative and qualitative components. The limitations of the design and its risks are also discussed in this section.

Section 4 describes the social, economic, political and health contexts within which this programme and the evaluation are situated.

Section 5 presents our key baseline findings from both our quantitative and qualitative sources. This section sets out the baseline values for indicators that are expected to change as a result of the programme. (We have placed the detailed presentation of quantitative survey results in Annex T, to improve the readability of the report.) In this section we also discuss the implications of the baseline findings for the evaluation.

Section 6 analyses each of the assumptions underpinning the programme ToC and uses this analysis to discuss the relevance and potential effectiveness of the programme.

Section 7 describes how we will assess the efficiency and sustainability of the programme at endline

Section 8 presents our conclusions, and summarises the implications of key baseline findings for the programme and the evaluation.

This report is our primary product relating to the technical evaluation design and baseline analysis, and will serve as a key point of reference for the final evaluation analysis, which will be completed after the programme finishes in 2016.

1.2 Intended audience of the report

While the report contains a lot of technical detail, every effort has been made to place much of the more technical detail in the Annexes to ensure the report is accessible to the non-technical reader.

The primary users of the baseline report fall into three categories, the first being the programme implementers, and its financers, as there are a number of findings that may have important implications for the programme ToC and the programme implementation. These implications are discussed in Section 6 and Section 8 respectively. Furthermore, the programme implementers might use the findings of the baseline report to update and / or triangulate target indicators in the programme logframe.

The second category of users includes civil society, the research community in Zimbabwe, and indeed globally, and the donor community who are interested in the provision and use of MNCH services and the role of the community in improving those services.

Finally, the third category of users of this report include the Zimbabwean national and local governments, particularly MoHCC and provincial and district health authorities. Data from the baseline can be used to expand the information regarding challenges that remain to be overcome in the provision and use of MNCH services in Zimbabwe, and they can also serve as an evidence base for making MNCH policy and programme decisions, particularly those concerned with HCCs.

The findings of the main report will be presented to representatives from all of the end-user groups identified above in Harare.

2 The programme

2.1 Programme description

The 'Strengthening Community Participation in Health' programme in Zimbabwe is a pilot programme funded by DFID and the EU. The programme is being implemented by SC and CWGH in 166 health facilities in 21 districts (14 funded by DFID and seven by the EU), across eight out of Zimbabwe's 10 provinces (Harare and Bulawayo are excluded). The programme is part of DFID's broader MNCH Programme in Zimbabwe.

The aim of the programme is to strengthen citizen engagement in the monitoring of MNCH services, in order to improve their quality and utilisation and hence improve MNCH outcomes. The programme will also contribute to national level advocacy to strengthen accountability mechanisms in order to increase the visibility of MNCH issues. The programme is intended to complement the supply-side support to the health sector provided through the recently established HTF, a multi-donor pooled fund the overall purpose of which is to improve MNCH in Zimbabwe.

The programme's work centres on establishing HCCs where they do not already exist, and training and providing ongoing support to the HCCs. It also provides training to HLFs on how to educate community members about MNCH issues and to CMs on how to administer community score cards.

As described by the training manual used by SC and CWGH:

> *HCCs were originally proposed by the MoHCW* [now MoHCC] *in the 1980s to assist communities identify their priority health problems, plan how to raise their own resources, organise and manage community contributions, and tap available resources for community development. The HCC is the mechanism by which people get involved in health service planning at local level. HCCs report on community grievances about quality of health services, and discuss community health issues with health workers. It is a joint community-health service structure linked to the clinic and covering the catchment area of a clinic (usually a ward or more).*

The programme is focusing specifically on HCCs and not Ward Health Teams/Committees or Sub-Health Committees. The country is presently in a period of transition, as it is transferring responsibilities from Ward Health Teams/Committees and Sub-Health Committees to HCCs. In some cases this merely involves a name change, but in other cases the change has affected operations as well. This has arisen following the introduction of an RBF model, which imposes requirements regarding the way a committee is formed and operates, including the need to elect committee members, which was not always required by Ward Health Teams/Committees or Sub-Health Committees.

Prior to this programme, there has been ongoing work looking at HCCs and their impact on health systems in Zimbabwe. Between 1989 and 2002, CWGH was setting up or revitalising HCCs and by 2001 the organisation covered 21 districts. Studies provide evidence of better service delivery and better quality of services in Rural Health Centres with an HCC than in

those without.[3] For example, in three districts with well-functioning HCCs, clinics with HCCs on average had more staff, larger allocation of funding from MoHCC, more expanded programme on immunisation (EPI) campaigns, and greater drug availability (even if overall availability of drugs was low) than clinics without.[4] However, these studies neither investigate whether this relationship is causal, nor do they provide a clear hypothesis of change that connects the presence of HCCs in communities and improved health outcomes in those same communities. As described in Section 3 below, this evaluation will aim to address this issue.

The HCC training manual used by the programme is adapted from the one used in CWGH's prior work. The CWGH manual outlines the roles and responsibilities of the HCCs. Under this programme two additional modules have been added. In the first of these additional modules, HCCs and HLFs are taught actions and practices which they can implement to reduce maternal, newborn and child mortality. In the second additional module HCCs are trained in relation to identifying vulnerable and marginalised groups in their communities and exploring ways of addressing their MNCH needs.

The programme emphasises the establishment and use of mechanisms for the community to provide feedback to the health facilities. The programme encourages the use of three main feedback mechanisms:

1. Community scorecards. The programme provides training and ongoing support in the use of community scorecards, by which the health service can be rated, and suggestions boxes, which community members can use to suggest new ideas or to raise concerns. The community scorecards are being developed by the programme and two CMs per health facility are being trained to administer these on a quarterly basis. The programme is also training HCCs to analyse data from community scorecards and HCC feedback forms.

2. Suggestions boxes. HCCs are trained to install suggestions boxes and to review the feedback.

3. HCC feedback forms. HCCs are trained to collect data on community perceptions of access to, and provision of, MNCH services using HCC feedback forms.

The HCCs are trained to produce a report using all information sources. The report is then shared with stakeholders at the community and district level.

The HLFs are trained to educate communities on their health entitlements using the 'rights and responsibilities' approach. The rights and responsibilities approach is captured in a community-produced checklist, which is set out in pictorial form, with images or photos produced by the community. The checklist is divided into two parts, one showing the community's rights and entitlements to quality MNCH services (which can be used in discussions with health providers) and the other side showing the responsibilities that the community has accepted, showing their commitment towards adopting healthy behaviours and practices to improve MNCH outcomes. It is intended that any possible solutions or strategies for change that could improve MNCH services that arise during the development of the checklist should be fed back directly to HCC members, who will engage in dialogue

[3] Training and Research Support Centre (TARSC)/CWGH, 2004. 'Assessing the impact of Health Centre Committees on health system performance and resource allocation'.
[4] TARSC/EQUINET, 2005. 'The impact of HCCs on health outcomes in Zimbabwe'.

with health care providers. HCC members should then collect feedback from health care providers and provide responses to community members. However, the programme implementers have indicated that due to budget constraints the full rights and responsibilities approach may not be implemented with the necessary depth and quality to influence behaviour relating to access and utilisation, particularly among those who hold strong beliefs against using services. The programme covers eight out of Zimbabwe's 10 provinces (Harare and Bulawayo are excluded), while the advocacy is working at the national level. Within these eight provinces, the programme is operating in 21 of the 59 districts. Table 1 outlines the programme's geographic coverage.

Table 1 Districts where the programme is operating

	District	Province	Implementing organisation	Donor
1	Buhera	Manicaland	CWGH	DFID
2	Mutasa	Manicaland	CWGH	DFID
3	Makoni	Manicaland	CWGH	EU
4	Goromonzi	Mashonaland East	CWGH	DFID
5	UMP	Mashonaland East	CWGH	DFID
6	Hwedza	Mashonaland East	CWGH	EU
7	Bubi	Matabeleland North	CWGH	DFID
8	Hwange	Matabeleland North	CWGH	EU
9	Bulilima	Matabeleland South	CWGH	DFID
10	Insiza	Matabeleland South	CWGH	DFID
11	Umzingwane	Matabeleland South	CWGH	EU
12	Guruve	Mashonaland Central	SC	DFID
13	Shamva	Mashonaland Central	SC	DFID
14	Rushinga	Mashonaland Central	SC	EU
15	Mhondoro	Mashonaland West	SC	DFID
16	Makonde	Mashonaland West	SC	EU
17	Zvimba	Mashonaland West	SC	EU
18	Bikita	Masvingo	SC	DFID
19	Masvingo	Masvingo	SC	DFID
20	Kwekwe	Midlands	SC	DFID
21	Mberengwa	Midlands	SC	DFID

The programme began with a design and inception phase that lasted from July 2013 to December 2014. In each district the programme usually begins with the establishment of the HCC if one does not exist and then the training of the HCCs. Following this the HLFs and CMs are trained and the programme works with the HCCs to establish community feedback mechanisms (suggestions boxes, community scorecards and HCC feedback forms). The programme also works with the HCCs to hold community and district level advocacy meetings and arranges HCC 'exchange visits' to share learning.

In October 2013 the programme began training HCCs, starting in seven of the 21 districts. By February 2015 the programme had begun operation in all DFID-funded districts but Memoranda of Understanding were still being agreed with MoHCC in some EU-funded districts. In the DFID-funded districts, HCCs, HLFs and CMs had been trained at all sites and the community scorecards were being administered. Very few sites had begun using the HCC feedback forms and suggestions boxes had been set up in about half the sites. Most facilities had begun holding community level advocacy meetings but very few had begun holding meetings at the district level.

The implications of the timing of programme rollout for the evaluation are discussed in Section 3.1.

2.2 Programme ToC

Here we discuss the programme's ToC, as we have understood it after consultations with SC and CWGH during the evaluation inception phase. In Annex E we provide a diagrammatic illustration of the ToC created by the implementing agencies, as well as our preliminary comments and suggestions regarding how it can be further developed prior to the endline evaluation.

The programme's overarching ToC is that increased community participation and influence over services (through, for example, monitoring service delivery and evidence-based advocacy) will contribute to improvements in the quality of MNCH services, which in turn will lead to a positive impact on service utilisation.

Central to the change processes is the inclusion of diverse social groups (drawn from current and potential service users) beyond local (and predominantly male) elites whose voices and influence are often dominant at local levels. The theory is that by raising awareness and increasing the broad-based participation of community members in issues concerning MNCH services, local accountability mechanisms and structures will become stronger and quality MNCH services will be better utilised.

At the same time the ToC envisages supply-side change, in the form of increased responsiveness on the part of MNCH service providers and decision-makers to community voices so that decision-making processes at the local level are increasingly influenced by evidence generated at the community level.

The ToC also recognises that community monitoring and feedback processes will identify issues that cannot always be resolved at local level but that require decisions to be made at district, provincial and national levels. Through the creation of a more enabling policy environment, it envisages the transmission of locally-generated evidence up the system through evidence-based advocacy, lobbying and engagement with policy-makers.

The ToC is structured around four key results areas. Below we describe each result area and the anticipated outcomes of each result area.

Result area 1: awareness and participation. This result area focuses on the programme objective of raising awareness on the part of local communities of their rights and entitlements to health, with reference to the Patient's Charter,[5] and the development of complaint mechanisms. It incorporates a strong communications focus and seeks to initiate a culture of challenge to the status quo, rather than acceptance of poor standards and bad practices in MNCH service delivery. The expected outcome is:

[5] The Zimbabwe Patients Charter was developed based on recommendations developed by the Consumer Council of Zimbabwe (CCZ) and the Zimbabwe Ministry of Health and Child Welfare (now the MoHCC) to offer protection to consumers and to improve the delivery of health services. According to the Charter, patients have a right to access the health system at times of need, both as non-paying and paying patients. General rights to access and treatment related to hospitality, confidentiality, privacy, discrimination, choice and redress of grievances.

- empowered communities with knowledge about their entitlements to free quality MNCH services from health facilities in target communities.

Result area 2: service monitoring. This result area comprises the programme objective to build demand amongst communities for greater accountability by strengthening existing HCCs and establishing new HCCs where they do not exist. The expected outcomes are:

- institutionalised community structures (HCCs, CMs and HLFs) that monitor the quality of MNCH are available in Rural Health Centres in target health facilities; and

- CMs and service users have the capacity to use monitoring mechanisms to provide evidence of service quality to HCCs in target health facilities

Result area 3: service governance. Result area 3 focuses on the programme objective of facilitating community engagement with health providers through strengthened HCCs and HLFs, and by establishing CMs. The aim is to build on existing and new community capacity to engage with health providers and duty bearers, using feedback mechanisms to engage communities in service governance. The expected outcomes are:

- increased community participation in health governance in relation to MNCH services in target health facilities in target districts of Zimbabwe;

- HCCs, CMs and HLFs are in place and operating as intended in target health facilities; and

- institutionalised City structures are regularly monitoring the quality of MNCH care available in target health facilities.

Result area 4: enabling policy environment. This result area addresses the programme objective of using advocacy to enable feedback from communities in order to produce changes in policy and institutional behaviour. The programme will use the data and information collected from the community level to develop advocacy and communications materials that will inform decisions at the district and national levels. Media advocacy is one of the key elements of the programme's strategy. Both CWGH and SC already have existing partnerships with the media, which will be harnessed for the benefit of the project. In early 2014 the CWGH signed a Memorandum of Understanding with the Health Journalists Association of Zimbabwe, opening the door for the programme to provide the media with briefings, press releases, and other opportunities to report on the progress of the programme. The strategy also includes plans for dissemination through newspaper adverts, opinion and editorial pieces, and involvement in radio and television slots by project staff.[6] The expected outcomes are:

- decision-makers act on evidence generated through feedback and advocacy to implement changes in policy and practice;

- creation of an enabling policy environment for the implementation of quality MNCH services by June 2016 in target districts; and

[6] CWGH (2014) 'Media strategy: Strengthening Community Participation in Health'.

- effective partnerships with local and international media (print and electronic), which will affect national dialogue and influence policy for improved MNCH outcomes.

3 Method

3.1 Overall evaluation design

The overall evaluation takes a theory-based approach and uses mixed methods. As discussed above, the main objective of the evaluation is to estimate the impact of the programme whilst also considering the other DAC evaluation criteria of the relevance, effectiveness, efficiency (including VfM) and sustainability of the programme.

The theory-based approach makes explicit use of the ToC to draw conclusions about whether and how the intervention has contributed to the observed results. The evaluation is mixed methods in that it employs both quantitative and qualitative research methods. The quantitative research will use a quasi-experimental method to address whether the intervention worked, and the qualitative research will look at how and why the intervention worked, or did not work.

There are various perspectives on the core characteristics of a theory-based evaluation. Within the resources available, our approach for this evaluation has involved:

1. the formulation of a programme ToC diagram during our inception phase, in consultation with SC and CWGH. This is shown in Annex E and is described in Section 2.2;

2. the articulation of the assumptions behind the ToC diagram. These are discussed in Annex F;

3. testing the assumptions behind the ToC at baseline to assess the strengths and weaknesses of the programme design and the likely effectiveness of the programme. This is discussed in Section 6;

4. a refinement of the ToC diagram, descriptions and assumptions following the analysis of our baseline data. This will be done in conjunction with SC and CWGH following the finalisation of this baseline report and before the endline evaluation;

5. and an assessment of the programme against the ToC at endline in terms of ‘theory success or failure’—that is, evidence for whether or not the theory, or elements of it, holds.

As mentioned above, our approach uses mixed methods, integrating a quantitative quasi-experimental design and qualitative research and analysis.

- The quantitative work will provide a statistically robust appraisal of the effect of the intervention on a number of key indicators along the ToC. A quasi-experimental design allows us to estimate the causal effect of the programme by constructing a comparison group. Using the comparison group we can assess the question of the counterfactual: ‘did the changes in outcomes (if any) occur as a result of the programme?’

- The qualitative element assesses how the programme has contributed to observed results by examining and explaining the processes that have influenced the observed

changes. This element will identify and assess any significant influencing factors (i.e. assumptions and contextual factors) that have played a role in the causal chain.

Internal validity refers to the extent to which a causal conclusion based on a study is warranted. If the matching process is able to identify comparison health facilities that are similar to the treatment health facilities, then this evaluation design will have high internal validity because we will have strong evidence that any observed impact is a result of the programme. In Annex S, we show that there is no significant difference, across almost all indicators, between treatment and comparison facilities; hence this evaluation design has strong internal validity.

External validity refers to the extent to which the results of a study can be generalised to other situations and to other people. The external validity of this study within Zimbabwe depends on the representativeness of the treatment facilities and districts within Zimbabwe. As the treatment facilities were selected purposefully by SC and the CWGH, in conjunction with the MoHCC, in our endline analysis we will use the available secondary data sources to examine how representative these facilities and districts are of the rest of Zimbabwe, in order to judge the external validity of this evaluation. Furthermore, testing the ToC and its underlying assumptions will identify the extent to which the context affects impact; the qualitative work will be able to inform this assessment.

The overall evaluation comprises this baseline and an endline. The baseline is intended to measure the situation on the ground before the programme starts while the endline will measure the impact of the programme after it has been operational for some time. The dates of key activities are summarised in the table below:

Date	Activity	Status
Feb 2014 – Jun 2014	Development of ToC and evaluation design	Completed
Jul 2014 – Aug 2014	Quantitative and qualitative baseline data collection	Completed
Sep 2014 – Feb 2015	Baseline report	Completed
Jul 2016 – Aug 2016	Quantitative and qualitative endline data collection	To be confirmed
Sep 2016 – Feb 2017	Endline (final) evaluation report	To be confirmed

The programme implementation began in October 2013 and will run until June 2016. Therefore, the programme rollout began before the baseline data was collected in July/August 2014. This occurred as a result of a delay in contracting the evaluation team and the programme implementers needing to begin operations in order to meet their own deadlines. We recognise that the risk arising due to having baseline data collection after the programme has begun is that the baseline may not accurately measure the pre-intervention outcomes. However, given the nature of the gradual rollout of the programme across and

within districts, there was very little likelihood of the programme influencing key indicators in the four months between the start of operations and collection of the baseline data. The first step in the programme implementation is establishing Memoranda of Understanding with the MoHCC and this is followed by establishing and training HCCs. At the time the survey was carried out, the community feedback mechanism process had not yet been rolled out. Therefore, the outcome that may have been affected by the timing of the data collection is the existence of HCCs. Indicators further along the causal chain, such as those relating to the quality and utilisation of the health facilities, are very unlikely to have been impacted in such a short time. Moreover, where we use secondary data sources to measure impact this problem is not relevant, as pre-April 2014 data are available. The effect of training that has already been conducted on the evaluation is analysed and discussed further in Section 5.8.

3.2 Quasi-experimental design

This section outlines the design and methodology of the quantitative part of the evaluation, which uses a health facility survey and secondary data. The following section, 3.3 describes the design and methodology of the qualitative component of the evaluation.

At baseline, as at endline, the quantitative component focuses on assessing the changes that occur as a result of the programme with regard to a range of key indicator areas along the ToC results chain. These indicator areas are: the quality and functionality of HCCs (output); knowledge of rights and entitlements (output); decision-making regarding health facility resources (output); complaint mechanisms at the health facilities (output); the technical quality of health facilities (outcome); perceived quality of care (related to outcome) and service utilisation (impact). In this way, quantitative data and evidence of change is gathered at various points along the expected causal chain. In brackets we have indicated where each of these measures sits in the ToC.

3.2.1 Identifying the comparison group

The evaluation will use a propensity score matching design to measure the impact of the programme at endline. In randomised experiments the randomisation enables an unbiased estimation of the impact of a programme because randomising who receives the intervention and who does not implies that treatment and comparison groups will on average be the same before the intervention begins. Matching attempts to mimic randomisation by creating a set of health facilities (and the communities they serve) who will not receive the treatment that are comparable, with respect to all observed variables, to the set of health facilities (and the communities they serve) that will receive the treatment.

As described in more detail below, the evaluation uses both primary data from a health facility survey we conducted, and secondary data from secondary sources that cover all facilities in Zimbabwe. The primary data only cover a sample of treatment facilities, but in regard to the secondary data, data are available for the full set of treatment facilities. For both types of data we have used propensity score matching to identify comparison health facilities. As was discussed in Section 2, interventions will be rolled out in 21 districts. Interventions will be implemented in less than 40% of the health facilities within each district. We have selected comparison health facilities from the remaining 60% of health facilities in these districts.

At baseline, our **health facility survey** covered a sample of health facilities where the programme is operating (treatment facilities) and a sample of health facilities where the programme is not operating (comparison facilities). At endline we will revisit the same facilities. The procedure used to sample treatment facilities is described in more detail in Annex J. We used nearest neighbour matching to identify one comparison health facility for each treatment facility in our sample.

For analysis with **secondary data**, again we used a similar matching procedure to identify a comparison group for all treatment facilities where the programme is operating.

For the endline analysis, where we measure the impact of the programme, we are not restricted to carrying out a simple comparison of treatment and comparison facilities. The propensity score matching method allows us to use a weighted average of the outcomes of more than one (and possibly all) comparison facilities that we have data for, to construct an estimate of the counterfactual.

Since we conducted our health facility survey in July/August 2014, some of the facilities where SC and CWGH are working have changed as a result of their consultations with the MoHCC. Our analysis in this report reflects the revised allocation of treatment facilities and, fortunately, the changes do not appear to have significantly impacted the similarities between treatment and comparison facilities. The balance tables shown in Annex S use the most recent (February 2015) allocation of facilities and there do not appear to be significant differences between treatment and comparison facilities.

3.2.2 Quantitative data

The quantitative data sources used in the evaluation are summarised in the table below.

Table 2 Quantitative primary and secondary data sources

Data source	Primary or secondary data source	Used for matching procedure to identify comparison facilities	Use at baseline	Use at endline
2011 Needs Assessment questionnaire from the National Integrated Health Facility Assessment (NIHFA)	Secondary	Yes	Not used	Not used
HMIS	Secondary	Yes	To measure baseline levels of utilisation of MNCH services	To measure the impact of the programme on utilisation of MNCH services
Health Facility Survey – Head of Facility Interview	Primary	-	To measure baseline levels of a number of outcomes of interest	To measure the impact of the programme on a number of outcomes of interest
Health Facility Survey – Under-Five Exit Interview	Primary	-	To measure baseline levels of knowledge of rights and entitlements, complaint mechanisms at the health facilities and perceived quality of care	To measure the impact of the programme on knowledge of rights and entitlements, complaint mechanisms at the health facilities and perceived quality of care
Health Facility Survey – ANC Exit Interview	Primary	-	To measure baseline levels of knowledge of rights and entitlements, complaint mechanisms at the health facilities and perceived quality of care	To measure the impact of the programme on knowledge of rights and entitlements, complaint mechanisms at the health facilities and perceived quality of care
Health Facility Survey – HCC Member Interview	Primary	-	To measure baseline levels of quality and functionality of HCCs, decision-making regarding	To measure the impact of the programme on the quality and functionality of HCCs, decision-making

			health facility resources, and complaint mechanisms at the health facilities	regarding health facility resources, and complaint mechanisms at the health facilities
Health Facility Survey – HMIS Verification Survey	Primary	-	To assess the quality of the HMIS data	To assess the quality of the HMIS data and to provide an alternative way to measure the impact of the programme on utilisation of MNCH services
MoHCC Quality of Care Checklist	Secondary	-	Not available*	To measure the impact of the programme on the technical quality of health facilities
Amount of RBF disbursement	Secondary	-	Not available*	To measure the impact of programme on the technical quality of health facilities and service utilisation
*The first RBF disbursement is scheduled for January 2015, and therefore the quality of care composite score will be available by health facilities quarterly, starting with data from quarter three (Q3) 2014. Hence, at the time of writing this report, these measures were not available and so we do not present the results in this report.				

The primary data sources from our health facility survey are described in more detail in Section 3.2.3. The secondary data sources used are:

- the 2011 Needs Assessment questionnaire from the NIHFA. This is a health facility survey that is designed to provide an analysis of the needs of individual health facilities throughout the country. The 2011 survey covered a total of 1375 public health facilities countrywide, or 95% of all health facilities;

- HMIS are a critical component of well-functioning health care systems, and a key tool for obtaining relevant information on the extent to which a specific population makes use of the health services offered to them. The Zimbabwe Health Management System records monthly utilisation of services, by service type and by facility for all facilities;

- the quality of the health facilities is going to be measured by the MoHCC as part of the HTF-RBF implementation. The MoHCC Quality of Care Checklist contains modules relating to general appearance, administration and planning, health information system management, infection control and waste management, outpatient services, family and child health, inpatient services, medicines, sundries and stock management, referral services, community services, and environmental health services; and

- under the HTF-RBF implementation, the amount disbursed to each health facility will depend on the quantity and the quality of services offered. Therefore we also propose to use the amount of RBF disbursement as a measure that combines quality and quality.

Note, the first RBF disbursement is scheduled for January 2015. Therefore the quality of care composite score will be available by health facilities quarterly, starting with data from Q3 2014. Hence, at the time of writing this report, these measures were not available and so we do not present baseline values in this report.

3.2.3 Health facility survey sample size

We sampled 140 health facilities in total: 70 treatment facilities and 70 comparison facilities. In each facility, we aimed to conduct on average 10 exit interviews of carers of under-fives, 10 exit interviews on average of ANC outpatients, an interview with one staff member (preferably the head of the facility) and one interview with an HCC member, thus yielding a net sample of 1400 carers of under-fives, 1400 ANC patients, 140 heads of facilities and 140 HCC members. In each facility we also collected data to verify the HMIS data

In practice, we drew a sample of 140 facilities with 10 supplementary facilities (five treatment, five comparison) to allow for the possibility that in some facilities we may not reach our target of 10 ANC patients and 10 carers of under-fives, because some facilities have very low volumes of patients. Therefore, in total we sampled 150 facilities and we reached our desired sample size after conducting interviews at 147 facilities.

As discussed in Section 3.2.1, since we conducted our health facility survey in July/August 2014, some of the facilities where SC and CWGH are working had changed as a result of their consultations with the MoHCC. This changed the number of treatment and comparison

facilities. The new allocation of our sample between treatment and comparison groups is shown below.

Table 3 Health facility survey sample size

Survey instrument	Total sample size	Treatment sample size	Comparison sample size
Head of facility	147	67	80
HCC member	145	66	79
Carer of under-five	1,514	684	830
ANC patient	1,415	688	727
HMIS verification	147	67	80

3.2.4 Health facility survey balance tests

The balance test tables aim to verify whether the treatment and comparison groups have the same average characteristics before the programme is implemented. This will be of key importance when evaluating the effect of the intervention. We use data from all primary sources and then test whether the treatment and comparison groups differ in a significant way.

In our analysis, we have used the revised allocation of treatment and comparison facilities based on the changes made after we conducted our health facility survey. Fortunately, the changes have not had a significant impact and the balance tests show that there are no significant differences at baseline between treatment and comparison facilities across all key dimensions. These balance test tables are shown in Annex S.

3.3 Qualitative component design

This section discusses the focus, design and methodology of the qualitative component of the evaluation. The qualitative component complements the quantitative survey by addressing the effectiveness, relevance and sustainability of the programme interventions within the overall context, in addition to providing data on impact both in terms of changes that have occurred (particularly those not measured using the quantitative survey) and reasons why change has or has not occurred.

The question of ‘what is working well or less well and why?’ was asked, in order to provide a clearer picture of the dynamics between central actors at community, district, and national levels. We also contextualised the accountability mechanisms that were introduced/ strengthened through the programme, in order to plot the experience of service users and providers against the implicit and explicit assumptions and goals of the programme. We demonstrate the links and relationships between the processes involved in efforts to change policy, practice, behaviour, and power relations.

The sustainability of the programme and the factors that contribute to enduring positive change will be assessed in light of the relationships between stakeholders at the different levels, and their different capacities and capabilities. Information and data concerning capacities, coordination and cooperation will be used to assess which outcomes or contextual pathways to change are most likely to influence the potential to scale-up the programme. The qualitative analysis of actors and events along the causal chain will provide evidence of plausible links between the accountability initiative, citizens’ empowerment and progress on broader development outcomes in MNCH in the intervention districts.

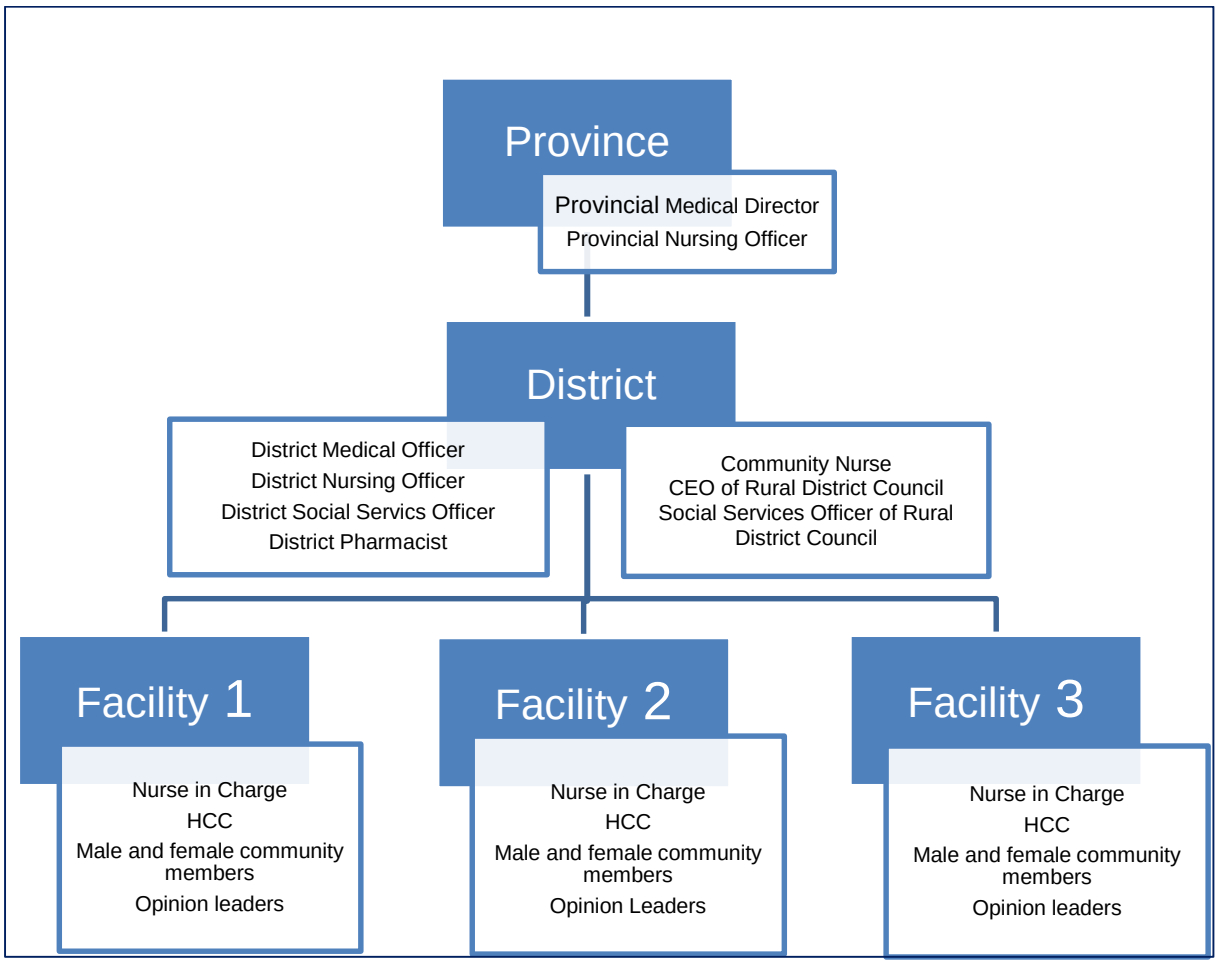
Qualitative data were collected at baseline in Bulilima District in Matabeleland South Province and Rushinga District in Mashonaland Central Province (the former predominantly Ndebele-speaking and latter Shona-speaking). We will also collect qualitative data at endline. At the time of the baseline study, the programme had begun in Bulilima District, but not in Rushinga, and therefore the initial round of fieldwork yielded programme information from the early stages of implementation, as well as baseline data through interview respondents’ and focus group discussion (FGD) participants’ recollection of the pre-programme period.

At baseline, the key questions we aim to answer are particularly linked to the ToC assumptions. This will provide the basis for revisiting and refining the ToC, in order to ensure that the initial assumptions are relevant and valid. At the endline, data will be collected on a range of areas to ensure the key evaluation questions are addressed. Key research questions and sub-questions are outlined in the evaluation matrix in Annex D.

3.3.1 Qualitative sampling strategy

Figure 1 below provides a visual depiction of the sampling conducted in the two districts where we collected baseline qualitative data. At endline we will follow the same sampling strategy, and will aim to return to the facilities and communities studied at baseline.

Figure 1 Qualitative component sample



Qualitative data were collected in three facilities per district sampled. For comparative purposes, in each district the sites comprised two treatment communities, where programme interventions are being implemented, and one comparison community, where no programme interventions are either being implemented or are planned. Within each district at least one field site for the qualitative component was within the quantitative survey's sub-sample.

The qualitative approach used sampling of small numbers of individuals and groups that are broadly representative of groups targeted by the programme to allow some identification of heterogeneous impact. At endline, the findings will build on the findings from the initial round of quantitative research, and will be further developed in light of the emerging quantitative findings.

Sampling districts

The selection of sites for this study followed a three-stage process: (1) sampling districts; (2) sampling individuals; and (3) sampling health centres and the surrounding communities.

Sampling health facilities and communities

The qualitative dimension of the evaluation sampled respondents from the catchment communities' areas of treatment and comparison health facilities in each district. The number of communities varied depending on the number of villages served by each facility.

Sampling individual respondents

Annex O provides a summary of the respondents interviewed. The sampling strategy for individual respondents differed depending on whether the respondents are located at community and facility level or higher. At the provincial and district level, a purposive sampling approach was used: we interviewed individuals with relevant knowledge and involvement in health services in Zimbabwe. As the diagram above shows, the individuals interviewed included: HCC chairs/ heads; facility heads; heads of DHEs; District Medical Officers; District Nursing Officers (DNOs); CEOs and Social Services Officers of the Rural District Councils; Community Sisters; Community Health Sisters-in-charge; Provincial Medical Directors; and Provincial Medical Officers.

At community level, respondents included:

- women in the community, including adolescents;
- men in the community, including adolescents;
- members of HCCs; and
- opinion leaders (including religious and traditional leaders, local business persons etc.).[7]

By convening separate FGDs with, on the one hand, opinion leaders and HCC members, and on the other hand women and men in the community, the tendency of those with higher social standing to dominate the discussion and inhibit those with less socio-economic status from voicing their opinions was minimised.

3.4 Limitations of the evaluation

This section outlines the limitations of the evaluation. In this section we briefly discuss these challenges, and how our approach affected the findings and conclusions presented in this report.

First, the quantitative data collection made use of a health facility survey and so we did not interview people who do not use health facilities. Thus, we cannot gain insights into the reasons for not using health facilities. Furthermore, in the qualitative study, it was not practically feasible to convene separate FGDs with users and non-users. However, care was taken, particularly in FGDs with female community members, to ensure that non-users were represented, and the facilitators were briefed as to the importance of identifying and including non-users, and making sure that their views and opinions were elicited alongside those of users. We recognise that, due to the approach taken in regard to gathering data on reasons for non-use, our findings are indicative of the experience of the respondents in the qualitative study sites, and are not meant to be generalisable.

[7] Where relevant, the FGDs with opinion leaders specifically included leaders of Apostolic organisations, such as the 'Vapostori', a group whose beliefs discourage women and children from accessing MNCH services. SC's advocacy strategy includes engaging with the Union for Development of the Apostolic Churches in Zimbabwe Africa (UDACIZA) to influence access to health care by women and children.

A second limitation is that the baseline evaluation does not address national level actors, which means that in this report we are unable to assess the attitudes of national level decision-makers, the extent to which information collected at community level reaches national level actors, or how such actors are likely to engage with programme activities. However, we did examine the pathways that such information would take to get from the facility to the district to the province, and we feel that the qualitative data collected about these processes are indicative of the opportunities and challenges that would also be involved in influencing national stakeholders. At endline, we will seek to interview relevant actors in health-related ministries and public officials at the national level, and use their recall of the programme period to identify to what extent evidence about MNCH service delivery has reached them from community level, and how (as well as whether) the programme’s planned Parliamentary Committee Meetings have influenced their decision-making on MNCH issues. We will also seek to interview media and civil society actors linked to the programme, as well as to examine secondary data sources where possible to assess the profile and perceived effectiveness of the programme’s planned mass media advocacy campaigns. Lastly, during the endline evaluation we will seek to interview legislators and review secondary data sources to assess what changes in regard to the recognition and regulation of HCCs have become part of national public health policy, and how these changes came about.

Finally, the evaluation relies on secondary data to assess the quality of health services; we therefore do not have control over the quality of these data

4 Context

This section discuss the context in which the programme is operating. It will highlight contextual factors that might affect the programme's implementation in a positive or negative way. We will also discuss any contextual factors that might influence the programme's intended outcomes or impact. Furthermore, this section will also highlight what the context tell us about how this programme might affect different groups differently (heterogeneity) and what the context tell us about how this programme impact might be the same or different if it was rolled out on a larger scale (generalisability). This section has been structured into discussions of the social, economic, political, and health contexts in Zimbabwe.

4.1 Social context

Zimbabwe has a population of approximately 13.5 million people, and the average population growth over the past 12 years is estimated to have been 1.2% a year.[8] The population structure is expansive, as is that of most developing countries, with a broad-based pyramid indicating high birth and death rates. In 2012, the national census showed that 1.978 million people (15% of the population) were under five years old.[8] The majority of Zimbabweans live in rural areas, with approximately 68% of the population residing in such areas and the rest in urban and semi-urban areas. The urban population is concentrated in the two largest cities, Harare and Bulawayo.

Rural life is characterised by lack of formal employment opportunities; 90% of those employed in the rural areas are self-employed. About 70% of women in rural areas are subsistence farmers, compared to just 35% of men. Women are also responsible for household work, which includes caring for the young. Men, on the other hand, constitute a much larger proportion of the formal employment labour force, with 75% of formally employed individuals being male.[9]

Nearly 23% of rural households are classified as extremely poor, compared to only 4% in urban areas. These extremely poor households tend to have children who are on average younger than the children in wealthier households. In such settings, where households are extremely poor, with larger numbers of children to provide for, the affected community members may perceive improving access to health care and the quality of health care services to be less important than income/food, so community mobilisation may be difficult, with direct relief programmes prioritised. Given that wealthy households and individuals have much lower rates of Rural Health Centre attendance than poorer individuals,[10] and given that they instead visit district and provincial hospitals more frequently, wealthy households may stand to benefit less from the programme than poorer individuals.

The national average household size is 4.2 members. Rural households are generally larger than urban households (4.7 in rural areas vs. 4 in urban areas).[11] Extremely poor

[8] 2012 census. http://www.zimstat.co.zw/dmdocuments/Census/CensusResults2012/National_Report.pdf.
[9] Luebker, M, 2008. 'Employment, Unemployment and Informality in Zimbabwe: Concepts and Data for Coherent Policymaking'. Issues Paper No. 32 and Integration Working Paper No. 90 International Labour Organization (ILO) Sub-Regional Office for Southern Africa Harare, Zimbabwe and Policy Integration and Statistics Department, International Labour Office, Geneva, Switzerland
[10] For example, 60% of the inpatient admissions (over the six months preceding the RBF impact evaluation household survey) were individuals from the poorest wealth quintile, while only 10% of the admissions were individuals in the wealthiest quintile
[11] Zimstat, 2013. 'Poverty and Poverty Datum Line Analysis in Zimbabwe 2011/12', p. 52.

households, mostly found in rural areas, tend to be even larger, with a national average household size of 6.2 members. In the baseline survey, average household size for under-five users is 5.4 and average household size for ANC users is 5.

Official employment figures estimate a national unemployment rate of under 10%. Eighty-five percent of those employed are in the informal sector, where work is often cyclical and earnings are typically below $200/month. The government is the largest formal employer in the country and average salaries for teachers, nurses and military service personnel, who form the bulk of the public sector, are typically around $450/month.[12]

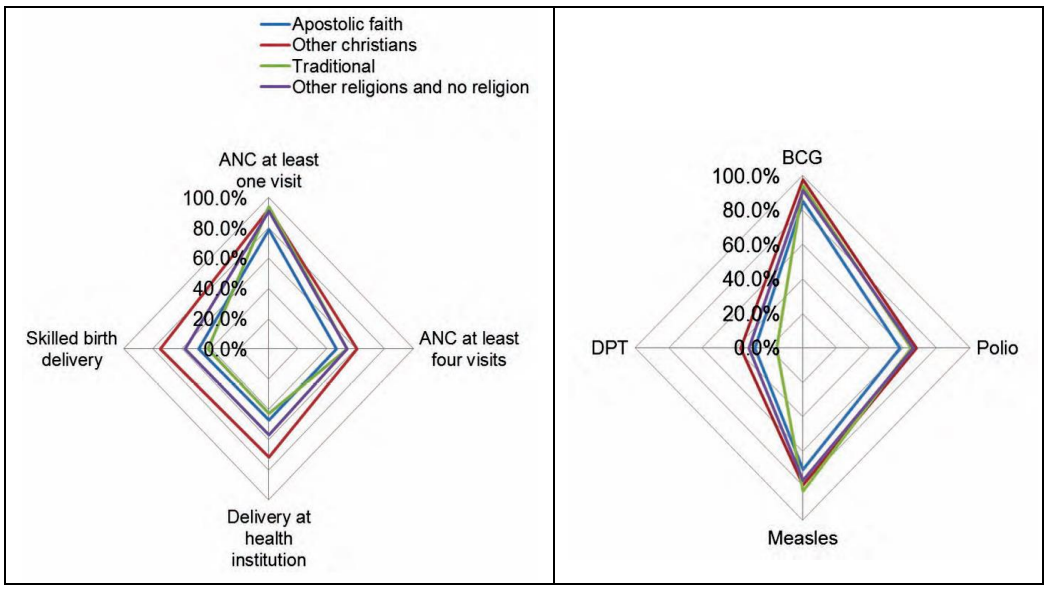
Church groups, burial societies and savings and credit groups are the most common informal organisations in the community and most people are members of at least one of these. The church is the single largest of these social institutions, as the country is predominantly Christian, with about 85% of the population belonging to this religion. The majority of Christians are members of the traditional Christian churches, Protestant and Roman Catholic. Approximately 43% of Christians are Pentecostal, Protestant and Roman Catholic while 33% belong to Apostolic churches.

The members of Apostolic churches are a group that are of particular interest in the context of MNCH utilisation in Zimbabwe. It is estimated that 73% of their members live in the rural areas. Of these rural members, 64% are women and the majority of these are aged between 20 and 29 years,[13] which also happens to be the median child-bearing age group for women in Zimbabwe. Although this is by no means one homogenous church group, the majority of the Apostolic churches are 'ultra conservative', with strong adherence to faith-based healing that has strong sanctions for violating church doctrine, which includes non-use of modern health care services. Some of these sanctions include confession, shaming or re-baptism. Research[13] identifies membership to this faith a potential barrier to MNCH utilisation; some of the evidence in this regard is shown in Figure 2 below.

[12] Zimbabwe has a high cost of living. The total consumption poverty line for Zimbabwe stood at $102.00 per person in January 2014. This means that as at January 2014 an individual required that much to purchase both non-food and food items in order not to be deemed poor (http://www.zimtreasury.gov.zw/189-poverty-datum-lines-january-2014). The average household sizes, employment rates and 'typical' earnings thus place most households below the poverty line.

[13] Muchabaiwa, L., Mazambani, D., Chigusiwa, L., and Mudavanhu, V. (2012). 'Determinants of Maternal Healthcare Utilization in Zimbabwe'. *International Journal of Economic Sciences and Applied Research* 5 (2): 145-162 (research also shows that traditionalist and Apostolic faith women are 25% less likely to use public health services than those from other religions).

Figure 2 Utilisation of health services among various religions in Zimbabwe[14]



According to the study that produced the diagram shown above, Apostolic church members have the lowest levels of ANC1 (first ANC visit) and ANC4 (fourth ANC visit) attendance, and immunisation rates, along with generally lower rates of primary health care utilisation in relation to skilled birth attendance and delivery at a health institution. Apostolic church group representatives may not readily support programme implementation and the programme may have a limited impact in areas with high proportions of Apostolic church members, unless there is a specific targeted approach for this group. In such areas, service utilisation may remain low unless the targeted efforts to incorporate them in the programme are effective.

There is a high level of literacy in Zimbabwe, at over 90% (national), and there continues to be strong support for school attendance. In the baseline study, 88% of ANC users reported having completed at least primary school, while 86% of the carers of under-fives completed primary school or higher. The average literacy rates from the baseline survey are close to the national literacy rate, and this would suggest that the target and comparison districts in the baseline survey do not have different levels of education to the rest of the country. With higher rates of participation in social institutions linked to higher levels of educational attainment,[15] the programme can, in general, expect good rates of participation.

Non-governmental organisations (NGOs) dominate relief and advocacy programmes and are widely accepted and appreciated by communities and participants, such as health care workers in this case. Through the HTF and bilateral agreements between the Government of Zimbabwe and *global funders of aid*, donors have funded visible improvements in the conditions of employment for health workers and in the availability of essential medicines and basic services. This is likely to ensure excellent cooperation from health workers in the target health facilities. Because most communities are very familiar with, and are largely receptive to donor/NGO work, the programme can expect a high level of interest initially.

[14] UNICEF (2011). 'Access to Health Services and Religion in Zimbabwe', May 2011.
[15] Gregson *et al*., 2004, found that community members with secondary school education were more likely to be part of a social institution such as a church group, peer support group, or other associative social arrangement than those with no schooling.

The larger, more prominent NGOs are well known for their relief efforts, mostly donating food, clothes, money, farming inputs, medicines and vaccines. This may create an expectation of 'hand-out' type benefits from the programme, and community interest may subside after the initial sensitisation, once communities realise there are no direct material benefits. There have been cases where NGOs have sometimes not delivered the promised results, leading to mistrust of them among these communities. In some cases, therefore, communities may not be immediately enthusiastic about the intervention, and may need to see quick results from the programme before they are willing to fully engage and participate.

4.2 Economic context

Zimbabwe endured a nine-year economic recession between 2000 and 2009, with GDP per capita falling by nearly 42% from $840 to $487 during this period. The economy stabilised in 2009, following the dollarisation of the economy, and since then has experienced some growth. GDP growth between 2010 and 2014 has averaged 7%, although the last two years have seen only modest growth (4.4% in 2013 and 3.7% in 2014). The largest sectors are manufacturing (20%), agriculture (17.8%) and transport and communication (16%). Despite the growth, the economy still faces many challenges and is characterised by tight liquidity conditions, company closures, rising formal unemployment and a disproportionate trade balance.[16]

The current macro-economic framework is the five-year (2013–2018) Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim-Asset).[17] This framework envisages 'an empowered society and a growing economy' and has four main focus areas (called clusters), namely: i) food security and nutrition; ii) social services and poverty eradication;[18] iii) infrastructure and utilities; and iv) value addition and beneficiation. Clusters i) and ii) have a direct bearing on children – they affect the availability of adequate food (the right amount and of the correct nutritional value) and the availability of social services, such as health care. Clusters iii) and iv) shape the institutional environment within which children live – by aiming to provide, for example, a legal framework in which the rights of the child are protected and promoted. The current macro framework in Zimbabwe is thus closely aligned to some of the main aims of the programme, particularly as they relate to the improvement of health services and establishing an enabling policy environment in which rights to those services are enforced.

Since 2009, the improving economy has seen an increase in expenditure by government on basic services and, according to the UN Development Programme (UNDP), Zimbabwe achieved its best Human Development Index score since 1980[19] in 2013. However, most health indicators are still below the levels required for Zimbabwe to achieve the health-related Millennium Development Goals (MDGs). If government is providing better basic services, this can build population-level confidence in primary health care and can help increase utilisation of basic health care services in general.

[16] Monetary policy Statement, Reserve Bank of Zimbabwe, August 2014.
[17] Zim-Asset 2013: available at: *http://www.herald.co.zw/wp-content/uploads/2014/01/Zim-Asset.pdf.*
[18] One of the social service delivery strategies includes 'undertak[ing] a national blitz to rehabilitate water supplies, sewage systems, roads, health facilities, waste management, schools and social amenities in all local authorities', Zim-Asset, 2013:65.
[19] Data available at: http://hdr.undp.org/en/content/human-development-index-hdi.

4.3 Political context

The Government of Zimbabwe is generally sensitive to criticism about its commitment towards providing basic services and improving their quality. While there are some accountability mechanisms in place, such as the Comptroller and Auditor General, and commissions for human rights, gender, media, anti-corruption, peace and reconciliation, among others,[20] the Government of Zimbabwe has historically shown limited interest in widespread public engagement. In recent years, however, the government has shown increased commitment towards improving the availability and access to health, measured by the growing budget allocation to basic health, and by the fact that the MoHCC has largely met its contribution commitments towards the multi-donor HTF fund.

Although official diplomatic ties between Harare, London and Washington remain complex, government policy is that all donor assistance is welcome and appreciated, as long as donors work in the best interests of the people and the government, and within the rules and regulations of the country. There is genuine support for donor activities in Zimbabwe, especially in health. As examples, donors recommended that the MoHCC Permanent Secretary chair the HTF steering committee, and in various meetings attended with donor partners it has been reported that this arrangement has been working very well. There has been a mutual improvement in donor/government perceptions, and government has recently increased funding to the RBF programme, a donor led initiative, for 2015, while the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) will, from 2015, channel more than $100 million of aid through government channels. Therefore, the programme can expect to engage freely with the target communities, as long as adequate sensitisation is achieved and relevant permissions are sought. It may be worth noting that government still reserves the right to suspend any operating licences held by donors, and the programme will need to avoid any political associations and affiliations.

Centralised power structures exist from the national level down to the rural district level, with low-level administration/leadership positions often appointed or directly influenced by central government. Given that national government supports the programme, DHE are likely to respond well to NGOs and to support the programme as long as the MoHCC's support to programme remains clear. Notwithstanding this, local politicians still have an influence in local politics and variations in the local political economy of the districts involved may influence programme outcomes and impacts across different districts.

Zimbabwe has experienced election violence in the past, with some elections severely disrupting daily life.[21] A elections are approaching in some politically sensitive districts where the local political situation remains tense for considerably longer periods after an election, and/or where volatility increases considerably sooner, than in other areas, communities may not be sure of the implications of participating (or not participating) in the programme. If they are unsure of the political implications of their participation, a subdued level of engagement may be experienced in those communities. The programme is most likely to work best in communities with low levels of political polarisation, higher levels of social trust and good social networks.

[20] UNICEF, October 2014, 'Update on the situation analysis of children and women in Zimbabwe'.
[21] Human Rights Watch (2009). 'Perpetual Fear Impunity and Cycles of Violence in Zimbabwe'.

4.4 Health context

The health context in Zimbabwe is strongly linked to the economic context. Economic challenges through the late-1990s and into the last decade contributed to a massive reduction in health spending, from approximately $42 per capita in 1992 to just over $6 per capita in 2009. The late-1990s saw a rise in HIV prevalence to a peak of between 27% and 30% in 1999. The economic challenges precipitated extensive out-migration – a 'brain drain' – especially of skilled health personnel, mostly to the UK and to neighbouring countries such as South Africa and Botswana. Such was the extent of this brain drain that a study estimated that in 2006, 24% of the nurses and 51% of Zimbabwean doctors were working abroad.[22]

The result of all these, and other, challenges has translated into a rapid deterioration of most key health indicators, notably MNCH indicators. Since 2010, a combination of economic stability, a greater commitment towards providing basic health services and increased donor funding in Zimbabwe has seen an improvement in the availability of essential health services, and subsequently in key health indicators. Shortages of highly skilled personnel still persist, although there has been an increase in mid-wife, nurse and doctor attendance at primary health care facilities. Table 4, immediately below, shows the trends in some of the main MNCH and health indicators in Zimbabwe over the past decade, while Table 5 shows the donor contributions to health in 2015.

Table 4 Trends in key health indicators in Zimbabwe, 2004–2014

Health Indicator	2004/2005	2009/2010	2013/2014
Life expectancy at birth[23]	43	51	58
Adult HIV prevalence[24]	19%	15%	15%
TB incidence[23]	800/100,000	633/100,000	600/100,000
Malaria incidence[25] (suspected cases)	153/1,000	58/1,000	21/1,000
Maternal mortality ratio	830/100,000[23]	960/100,000[26]	614/100,000[27]
Infant mortality rate	60/1,000[28]	57/1,000[26]	55/1,000[27]
Under-five mortality rate	74/1,000[29]	84/1000[26]	75/1000[27]
Proportion of deliveries with skilled birth attendant/in facility		66%[26]	80%[27]
Percentage infants fully immunised	53%	65%[26]	69%[27]
Proportion of pregnant women attending at least four PNC visits		65%[26]	70%[27]
Percentage of health facilities with over 70% of essential medicines available[30]		25%	88%

[22] Clemens, M. and Pettersson, G. (2008). 'New data on African health professionals abroad'. *Human Resources for Health,* 6(1).
[23] Word Development indicators, World Bank: http://data.worldbank.org/country/zimbabwe.
[24] UNAIDS indicators: http://data.unaids.org/Publications/fact-sheets01/zimbabwe_en.pdf.
[25] UNDP, May 2013
[26] Demographic and Health Survey (DHS) 2010–11.
[27] Multiple Indicator Cluster Survey (MICS), 2014.
[28] ZimStat 2010/2011.
[29] http://www.childmortality.org/index.php?r=site/graph#ID=ZWE_Zimbabwe.
[30] Vital Medicines Availability and Health Service Survey (VMAHS) rounds 6 and 21.

There has been a notable improvement in many of the indicators between 2009 and 2014, as Table 4 above shows. Despite these improvements, a number of key challenges in health remain and these include:

- the sustainability of health funding (more than 35% of health funding in 2014 was from official development assistance);
- health-seeking behaviour among the poor remains lower than among the better off, regardless of service availability and quality;[31]
- institutional capacity to plan and formulate clear policies remains weak in some areas;
- most health indicators are still below the levels required for Zimbabwe to achieve health-related MDGs;
- weak referral and patient management systems;[32]
- quality gaps in the delivery of best practices for routine MNCH services; and
- no national-level focused and measurable process of measuring care quality.

Expenditure on health by donors has increased since 2009, with the Global Fund being the largest single contributor to health interventions in Zimbabwe.

Table 5: Contributions towards health initiatives by main donors in Zimbabwe (2015 budget)

Donor	(USD millions)	% of health donor funding	Main health initiatives funded
UNDP/Global Fund	119.8	32.6%	HIV/AIDS, malaria and TB commodities procurements and health systems strengthening initiatives
United States Agency for International Development (USAID)	85.7	23.3%	HIV/AIDS, malaria, TB prevention activities, behaviour change communication, technical support to health systems strengthening
UNICEF	44.9	12.2%	HTF – human resources in health retention, health commodities and equipment, training of midwives and outreach support
Centers for Disease Control and Prevention (CDC)	31.9	8.7%	Infection prevention and control, epidemiological surveys, health data dissemination and use (District Health Information System (DHIS) 2), male circumcision, antiretroviral therapy (ART) initiation
EU	31.6	8.6%	$28m towards HTF, and community accountability for health,
DFID	27.0	7.3%	Contribution to HTF, sexual reproductive health services commodities and integrated services, monitoring and evaluation (M&E), community accountability

[31] According to the PICES survey, 38.5% of the non-poor did not seek care when sick, compared to 45.8% of the extremely poor (PICES survey, 2011/12). According to the ZDHS 2010/11, 51.7% of the poorest households did not send their last born to a health facility in case of diarrhoea, compared to 54.3% from the richest households

[32] Mutasa, R & the Zimbabwe Health Team (World bank), 2013. RBF in Zimbabwe-Design Evidence and Early Lessons on Pay-for-Quality

Embassy of Switzerland	10.9	3.0%	Child protection fund, psychosocial support, HIV/AIDS prevention programme, policy and legal environment for sexual reproductive health
Embassy of Sweden	10.7	2.9%	$7m contribution to HTF, integrated support programme (ISP) for sexual reproductive health, cervical cancer, HIV, gender-based violence services
Irish Aid	3.4	0.9%	$2.5m contribution to HTF, ISP
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	1.0	0.3%	HIV prevention
Norway	0.7	0.2%	HTF contribution
Total	**367.53**		

* There may be some duplication, especially where multiple bilateral donors have contributed to a multilateral-led activity, such as the HTF.

The World Bank and UNICEF, through funding from multi-donor trust funds, are helping the Government of Zimbabwe to implement a national RBF programme. The transition of the HTF to a RBF model was initially scheduled for June 2014. There were some delays, however, and this deadline could not be achieved, but health facilities received their final payments under HTF in late 2014. Subsequent quarterly disbursements of funds to health facilities, from January 2015, are to be under the RBF model.[33]

The RBF model is structured around three primary design components: results-based contracting; management and capacity building; and monitoring and documentation. The RBF model has the following key features:

- health facilities receive financial incentives for performing according to pre-agreed standards and quantity of services – with HCCs playing an important role in community participation and involvement;[34]
- financing is decentralised so that health facilities will purchase equipment/commodities, verify service utilisation and engage in strategic management of the facilities. It requires improved health facility governance to enable effective planning for use of resources generated under the programme; and
- Health facilities will be monitored on a quarterly basis using a quality of care checklist administered by MoHCC staff and a client satisfaction survey administered by community-based organisations. The quantity of services will be measured using the HMIS, which is being regularly verified by Crown Agents.

[33] Actual payment will depend on when the specific health facility is able to meet the RBF conditions for disbursement, which include submitting complete financial reconciliation records for the previous quarter (acquittals). As the system transitions to the RBF, health facilities not fully compliant with RBF requirements may experience a delay in payments, which could affect the quality and scope of services provided in the short term.
[34] The Government of Zimbabwe recognises the importance of community participation in the improvement of health outcomes, and one of the objectives of the National Health Strategy (2009–2013) is to 'Enhance community participation and involvement in improving health and quality of life' (Government of Zimbabwe , 'The National Health Strategy for Zimbabwe 2009–2013. Equity and Quality in Health: A People's Right'.)

One of the implications of the RBF model is that there will be a closer focus on results. The RBF model creates a need for much improved financial auditing and monitoring, and health statistics quality will also need to be strengthened to ensure the system works effectively. There are various initiatives to address some of these challenges, for example, the United States CDC is working with government to finalise the new DHIS 2.

Under an RBF model, poorly performing health facilities could create health service provision gaps among vulnerable populations, as future resources/budgets will be based on past performance. An RBF model can lead to disparities in levels of service and quality of healthcare across the country, with poorly performing health facilities failing to get additional funds with which they can provide adequate health care services.

The introduction of RBF is likely to produce a change in the relative importance of some of the HCC roles. One of the main roles of HCCs is community mobilisation, and, in the context of very limited resources and irregular cash disbursements from the Government of Zimbabwe to health facilities before the RBF (and the outgoing HTF/HTF-plus), HCCs had to mobilise financing from the communities to be able to cover some running costs such as the cost of security guards, maternity feeding shelters, improvement of toilet facilities etc. With the introduction of RBF, some of this work may no longer be as important, as most facilities are expected to perform at a level that will guarantee adequate funding for at least the most basic services and provisions.

Under the RBF model, HCCs have a responsibility to prioritise expenditure at health facilities. This role will therefore affect how effectively the RBF funds are used. HCCs are responsible for deciding how the money received at the health facility is spent and if the HCCs are well governed: use of funds will be prioritised according to community health needs. HCCs will thus have an instrumental role in improving the allocation of RBF funds – with funds prioritised according to the specific needs of a community. Conversely, poorly governed/working HCCs may result in inefficient allocation of RBF funding if their prioritisation of expenditure is not aligned to that of the communities they serve. HCCs thus have an allocative role in the spending of RBF finances.

Another key role of the HCCs, in the context of the RBF, is improved health governance. RBF requires that health facilities develop annual operating plans and HCCs are an integral part of this planning process. The involvement of HCCs in planning can be expected to help communities understand better what the RBF is, how it works, and some of its benefits. If understanding the nature of interventions in a particular community is linked to greater ownership and support for such a programmes, then HCCs may well serve as a communication and dissemination platform for the RBF, and could lead to better engagement by communities.

5 Key baseline findings

This section will describe the baseline situation of indicators that are expected to change as a result of the programme. Thus, this section relates to the impact DAC criteria. The outcomes are presented in the order in which they appear in the ToC. The data used to inform this section comes from both our quantitative and qualitative sources and relates to:

1. the quality and functionality of HCCs;
2. knowledge of rights and entitlements;
3. decision-making regarding community and health facility resources;
4. complaints mechanisms at health facilities;
5. technical quality of health facilities;
6. perceived quality of care; and
7. MNCH service utilisation.

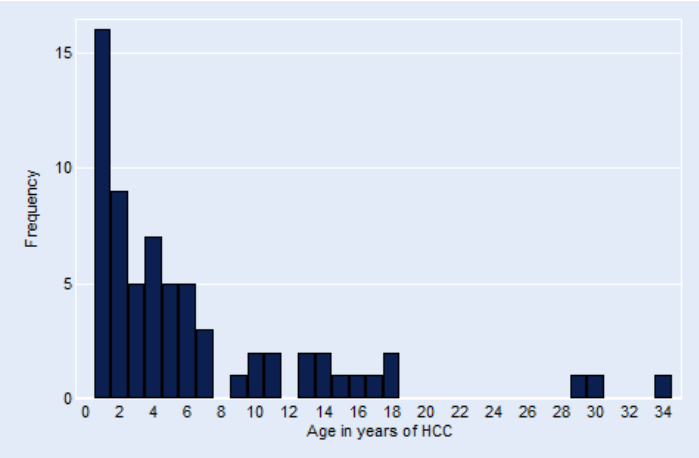
5.1 Quality and functionality of HCCs

Almost all facilities (99%) have some kind of health committee but they are not always called an HCC. Eighty-eight percent of facilities have an HCC and approximately one-quarter have another committee as well (called a Ward Health Committee, a Sub-Health Committee, a Ward Health Team or a Ward Health Sub-Committee). As the country is presently in a period of transition, as it is transferring responsibilities from Ward Health Teams/Committees or Sub-Health Committees to HCCs, for the purpose of the results presented below we refer to all of these bodies as HCCs, but of the committees we spoke with 86% identified as HCCs and the remainder as Ward Health Committees, Sub-Health Committee, Ward Health Teams or Ward Health Sub-Committees.

A summary of the key results regarding the quality and functionality of HCCs is presented below:

- The average age of the HCC is 6.5 years and the average number of years since the most recent HCC election is 1.57 years.

Figure 3 Age of HCCs



- Table 6 below shows the composition of HCCs. The HCCs have an average of 8.7 members, of which 4.7 are men and 4.0 are women. In the case of almost all HCCs interviewed for the quantitative survey nurses in charge are represented, as well as

'ordinary community members'. It is also very common to find community health workers, traditional community leaders and political leaders on the HCC.

- The composition of the HCC varies in both districts where the qualitative study was conducted. For example, in Bungwe, Rushinga District the HCC includes four men and three women members, representing farmers, ordinary community members and community leaders or opinion leaders. However, no members of the Apostolic church are represented on the HCC, despite the fact that the majority of community members belong to this religious group. In this instance, it is likely that the voice of Apostolic church members is not represented because they have opted out of the health system for reasons to do with doctrine rather than individual freedom of choice. The HCC of Makhulela clinic, Bulilima District, includes representatives from across the five villages in the catchment area, including people living with HIV/AIDS, traditional healers, health staff, community and church leaders, and youth. However, it is heavily unbalanced in gender terms, with eight male members and only one female member (for context, the survey found that HCCs have an average of 8.7 members, of which 4.7 are men and 4 women). Elsewhere (particularly the other study areas in Bulilima District), some respondents perceive female HCC members to be playing a principal role in influencing decisions on MNCH taken by the HCC. It should be noted that in both districts where the qualitative study was conducted, members or chairs of the HCC are more likely to express this opinion than men or women interviewed in the community, illustrating a possible inconsistency between how HCCs function and how people believe they function.

  > *Since the Chairperson is a woman we have a strong say in the committee. [We] do not put politics in the committee. We are united and work together.* (HCC member, Bulilima District)

  > *Women are the most vocal people in the group and the issues we deal with as the HCC affect women the most so their ideas are the most relevant and valid. The location of the waiting mothers' shelter was a woman's idea.* (HCC Chairperson, Bulilima District)

Table 6 HCC membership

	Sample mean	N	Lower 95% CI	Upper 95% CI
Number of HCC members				
Total	8.68	143	8.17	9.19
Male	4.74	145	4.40	5.08
Female	3.97	143	3.61	4.32
Proportion of HCCs where the following are represented				
Nurses in charge	0.96	145	0.93	0.99
Ordinary community members	0.92	145	0.88	0.97
Local political leaders (e.g. councillors)	0.75	145	0.68	0.82
Traditional community leaders	0.67	145	0.59	0.75
Community Health Workers	0.66	145	0.58	0.73
Church representatives	0.51	145	0.43	0.59
Other health facility staff	0.49	145	0.41	0.57
Government extension workers	0.46	145	0.37	0.54

School headmaster/health master	0.41	145	0.33	0.49
Youth organisation	0.33	145	0.25	0.41
NGO/civil society organisation (CSO)	0.18	145	0.12	0.24

- The chairperson and the treasurer are most likely to make decisions in the HCC but there is strong participation from other members (secretary, health workers, vice chairperson), and in some cases, ordinary community members.

- The committees meet just under once per month and are good at keeping records of their minutes. The nurse in charge was more likely to be able to show us the records than the HCC member interviewed, and in both districts covered by the qualitative study was particularly knowledgeable about the roles and functionality of the HCCs.

- Almost all (97%) committees visit the health facilities for monitoring but just under one-third (31%) keep records of the visits. The committees report an average of 15.9 monitoring visits in the past 12 months but their records show substantially fewer (9.6 visits). The monitoring visiting is used to check on the delivery of services, progress against the facilities operational plan, the cleanliness of the facility and the state of infrastructure.

- 86% of committees meet with the community. The committees meet with the community about once every two months, and record-keeping is good but not as good as for their internal meetings, with about 71% keeping minutes; of those only 31% could show the minutes to our team. The qualitative study found that HCCs also commonly meet with village heads rather than with the community members.

- Only 56% of committees meet with the DHE. They generally report that they are adequately kept up to date on health developments by the DHS, with only 12% reporting that they are rarely or never kept up to date—though the level and quality of the HCC’s contribution and participation in these meetings is not clear and may be limited by the fact that many HCCs have low capacity and are not aware of their role.

- Most (84% as reported by the nurse in charge, or 66% as reported by the HCC member that we interviewed) of the committees had implemented a new initiative in the past 12 months. The initiatives were most commonly in the areas of providing new infrastructure, conducting repairs, buying supplies, providing security or improving the environmental sanitation of the facility. 73% of HCCs undertook other initiatives apart from the new initiatives mentioned above. Of these, the most common activity was sensitisation / community mobilisation, with mobilisation around building projects in particular being widely mentioned in the qualitative study.

- 30% of committees raise money for the facilities and the average amount raised is US$879, which is quite a significant amount given that it is approximately 11% of the average annual amount received from HTF/HSF/RBF. The funds are used for new infrastructure, repairs and to ensure the security of the facility.

- Across study sites, HCC members appear motivated to continue working as volunteers, but widely mention their desire for incentives. In both Rushinga and Bulilima Districts, HCC members expressed interest in cash, in-kind and logistical support, including mobile phones for communication, transport to attend meetings,

and food and refreshments. These incentives are generally not seen as being equal to payment or a salary, but are described as 'boosting the morale' of volunteers.

Some areas where there is significant scope for the HCC's quality and functionality to improve are:

- Both quantitative and qualitative data sources found that the HCCs are not well known in the community (only about one-quarter of ANC patients and carers of under-fives knew of the HCC in their community) but of those who were interviewed in the survey and who do know of the HCC, most think they are providing a valuable service. This result remains the same when results are disaggregated by HCC quality and the poverty status of the respondent. This means that people living in communities with better functioning HCCs appear no more likely to have heard of the HCC than those living in communities with less well-functioning HCCs. Also, richer people are no more likely to have heard of the HCC than poor people. However, as discussed further in Section 5.8, it is encouraging to see that community members who have received some training on patient rights and entitlements in the past 12 months are more likely to have heard of the HCC.

- However, respondents in both study districts of the qualitative study widely perceived the HCCs as being non-functioning and having produced few tangible changes in the quality of services, particularly as compared to Ward Health Teams, which are better known and are perceived to be creating tangible changes.

- The HCCs in the catchment communities of the six health facilities studied for the qualitative baseline displayed varying levels of recognition. In Rushinga District, HCCs were widely recognised by respondents at provincial, district, facility and community level, though some female respondents in Bungwe reported being unaware that there was an HCC. In contrast, in two of the three study sites in Bulilima District (Makhulela – comparison, and Masendu – treatment), community level respondents—groups of local men and women—reported that they had not heard of HCCs before or were not aware of the existence of HCCs at their facilities. Some respondents assumed that the HCC was a group that only works with village heads and gave this account to explain why the HCCs had not engaged with community members.

  > *The HCC role is recognised by the community mainly because the community attends every meeting called for by the HCC. As for the higher authority they recognise the role of HCC, they include the HCC in every developmental meeting organised by the District Health Executive Team. Also the facility staff invite HCC to every facility planning meeting.* (HCC Member, Bungwe, Rushinga District)

- In both districts where the qualitative study was conducted, community members who are aware of HCCs typically tend not to have a clear understanding about their mandate, or how it is distinct from that of the Ward Health Teams, which have a long-standing and, thus, better understood role. Of the quarter of ANC patients and carers of under-fives surveyed who knew of the HCC in their community, most (93% of ANC patients and carers of under-fives interviewed at the facility) think they are providing a valuable service. However, some people are not clear about the HCCs' mandate and function and how HCCs differ, if at all, from the Ward Health Team. Discussions with HCC members indicated that they themselves are often unclear of their function

and mandate, particularly in the study areas—those listed above, Makhulela and Masendu—where community members are unaware of their existence.

> *We are not very useful. We have not done much to develop the clinic because of not being sure of how to handle the responsibility and what is required of us. We as the HCC are not sure what is really expected of us.* (HCC Chairperson, Bulilima District)

> *People know there is an HCC but do not know its function.* (Female respondent, Bungwe, Rushinga District)

- Less than one-third of committees had copies of the HCC handbook and the Patients Charter and, of those, about half could show their copies to our team.

- Most HCCs do not regularly display MNCH statistics in the facilities. When we visited, 12% of HCC had the statistics available for our teams to see.

- Only about one-third of committees submit written reports on MNCH access and service provision to the DHE; the reports are submitted quarterly, on average.

- Most HCCs report having received training but nevertheless almost all believe that further training is needed. 81% of HCCs have received training to help them in their role in the past 12 months. The training was most often provided by the District Health Team and Ministry of Health staff. 13% and 9% of HCCs reported having received training from SC and CWGH, respectively. This allocation of those trained between treatment and comparison facilities is discussed further in Section 5.8, and the specific facilities are discussed in Annex R. The training was most often on preparing, analysing, monitoring and tracking budgets and the functions of the HCC. Despite most HCCs having received training, of those who received training 97% of HCC respondents feel that HCCs need further training on the functions of the HCC, mobilising financial resources, and preparing, analysing, monitoring and tracking budgets.

- Despite the fact that 99% of HCC members interviewed believe that discussions held in the HCC contribute to the improvement of people's health, 97% believe that the HCCs need additional support to perform their duties. 91% of HCC members interviewed reported shortage of money as the main challenge, and 13% reported that the main challenge was a lack of community willingness to participate. In Section 6.2 we discuss further HCCs' perceptions of their challenges and the support needed to meet these challenges.

Table 7 below provides an example of one HCC that is perceived to be functioning well, and one that is functioning less well, in Bulilima District, illustrating the variability in HCC quality.

Table 7 Comparison of functioning and non-functioning HCC

Functioning HCC	Non-functioning HCC
In this HCC, the community noted that it was the HCC that facilitated the construction of a laboratory at the clinic, the procurement of medicines, the purchase of new beds and blankets at the clinic, the provision of food for the waiting mothers'	This HCC was described by one respondent as 'old and clueless'. This is because, thus far, the HCC has not managed to put in place a complaints communication channel, the majority of complaints have not been addressed, and

shelter, and nutritious porridge for children under-fives. The higher authorities recognise the role of the HCC because they support them with training and a member was made a signatory to the health facility bank account. The HCC is responsive to women members' contributions, and is known to pass on community issues to the health facility staff. *The HCC is working really well. They bought curtains, benches, the ones we are sitting on, and also tubing for electricity. They are really developing.* (Male respondent) *They are developing so they are useful to us. They also bought machines for BP* [blood pressure] *testing and provide food for expecting mothers who will be in the shelter.* (Male respondent) *The idea of mobilising the community to bring material for the construction of waiting mothers' shelter was raised by women in the HCC committee (*Sister in Charge) *HCC is responsive in the sense that they collect complaints and handover to facility staff and make a follow up.* (HCC member)	community members and HCC members themselves are not clear of their roles and responsibilities, as against those of Ward Health Committees. No tangible changes or improvements had been made. *We have never heard of an HCC. Maybe they just work with the village heads.* (Female respondent) *We are not very useful. We have not done much to develop the clinic because of not being sure of how to handle the responsibility and what is required of us.* (HCC Chairperson) *The HCC is known to be there but they are not doing anything that we see. They need to be taught about how to be effective in their offices and be exposed to the other HCCs so they can learn from them and come and implement what they would have learnt for the benefit of the community.* (Village Health Worker) *We have not done anything tangible about complaints that have been brought to us.* (HCC Chairperson)

Source: Authors' own table, generated from qualitative research

5.2 Knowledge of rights and entitlements

Even though very few people were aware of the Patient's Charter per se, there was reasonable knowledge about rights and entitlements. The main source of information regarding patient rights was facility staff and general knowledge. Approximately three-quarters of ANC patients and carers of under-fives know that services are meant to be free. This information was most commonly obtained from facility staff or friends and relatives, rather than HCC/HLF/Community Health Workers.

39% of ANC patients and 44% of carers of under-fives said that they understood the rights of patients at the health facility, and again this information was most commonly obtained from facility staff or friends and relatives. There is no difference in the level of understanding of patient rights in communities with high and low functioning HCCs, which is consistent with the view that information is obtained most frequently from facility staff or friends and relatives. When disaggregating results by the poverty status of the respondents, we see that for ANC patients, richer people are somewhat more likely to understand their rights, but

there is no significant difference between richer and poor respondents as regards the carers of under-fives. The most commonly mentioned rights were:

- the right to health care and humane treatment (e.g. care, respect, consideration and dignity, receiving clinical care regardless of ability to pay, the right to competent health care regardless of sex, race and wealth);
- the right to confidentiality (e.g. the confidentiality of all patient's records, treatment and other information); and
- the right to a healthy environment (e.g. a clean health facility, safe use of equipment, safe disposal of equipment, etc.).

21% of ANC patients and carers of patients under-five reported having received training or information on patient rights and entitlements in the past 12 months – mostly from facility staff, but also from CWGH. The allocation of those trained between treatment and comparison facilities is discussed further in Section 5.8.

5.3 Decision-making regarding community and health facility resources

This section refers to the development and use of an operational plan and decision-making around money, in particular the funds received from through HSF/RBF/HTF. A summary of the key results is presented here:

- Most (91%) facilities have an operational plan. 98% of HCCs committee members we interviewed report that their HCC was involved in the development of the current operational plan for the health facility, and, of those, 92% consulted the community. However, as reported by the head of facilities, only 80% of facilities had involvement from the HCC in developing the operational plan.
- The health facilities are regularly visited by the HCC (approximately once a fortnight) and the DHE (approximately one a month).
- 99% of facilities received funds from HSF/HTF/RBF in the past 12 months. The mean amount received in the past 12 months was US$7716 (or US$1929 per quarter) as reported by the head of facility (the amount received in past 12 months as reported be HCC members was US$9742). The money was used to buy supplies, drugs or equipment by 92% facilities and it was also frequently used for repairs and new infrastructure.
- However, only 83% of facilities have a bank account and of those about one-fifth have trouble accessing it due to difficulties in the banking sector and the closure of some locally-owned banks. 95% report keeping a record of transactions to and from the bank account, but only 75% of all facilities were able to show us the records. 88% of HCCs are signatories to the facility’s bank account.
- The health facilities staff and the HCC are the primary decision-makers regarding spending the HSF/RBF/HTF money. Only 1% of the HCC respondents said that they felt the health facility expenditure was not at all in line with their priorities, 81% said it was fully in line, and 19% said it was partly in line.

- All expenditure is approved at district level. However, some respondents in the qualitative study, particularly in Rushinga District, expressed the view that local service providers have adequate decision-making power. In these cases, service providers themselves highlighted the ways in which they believe their contextual knowledge and successful implementation of MNCH-related strategies empowers them to make decisions. However, some respondents noted that although nurses have authority, the bureaucratic process and lack of resources limits service providers' ability to execute decisions once they are made. There appears to be a difference between the *perception* of being empowered (a sense of being entrusted by the district with creating MNCH strategies) and *evidence* of empowerment, which would be decisions made and acted upon with positive, sustainable effect.

  > *We have little authority because all the major decisions are made at district level so no change can be made if the district does not approve.* (Sister in Charge, Bulilima District)
  >
  > *As the staff we are the ones who know the problems so we can decide on what needs to be done, such as buying equipment.* (Sister in Charge, Rushinga District)
  >
  > *To some extent local service providers have sufficient decision-making authority to effect change since we come up with strategies to curb home deliveries.* (Sister in Charge, Rushinga District)
  >
  > *The decision-making authority is there but they lack resources to implement decisions made. At times they need approval from council when it comes to infrastructure renovation, which usually comes after a long time. We need to get approval from council for renovations and it takes time in coming.* (Sister in Charge, Bulilima District)

- Some respondents (DNOs) mentioned that district-level decision-making responsibility often rests with newly certified doctors whose priorities, interests, and skills tend to concern clinical matters rather than policy processes.

5.4 Complaints and monitoring mechanisms at health facilities

This section describes the availability and use of complaints mechanisms at health facilities.

- Only about half of all facilities have a formal mechanism (such as client surveys, or a complaints or suggestions box) to collect patient feedback, and these are not used very much. Of the 51% of HCCs that have a record of complaints by community members about the health facility and health service delivery in general for the past 12 months, only one-quarter could show the records to our team when we visited. Where we could review the records, we found a mean of 4.25 complaints recorded in the past 12 months, and of those an average of two were signed off by the District Health Team as being addressed.

- The qualitative study found no CMs in Rushinga District, where the project had not yet started at the time of the baseline research. Groups of CMs have been identified at all three study sites in Bulilima, though only one group had received training at the time of the baseline study.

- As reported by the head of facility, the average number of times in the past 12 months that the HCC had informed health facility staff about patient opinions or complaints was 3.9 (so about once per quarter) (5.5 times in the last 12 months as reported by HCC). The average number of times changes occurred at this facility as a result of patient opinion in the past 12 months was 2.9.

  > *As the HCC our role is important because we pass and receive complaints from the community and share with the facility staff. We collect community views and give them feedback through meetings with them.* (HCC member, Rushinga District)

- Both quantitative and qualitative sources found that very few patients knew of the HCC. However, the health facility survey found that those who did know of the HCC felt that they could easily complain to the HCC if they were unhappy or unsatisfied with the health staff or facility, and that the HCC would act on their complaints. In contrast, the qualitative study found that, among those who did know of the HCC, opinions varied as to whether they would use the HCC as a complaints mechanism.

- Most (62%) of HCCs report that health facility staff are very responsive to complaints and only 2% said health facility staff are not at all responsive to complaints. The DHE was seen as less responsive, but still viewed positively overall, with 41% saying the DHE was very responsive to suggestions and 4% saying the DHE was not at all responsive.

- If they were unhappy about something at the facility, only 59% of ANC patients and carers of under-fives would complain – mostly to the nurse in charge. Both qualitative and quantitative data shows that if they would not complain this is generally because they do not know where to go to make a complaint, or they are afraid of what would happen if they did.

- There is no difference in the likelihood that an ANC patient or carer of under-five would complain when comparing those living in communities with high and low functioning HCCs, suggesting there is significant scope for the HCCs to improve in this regard. When disaggregating results by the poverty status of the respondents, we see that for ANC patients, richer people are somewhat more likely to complain about infringements of their rights, but there is no significant difference between richer and poor respondents in regard to carers of under-fives.

- The findings show that community members, opinion leaders and service providers have a range of opinions about how complaints are currently handled, or should be handled, some of which do not include the HCC as part of the solution. Respondents reported that complaints can be made in a written form and put in suggestions boxes (although nurses have been known to remove suggestions boxes at one study site, and Madlambudzi and Masendu clinics in Bulilima do not have suggestions boxes).Alternatively, community members can approach their leaders with their complaints, who in turn are expected to deal with the issues quickly and effectively, and then provide feedback. However, in both districts where the qualitative study was conducted, community-level respondents say that it is not clear whether that feedback has influenced decision-makers at district level, or how the complaints reach them in the first place. In contrast, district-level decision-makers, particularly in

Rushinga District, expressed awareness of the need to incorporate community-level concerns brought by the HCC into their plans.

> *The channel for feedback is really not clear. Because it's from the community to the village heads then the nurses only. And I am not sure how it goes from there.* (Opinion Leader, Bulilima District)

> *There is really no proper channel for complaints even for sharing of ideas. We can discuss something, but to whom do we take it to? ... Half the time it ends there.* (Female respondent, Rushinga District)

> *There is need to have everything documented and also to come up with ways of dealing with issues as they come in. The issues should also be documented, as well as the action taken. There is also need to have planning meetings with the HCC in order to include community views and opinions.* (DNO)

5.5 Technical quality of health facilities

The evaluation will primarily rely on secondary data sources to measure the technical quality of health facilities. This is because the quality of the health facilities is going to be measured by the MoHCC as part of the HTF-RBF implementation (discussed in Section 3.2.2) and we can make use of these data to use the evaluation resources most effectively.

As described earlier, the MoHCC Quality of Care Checklist contains modules on general appearance, administration and planning, health information system management, infection control and waste management, outpatient services, family and child health, inpatient services, medicines, sundries and stock management, referral services, community services, and environmental health services.

Under the RBF model for the HTF, the amount disbursed to health facilities depends on their performance measure in terms of quantity of services delivered and quality of care. Therefore the evaluation will use the RBF quality of care composite score, as well as the amount disbursed to health facilities, as measures of the technical quality of health facilities. The first RBF disbursement is scheduled for January 2015. The quality of care composite score will be available by each health facility quarterly, starting with data from Q3 2014. Hence, at the time of writing this report, these measures were not available and so we do not present results here.

However, a small number of indicators in our quantitative survey measure the quality of facilities; the results of these are therefore discussed below.

- Most facilities are headed up by a Primary Care Nurse (51%) or a State Registered Nurse (37%). A State Registered Nurse is a fully qualified and registered nurse who has undergone the traditional three-year course, while a Primary Care Nurse is trained over one year. The Primary Care Nurse was introduced in response to the short supply of nurses as many State Registered Nurses left Zimbabwe during the economic collapse in the 2000s.

- The facilities met with Community Health Workers about once per month.

- All ANC patients interviewed had an ANC card.
- Despite the free MNCH health care policy, a small proportion of ANC and carers of under-fives are being charged for services and medicines.
- Problems commonly mentioned by the HCC members and community included staff accommodation, lack of water and electricity, facilities being too small and not having any/enough maternity beds, and the lack of transport at facilities. At Rushinga Rural Health Centre, there is no running water, and no borehole. Patients are required to bring two litres of water per person being treated; those without are turned away.

> *Electricity is a huge issue because it makes it difficult for pregnant women to be assisted, especially at night, if you do not have a candle then you need to buy one and if you don't have cash to buy then you are turned away.* (Male respondent, Rushinga District)

> *The service is really bad here, you can get here by 8am but get to leave around 4pm, they take long to serve and also though I don't know how it works but you get the same medicines as given children even if the sickness is different.* (Female respondent, Rushinga District)

5.6 Perceived quality of care

This section aims to measure whether or not community members believe the services provided at the health facilities are of good quality. How one perceives the quality of services depends on one's expectations of quality. Therefore, perceived quality changes when expectations change, and perceived quality can change even when the actual quality of the services does not change. Perceived quality is important for this programme because the programme aims to increase community members' expectations of the quality of services to which they are entitled, and to increase the community members' voice in the governance of the health facilities. It then seeks to enable community members' to use their increased expectations to demand better services and it is hoped that this will lead to an improvement in the technical quality of the services, and that this, in turn, will lead to increased utilisation of services. Therefore, over the life of this programme we could expect that perceived quality will initially fall as expectations are raised, and then perceived quality may rise if quality of services improves.

Despite the significant and commonly mentioned problems relating to the quality of health facilities infrastructure (lack of staff accommodation, lack of water and electricity, facilities being too small given the number of patients, the lack or shortage of maternity beds, and lack of transport at facilities), ANC patients and carers of under-fives report very high levels of satisfaction with the health care provided at the primary health care centres, including high levels of trust in the health workers. The qualitative study found that, although two out of the three facilities visited in Bulilima District do not have electricity, and all three clinics visited in Rushinga have no running water, community respondents largely describe health facility structures as being 'adequate'. Even in the catchment area of Rushinga Health Centre, which had no water or electricity, and where women faced being turned away if they did not bring two litres of water per person being treated (i.e. two litres for the mother, and two litres for the child), respondents still preferred to deliver their babies at the clinic and to bring children for PNC visits rather than deliver at home or using traditional medicines.

But the staff here are good it's just they are few so work becomes too much for them so we really have little to complain about them. (Male respondent, Bulilima District)

The satisfaction levels are lowest when respondents are asked about the convenience of getting to the facility, the amount of time they must wait to be seen and the ease of obtaining medicines.

Perceived quality of care was measured using both qualitative and quantitative methods. Measuring perceived quality is challenging in an environment where people fear that any negative responses may be fed back to facility staff and they may be in some way punished as a result. For the quantitative surveys we aimed to mitigate this risk by conducting one-to-one interviews in a private space and by highlighting the confidentiality of the interviews and the data. However, in focus groups it is not possible to ensure confidentiality because other focus group participants could share information outside the group, but both our quantitative and qualitative methods produced similar findings.

Table 8 ANC patients' perceived quality of care

	N	Strongly disagree	Slightly disagree	Slightly agree	Strongly agree
Overall satisfaction					
Proportion of users who…					
Are very satisfied with the quality of care received during the visit at this facility	1,414	0.01	0.01	0.06	0.92
Satisfaction with health workers					
Proportion of users who…					
Completely trust the health workers in this facility	1,400	0.01	0.02	0.13	0.84
Believe that health workers in this facility are extremely thorough and careful	1,413	0.01	0.01	0.10	0.88
Trust in the skills and abilities of the health workers at this facility	1,406	0.01	0.01	0.11	0.87
Completely trust the health workers' decisions about medical treatments at this facility	1,411	0.00	0.01	0.10	0.88
Believe that health workers at this facility are very friendly and approachable	1,408	0.01	0.02	0.11	0.86
Believe that health workers at this facility are easy to make contact with	1,400	0.01	0.02	0.11	0.86
Believe that health workers at this facility care about their health just as much or more than they do	1,396	0.01	0.02	0.14	0.84
Believe that health workers did a good job of explaining how to take care of their unborn baby	1,413	0.02	0.01	0.10	0.86
Believe that health workers spent a sufficient amount of time with them	1,414	0.01	0.01	0.10	0.88
Believe that health workers at this facility are often absent	1,353	0.91	0.03	0.03	0.03
Believe that health workers at this facility act differently towards rich people compared to poor people	1,308	0.88	0.04	0.03	0.05

Satisfaction with the facility and costs					
Proportion of users who…					
Believe that it is convenient to travel from their house to the health facility	1,412	0.12	0.06	0.11	0.71
Believe that the amount of time spent waiting to be seen by a health provider was reasonable	1,413	0.06	0.05	0.11	0.78
Believe that it is easy to get the medicines that health workers prescribe	1,388	0.03	0.04	0.14	0.79
Believe that they had enough privacy during the visit	1,413	0.00	0.01	0.07	0.92
Believe that the health facility is clean	1,407	0.01	0.02	0.14	0.83
Of those who paid health facility fees today, proportion who believe that the total fees were reasonable	41	0.12	0.02	0.02	0.83

Table 9 Carers of under-fives' perceived quality of care

	N	Strongly disagree	Slightly disagree	Slightly agree	Strongly agree
Overall satisfaction					
Proportion of users who…					
Are very satisfied with the quality of care received during the visit to this facility	1,511	0.01	0.01	0.07	0.90
Satisfaction with health workers					
Proportion of users who…					
Completely trust the health workers at this facility	1,507	0.01	0.02	0.13	0.84
Believe that health workers at this facility are extremely thorough and careful	1,508	0.01	0.02	0.11	0.86
Trust in the skills and abilities of the health workers at this facility	1,504	0.01	0.01	0.11	0.87
Completely trust the health workers' decisions about medical treatments at this facility	1,507	0.01	0.01	0.10	0.89
Believe that health workers at this facility are very friendly and approachable	1,508	0.00	0.01	0.08	0.83
Believe that health workers at this facility are easy to make contact with	1,498	0.01	0.01	0.09	0.83
Believe that health workers at this facility care about their health just as much or more than they do	1,495	0.01	0.01	0.12	0.79
Believe that health workers did a good job of explaining how to take care of their unborn baby	1,506	0.01	0.01	0.06	0.87
Believe that health workers spent a sufficient amount of time with them	1,509	0.01	0.01	0.07	0.86
Believe that health workers at this facility are often absent	1,448	0.86	0.02	0.03	0.02
Believe that health workers at this facility act differently towards rich people compared to poor people	1,409	0.81	0.03	0.03	0.06
Satisfaction with the facility and costs					

Proportion of users who…					
Believe that it is convenient to travel from their house to the health facility	1,510	0.09	0.05	0.09	0.69
Believe that the amount of time spent waiting to be seen by a health provider was reasonable	1,511	0.04	0.04	0.08	0.74
Believe that it is easy to get medicines that the health workers prescribe	1,484	0.03	0.04	0.12	0.73
Believe that they had enough privacy during visit	1,508	0.02	0.02	0.06	0.84
Believe that the health facility is clean	1,507	0.01	0.01	0.12	0.77
Of those who paid health facility fees today, proportion who believe that the total fees were reasonable	18	-0.25	-0.22	-0.06	0.08

5.7 MNCH service utilisation

Examining the HMIS data from January 2013 to July 2014 we can see that utilisation of ANC services has been increasing and women are coming for their first visits earlier in their pregnancy (this is seen by an overall increase in first visits and a decrease in first visits after 28 weeks of pregnancy, as discussed in Annex U). The use of PNC services has also been increasing, particularly postnatal care within three days of giving birth. The number of children being vaccinated has remained approximately constant. The tables below present the average number of visits per facility per month for different ANC, PNC and vaccination services. In both districts visited as part of the qualitative study, some service providers and decision-makers attribute the increase in ANC and PNC visits to HTF and RBF funds and improved community participation and outreach.

> *Only those of the Apostolic sect most of them do not use the services provided at the clinic and also do not attend community meetings.* (Female respondent, Bulilima District)

> *Most people now prefer to come to the clinic. There are groups that do follow-ups on women and children so they push people to come to the clinic and get help. Most women still need more education on issues of health pertaining to their pregnancies and their children.* (Male respondent, Rushinga District)

Figure 4 Average number of new outpatients per facility per month

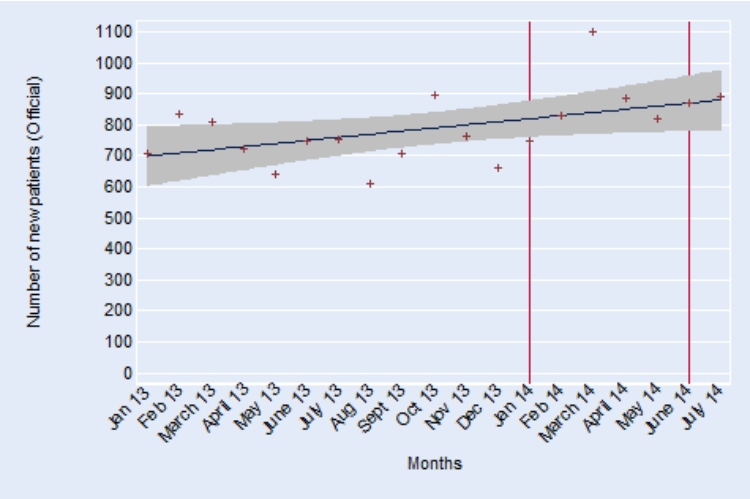


Figure 5 Average number of ANC first visits per facility per month

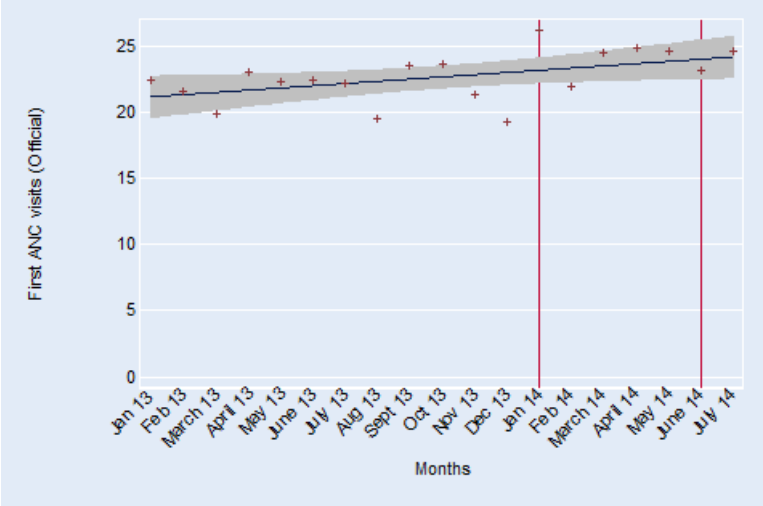


Figure 6 Average number of PNC visits (three days after giving birth) per facility per month

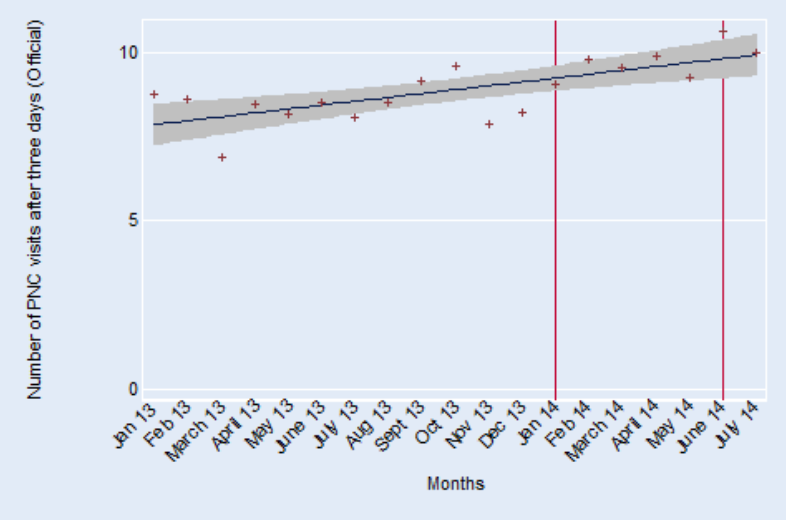
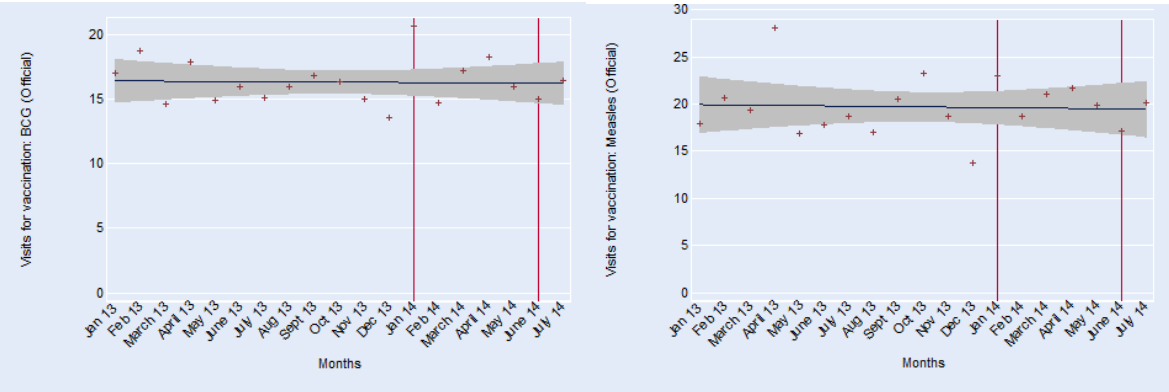


Figure 7 Average number of BCG and measles vaccinations per facility per month



- On average each health facility provides services to a catchment population of 7,877 people, of which 1,758 are women aged 15–49 and 1,217 are under five.
- All respondents report wanting/planning to give birth in a health facility.
- The main barriers to utilisation of MNCH services identified are cultural barriers, mainly from some members of the Apostolic church (in total, members of the Apostolic church constitute 33% of Christians in Zimbabwe). Distance to the facility is also a key barrier. Of less importance in terms of increasing utilisation is the quality of facilities. While staff attitudes were often cited as a reason for non-use, poor physical infrastructure was not. While it is often reported that there is poor physical infrastructure (lack of mothers’ shelter, electricity, water etc.) or a shortage of staff, this was not often given as a reason for not attending. There is a sense of resignation, that the facilities are doing the best with the resources they have, and a recognition of the fact that quality has improved significantly since the low point in 2008. As services get better, non-quality barriers become more important.
- Other studies of a larger scale and scope also indicate that poor (perceived) service quality has not been found to be reported as a major barrier to use of MNCH services.[35] These studies, which include the 2011 DHS, found a range of primary barriers of which the programme should be aware, including, for use of ANC: lack of money for treatment, not wanting to go to the facility alone, and failing to get permission for treatment. The studies also highlight heterogeneity among Apostolic church groups, which are largely, but not uniformly, against the use of formal health services.

5.8 Implications of the key baseline findings for the evaluation

In this section, we assess in more detail the exposure of HCCs and community members to the type of training that is offered by the programme. The purpose of this discussion is to assess the extent to which the comparisons groups may have already been affected by the intervention or similar interventions, and also to give some indication of the potential effect of the programme intervention.

[35] Refer to references 16, 30, 31 and 35 in the Bibliography.

A summary of training that the HCCs, ANC patients and carers of under-fives report having received is shown below, and we describe how this is split between the treatment and comparison groups.

1. **HCC level.** 81% of HCCs have received training. They were mostly trained by the District Health Team, other MoHCC staff or health staff at the health facility. The training focused on the functions of an HCC, preparing and tracking budgets, organising and mobilising communities for health, and mobilising financial resources. Of those trained, 13% received training from SC and 9% received training from CWGH. Of those trained by SC or CWGH, 60% are from treatment facilities and 40% are from comparison facilities.

1. **Community level.** 21% of ANC patients have received training (in the sense of attending sessions that provided them with information). They were mostly trained by health facility staff. Of those trained, 3% received training from SC and 24% received training from CWGH. Of those trained by SC or CWGH, 50% were interviewed in treatment facilities and 50% were in comparison facilities. Similarly, 21% of carers of under-fives have received training. Of these, 1% received training from SC and 27% received training from CWGH. Of those trained by SC or CWGH, 47% are from treatment facilities and 53% are from comparison facilities.

A list of treatment and comparison facilities where HCCs and community members report having been trained by SC/CWGH is given in Annex R. The evaluation team are following up with SC/CWGH to identify if/when the training reportedly undertaken by SC/CWGH in the comparison group occurred.

In the tables below, we present a number of outcome measures, disaggregated by respondents' exposure to training, to see if there are differences between those who have already received some training and those who have not. The tables are split between those who have not received any training, those who have been trained by SC or CWGH, and those who have been trained by anyone else other than SC/CWGH (usually the District Health Team, health facility staff or other MoHCC staff).

1. **HCC level.** For the HCC outcomes there is very little difference between those who have been trained and those who have not. The only significant difference is that those who have been trained by someone other than SC/CWGH are more likely to have a copy of the Patient's Charter than those who were not trained at all.

2. **Community level.** For the ANC patients' and carers of under-fives' outcomes, there are a number of notable differences between those who have been trained and those who have not. Those who have been trained by SC/CWGH or anyone else are more likely to know of the HCC in their community, to be aware of the Patient's Charter and to say they would complain if they were unhappy about the facility or its staff.

The implications of these observations for the evaluation are summarised below.

1. **HCC level.** As described above, the majority (81%) of HCCs have already had some training, mostly from the MoHCC, so this evaluation will be measuring the effect of *additional* HCC training, rather than of some HCC training compared with none. However, there does not appear to be a significant difference between HCCs who have been trained and those who have not been trained along our HCC outcomes of

interest, so either the previous training did not cover the areas tested below, or if it did, the training does not appear to have had a significant effect. The programme implementers should note this, and should consider if the HCC training needs to do anything differently in order to have a sustained effect on key areas of interest.

2. **Community level**. As described above, about one-fifth of ANC patients and carers of under-fives have already received some training, and this training appears to have had a significant effect along some key areas of interest (although noting that there is likely to be some selection bias here in that those most interested in the relevant issues may have attended the training). The implications for the evaluation is that we do not have a pure baseline, but as shown by the balance tables, there is not a statistically significant difference between treatment and control groups so this is not a serious concern. The implications of this for the programme implementers are more positive. The vast majority of people have not been trained, so there is a need for this programme activity, and it appears that the training has the potential to have the desired impact.

Table 10: HCC members' indicators – disaggregated by exposure to training

	Mean not trained	Mean trained by others	Difference in means	Mean not trained	Mean trained by SC/CWGH	Difference in means	Mean trained by others	Mean trained by SC/CWGH	Difference in means
Proportion of HCCs on which the following were represented									
Nurse in Charge	1.0	1.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Ordinary community members	0.9	0.9	0.0	0.9	1.0	0.0	0.9	1.0	0.0
Local political leader (e.g. councillor)	0.9	0.7	0.2**	0.9	0.8	0.1	0.7	0.8	-0.1
Traditional community leader	0.8	0.6	0.1	0.8	0.5	0.3**	0.7	0.5	0.2
Community Health Worker	0.7	0.7	0.1	0.7	0.6	0.1	0.7	0.6	0.1
Church representative	0.5	0.5	0.0	0.5	0.4	0.1	0.5	0.4	0.1
Other health facility staff	0.6	0.5	0.1	0.6	0.7	-0.1	0.4	0.7	-0.3**
Government extension workers	0.5	0.4	0.1	0.5	0.5	0.1	0.4	0.5	-0.1
School headmaster/health master	0.3	0.4	-0.1	0.3	0.5	-0.2	0.4	0.5	-0.1
Youth organisation	0.4	0.3	0.1	0.4	0.4	0.1	0.3	0.4	-0.1
NGO/CSO	0.1	0.2	0.0	0.1	0.1	0.1	0.2	0.1	0.1*
Proportion of HCCs with a…									
Chairperson	0.9	0.9	0.0	0.9	1.0	0.0	0.9	1.0	0.0
Vice chair	0.8	0.8	-0.1	0.8	0.8	0.0	0.8	0.8	0.1
Treasurer	0.9	0.9	0.0	0.9	1.0	0.0	0.9	1.0	0.0
Secretary	0.9	0.9	0.0	0.9	1.0	0.0	0.9	1.0	-0.1
Proportion of HCCs that…									
Have a copy of HCC handbook	0.2	0.4	-0.1	0.2	0.3	-0.1	0.4	0.3	0.0
Have a copy of Patient's Charter	0.1	0.3	-0.2***	0.1	0.3	-0.2	0.3	0.3	0.1
Display MNCH statistics, including current month statistics	0.1	0.1	-0.1	0.1	0.1	0.0	0.1	0.1	0.0

Display MNCH statistics, not including current month	0.2	0.2	0.0	0.2	0.4	-0.1	0.2	0.4	-0.2
Do not display MNCH statistics, including current month	0.7	0.6	0.1	0.7	0.5	0.2	0.7	0.5	0.2
Submit written reports on MNCH access	0.3	0.4	-0.1	0.3	0.5	-0.3**	0.3	0.5	-0.2
Make visits to health facilities for monitoring purposes	0.9	1.0	0.0	0.9	1.0	-0.1	1.0	1.0	0.0*

Table 11: ANC patients’ indicators – disaggregated by exposure to training

	Mean not trained	Mean trained others	Difference in means	Mean not trained	Mean trained by SC/CWGH	Difference in means	Mean trained others	Mean trained by SC/CWGH	Difference in means
Proportion of users who…									
Are very satisfied with the quality of care received during the visit at this facility	1.0	1.0	0.0	1.0	0.9	0.1	1.0	0.9	0.0
Know of the HCC in their community	0.3	0.5	-0.2***	0.3	0.6	-0.3***	0.5	0.6	0.0
Know of any HCC members in their community	0.8	0.9	-0.2***	0.8	0.9	-0.2***	0.9	0.9	0.0
Feel HCC provides a valuable service in their community	0.9	1.0	0.0	0.9	1.0	-0.1***	1.0	1.0	0.0
Are aware of the Patient’s Charter	0.1	0.2	-0.1**	0.1	0.3	-0.2**	0.2	0.3	-0.2
Admit to knowing their patient rights at the health facility	1.0	1.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Would complain if unhappy about the facility or its staff	0.7	0.8	-0.1*	0.7	0.7	0.0	0.8	0.7	0.1
Have been unhappy/unsatisfied with the health facility or staff in the past 12 months	0.1	0.1	0.0	0.1	0.0	0.0	0.1	0.0	0.1

Table 12: Carers of under-fives' indicators – disaggregated by exposure to training

	Mean not trained	Mean trained by others	Difference in means	Mean not trained	Mean trained by SC/CWGH	Difference in means	Mean trained by others	Mean trained by SC/CWGH	Difference in means
Proportion of users who…									
Are very satisfied with the quality of care received during the visit to this facility	1.0	1.0	0.0	1.0	0.9	0.1	1.0	0.9	0.1*
Know of the HCC in their community	0.4	0.6	-0.2***	0.4	0.6	-0.3***	0.6	0.6	-0.1
Know of any HCC members in their community	0.8	0.8	0.0	0.8	1.0	-0.1**	0.8	1.0	-0.2**
Feel HCC provides a valuable service in their community	0.9	1.0	0.0	0.9	1.0	-0.1***	1.0	1.0	0.0
Are aware of the Patient's Charter	0.1	0.2	-0.2***	0.1	0.3	-0.3***	0.2	0.3	-0.2
Admit to knowing their patient rights at the health facility	1.0	1.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Would complain if unhappy about the facility or its staff	0.7	0.8	-0.1***	0.7	0.9	-0.2***	0.8	0.9	-0.1
Have been unhappy/unsatisfied with the health facility or staff in the past 12 months	0.1	0.1	0.1*	0.1	0.1	0.0	0.1	0.1	-0.1

6 Testing the assumptions behind the ToC

Section 5 assessed the baseline values of the indicators that are expected to change as a result of the programme, and hence relates to the impact DAC criteria.

In this section we use an analysis of each of the assumptions underpinning the programme ToC to discuss the relevance and potential effectiveness of the programme. As shown in Annex E, we have developed a narrative which discusses the major assumptions underpinning the programme ToC. Reflecting on the assumptions, you will notice that they relate to the relevance and effectiveness of the programme. We have grouped the assumptions under the appropriate DAC criteria, and end each section with a brief summary of the conclusions regarding the programme's indicative strengths and weaknesses.

As this is a baseline report, it is too early to comment on the efficiency or sustainability the programme but in Section 7 we describe how we will assess efficiency and sustainability at endline.

6.1 Relevance

Here we discuss the assumptions in the ToC that help answer the question of to what degree the programme's objectives remain valid, and whether the programme's activities and outputs are consistent with its key goals and objectives, intended impacts and effects. For each assumption we look at:

- whether each assumption has held; and
- to what extent the programme objectives address each assumption.

Assumption 1: Community members lack knowledge about their rights and entitlements to MNCH services

This assumption partially holds. As described above in Section 5.2, while knowledge of the Patient's Charter is found to be very limited in all study sites, broadly speaking, community members are aware that they are entitled to a certain standard of care, but lack awareness about how to challenge unacceptable standards or influence MNCH decision-making processes.

As such, the programme's main value may not be in introducing community members to their rights, but enriching their knowledge of their rights and entitlements by promoting awareness of the Patients' Charter and making it widely available in local languages. Most relevant, then, is the programme's aim to develop understanding that can be acted on by community members regarding their entitlements to better quality and more accessible services, enabling them to become part of MNCH service governance by providing feedback through HCCs and CMs.

Assumption 2: This lack of knowledge about rights and entitlements to MNCH services as a major barrier to utilisation of MNCH services

This assumption does not hold. As discussed in Section 5.7, most people plan to, or desire to, use MNCH services. The barriers to MNCH services are discussed in Section 5.8.

The programme activities are not designed to address the primary barriers to utilisation of MNCH services observed during the baseline study.

The most commonly cited reason for non-use of MNCH services is cultural beliefs. The manual which forms the basis for the HCC training curriculum includes a brief section on sensitisation to the cultural factors that prevent communities from engaging well with health workers.[36] However, it does not appear that HCCs are instructed to view navigating these cultural factors as key to successfully carrying out their duties.

Distance to health facilities is another commonly reported reason for non-use of MNCH services. The baseline evaluation found that, among ANC services users, for example, health facilities are reported to be an average of 4km away from home and it takes women and their children about 1.5 hours to arrive by foot. It is outside the scope of the programme to address issues regarding distance directly, but as the programme aims to channel major complaints such as long distances or low coverage of facilities upwards to national level decision-makers, there is the possibility that this problem will be addressed through grievance mechanisms or through an increase in the provision of outreach services.

The final reason for non-use of MNCH services reported is negative staff attitudes. While the programme aims to formally promote collaboration and communication between communities and service providers, it does not address the underpinning reasons for, or the informal relationships that sustain, such negative attitudes and behaviour among staff.

Assumption 3: This lack of knowledge about rights and entitlements to MNCH services is a major barrier to participation in activities to influence improvements in MNCH quality standards

This assumption does not hold. Across study areas, respondents described various activities they have participated in to improve MNCH quality standards at the health facilities in their communities, which demonstrates that they are already participating in such activities.

As stated above, the programme activities do not address the primary barriers to participation in activities to influence improvements in MNCH service quality, and also do not explicitly/directly include ways to leverage community members' readiness to improve MNCH service quality.

Assumption 5: The poor quality of MNCH services is a major barrier to utilisation of MNCH services

This assumption does not hold. The barriers to MNCH services are discussed in Section 5.8. The poor quality of the facilities (the need for water and electricity to ensure hygienic conditions and storage of medicines) does not feature as a primary or secondary reason for non-use of MNCH services. Section 5.6 provides a discussion of the baseline findings on the perceived quality of care. Additionally, a desk review of wider studies on reasons for non-use of MNCH services found that poor service quality of the facilities or the services that they offer was not identified as a leading barrier.[37]

As discussed above, although the programme activities assume that community members are dissatisfied with the quality of MNCH services, the baseline research found that they are

[36] TARSC and CWGH (2011) 'Supporting the Role of Health Centre Committees: A Training Manual', p. 36.
[37] Refer to references 16, 30, 31 and 35 in the Bibliography.

widely satisfied. In addition, the primary and secondary barriers to utilisation of MNCH services are not directly addressed by the programme.

Assumption 12: The policy environment is weak and does not enable or support the implementation of quality MNCH services

This assumption partially holds. As discussed in Section 5.3, there are indications of a positive enabling environment, such as the HTF/RBF funding channelling financial resources to processes aimed at improving MNCH services. However there are also 'weak links' which limit the ability of frontline service providers and district-level decision-makers to take advantage of a positive enabling environment.

The programme addresses weaknesses in the enabling environment at the district and national level. At the district level, it aims to facilitate change by increasing the extent to which local community members and those who represent them are embedded in decision-making processes that affect implementation of quality MNCH services, and reinforcing the duty-bearing responsibilities of stakeholders at that level. At national level, the approach to strengthening the enabling environment includes: plans to lobby health and health-related ministries and public officials; mass media campaigns; generating consortium papers; leveraging existing relationships, such as those with the Zimbabwean parliament and MoHCC; and building on existing work to integrate HCCs into legislation.

Assumption 13: The existing community structures (HCCs, CMs and HLFs) for monitoring the quality of MNCH care are not institutionalised

This assumption partially holds. We have noted in Section 5.1 that HCCs have been in place nation-wide for many years, though they are better institutionalised in some areas compared with others. And, as discussed in Section 5.4, the formation and performance CMs and HLFs is limited.

The project is addressing these issues directly, through: training and capacity building to inform HCCs of their roles and responsibilities, develop their administrative and management skills, and strengthen their ability to enable dialogue between the community and the health facility; training HLFs; and establishing and training CMs.

Assumption 14: There is limited or no community participation in health governance in respect of MNCH services

This assumption holds. Whilst there is some evidence that in some areas community structures are institutionalised and are recognised as being part of health systems, the data from the qualitative baseline study suggest that these structures have not yet been operationalised towards facilitating community participation in the governance of MNCH services. This issue is addressed through the programme's work to raise the profile of HCC reporting and strengthen HCCs' relationships with district-level decision-makers (DNOs especially). It is also being addressed through the planned activities of CMs: specifically, the use of scorecards for the ongoing monitoring of service delivery, with the intention of feeding the data collection to local authorities and key stakeholders, and systematising social accountability reporting. Section 5.4 outlines the availability and use of existing complaints mechanisms at health facilities.

Summary of analysis of programme relevance

The programme design has strengths and weaknesses that contribute to the overall relevance of the activities and the objectives it aims to accomplish.

Among the most relevant programme activities are those that focus on:

- strengthening the profile and capacity of HCCs;
- establishing monitoring and feedback mechanisms systems that are currently weak or not in place; and
- creating an enabling policy environment that is responsive to concerns voiced at the community level.

Assumptions that partially hold or do not hold present opportunities for the programme to assess how it can be more relevant to the implementation context and the needs of community members and service providers:

- In particular, programme activities that aim to exploit the link between the lack of knowledge of rights, poor MNCH service quality and service utilisation are not aligned with the factors that drive service use or non-use.

6.2 Effectiveness

In this section we discuss the findings of the baseline research regarding the current status of major factors that are likely to influence the achievement or non-achievement of the objectives of the programme, and whether the assumptions in this regard have held.

Assumption 4: Different community members are willing, motivated and confident in regard to engaging in community level programme activities, and diverse voices and views are represented

This assumption holds. In both districts where the qualitative study was conducted, respondents reported that communities of different genders, livelihood types and social status have expressed a willingness to engage in community-level activities to improve the quality of MNCH services in their area, though we note that this is distinct from participation in activities focused on the *governance* of MNCH services. Across all six sites in the qualitative study, respondents reported that community members have brought together resources such as bricks, pit sand, water and labour for the construction of toilets, nurses' houses, and waiting mothers' shelters.

> *The community is moulding bricks to build the waiting mothers' shelter and the nurses' cottages and they are building the structures themselves. Every member of the community is helping out and they cooperate with the nurses.* (Sister in Charge, Masendu, Bulilima District)

> *The community was involved in building toilets, and we also built a maternity home. The community contributes one dollar per household. We built the mother's shelter with the assistance of OPHID [Organisation for Primary Heath Intervention Department], which provided some of the materials, and we provided the bricks and builders.* (Male respondent, Bungwe, Rushinga District)

Assumption 6: Opinion leaders (such as traditional and religious leaders) are willing to give their support to awareness-raising around community rights and entitlements to MNCH services, even if this might be perceived to be against their interests in

some way (e.g. it will possibly mean a loss of influence within the community, or it may lead to changes that are against particular traditional social norms, etc.).

This assumption holds. Opinion leaders play a significant role in sensitising and mobilising community members to utilise MNCH services at local health facilities. Headmen and chiefs sensitise members during their meetings, while religious leaders encourage church members to receive treatment from a health facility rather than relying on other sources. Traditional leaders in Rusambo, Rushinga District and Masendu, Bulilima District—both relatively remote communities with strong cross-border ties to Mozambique and Botswana, respectively—have introduced punitive measures to ensure that all pregnant women deliver in a health facility. Anyone who delivers at home is required to pay a goat as a fine. In Rusambo, most pregnant women are now using the health facility for delivery because of the punitive measures, as highlighted in the following statement:

> *When someone delivers at home they are made to go and pay a goat to the chief, two chickens to the kraal head and one chicken to the Village Health Worker* (Female respondent, Rusambo, Rushinga District)

The councillors also support this system and discourage home deliveries. In the three sites visited in Rushinga District, opinion leaders – particularly village heads, headmen and chiefs – encourage the villagers to make use of the health facility for MNCH services in all of their community meetings. Opinion leaders noted that the statistics provided by nurses indicate that more people are coming to the facility than before.

Equally, opinion leaders in Madlambudzi have been teaching people about MNCH during their community and ward meetings. They help in community mobilisation, especially when there is an outreach activity in their area. Church leaders (excluding those from the Apostolic sect) also play a role, by encouraging members of their congregations to utilise health facilities, especially for MNCH services. Headmasters pass the message through their students to their parents that they are supposed to come to the facility to get immunised. The involvement of opinion leaders in MNCH issues has helped reduce cultural barriers that previously hindered women from accessing health services, since the opinion leaders are listened to as custodians of the community's culture. Even traditional midwives are said to be encouraging pregnant mothers to give birth in a clinic, not at home.

> *What we advocate for as village heads is for every pregnant mother to go to the clinic, even those with children, especially on immunisation.* (Opinion leader, Rushinga, Rushinga District)

> *Opinion leaders hold meetings where they teach the community to utilise MNCH services such as early bookings (visiting the clinic during their eight months, and making arrangements to deliver there).* (HCC Chairperson, Madlambudzi, Bulilima District)

> *We were told by the village heads if you deliver at home you will be fined a fine of a goat so this encouraged more women to come to the clinic.* (Female respondent, Rusambo, Rushinga District)

> *Our chief said if you give birth at home be prepared to lose one of your animals.* (Male respondent, Masendu, Bulilima District)

Assumptions 7 and 8: CMs have sufficient capacity (e.g. time, resources, etc.) to effectively monitor MNCH service quality, and CMs can play pivotal roles in collecting feedback and evidence from community members to ensure that the needs of those with less of a voice are taken into account by MNCH service providers and decision-makers

This assumption will be tested at endline as programme activities relating to developing the capacity of CMs have been limited thus far. At the time of the baseline study, implementation of the programme had not yet started in Rushinga District. As such, there were no CMs or HLFs in Bungwe, Rusambo and Rushinga town. In Bulilima District, CMs had been identified in both treatment sites visited: they had received training three months prior to the study in Madlambudzi, and were awaiting training in Masendu. No CMs were available for interview during the baseline research, and as their scorecard activities had not begun in Bulilima District, respondents there were unable to provide views or opinions about the effectiveness of CMs.

Assumption 9: Political will exists at national level to improve service quality, client satisfaction and health services

Baseline research did not test this assumption. National level perceptions will be addressed as part of the endline evaluation.

Assumption 10: Local level service providers are willing to engage with service users in order to improve MNCH service quality and accountability, and do not feel threatened by service user feedback

This assumption partially holds. The baseline research indicates a contradiction between service providers' willingness to receive feedback, and community members' perceptions of service providers. As noted in Section 6.1, across study sites in both districts where the qualitative study was conducted, negative staff attitudes was the second main reason cited for non-use of MNCH services. Only 59% of ANC patients and carers of under-fives interviewed said that they would complain if they were unhappy about the facility or its staff. The primary reasons that people gave for not complaining were that they did not know where to report a complaint, or there is nowhere to report a complaint, and that they are afraid to report a complaint. This would suggest that users and potential users do not perceive providers as willing to engage with MNCH patients in a way that would allow them to improve service quality or accountability. However, service providers interviewed in both districts where the qualitative study was conducted expressed openness in regard to receiving feedback from the community.

> *We need monitors to work with service providers. They need to hold more meetings so that feedback generated by community level monitoring effects significant improvements. More qualified staff and resources in the form of funds are needed to make the health centre better.* (HCC Chairperson and service provider, Rushinga Clinic, Rushinga District)

> *What is required is a suggestion box to receive patients' complaints and there is a need to open the suggestion box in the presence of HCC members and the facility staff and review all the findings together to come up with solutions and then give feedback to the community through implementing the suggested changes.* (Sister in Charge, Madlambudzi, Bulilima District)

> *We don't complain about service delivery because we don't know where to complain and also we are afraid that if you complain when you come back for treatment you will be chucked out.* (Female respondent, Madlambudzi, Bulilima District)

> *The nurse reported to the police that she was being harassed after we had complained to her and the councillor got arrested.* (Male respondent, Bungwe, Rushinga District)

Assumptions 11 and 15: The role of HCCs is formally recognised by the relevant authorities and the communities they serve, and the HCC functions, mandate and roles are clear and widely understood within the HCCs and the communities they represent

These assumptions do not hold. The concept behind HCCs is not new in Zimbabwe, as there have been groups and committees with similar roles (such as the Ward Health Teams) since the early 1980s. As outlined in our analysis of the quality and functionality of HCCs in Section 5.1, HCCs are not widely known in communities. It follows, then, that the roles and mandate of the HCCs are not universally understood by community members across the study areas.

Assumptions 16 and 17: HCC membership is representative of the diverse communities they serve, and the HCC responds to and acts on the voices of all community members, including those groups usually excluded

These assumptions do not hold. The composition of the HCCs is shown in the table in Section 5.1. Men and women are both commonly represented in the HCCs, though the composition of the HCCs varied in both districts where the qualitative study was conducted.

Assumption 18: The HCCs are not vulnerable to domination and capture by powerful elites

This assumption does not hold. Representation within the HCCs is discussed extensively above, in Section 5.1. While HCCs tend to consider themselves free from the influence of powerful members of the community, some community members and service providers note that HCC members are often selected by the village heads or are community leaders themselves. This is reported as being particularly problematic in one health centre in Bulilima:

> *HCC members are three females and seven males. They are not representing all the community members because all the members are people of influence in the community, like village heads.* (Sister in Charge, Madlambudzi, Bulilima District)

In some cases respondents reported a problem in that local political office-holders, especially some councillors, try to use membership of the HCC as a means of furthering their own personal political ambitions, or as a way of signalling to the community that they are fulfilling their campaign promises.

Assumption 19: Participation of members in HCC activities is not limited by lack of motivation regarding volunteer work

This assumption partially holds. Although, as the evidence in Section 5.1 suggests, the discussions suggest that HCC members are willing to operate as volunteers, there are also indications that there are limitations with regard to the requirement that they should work for the committees without payment. If a conflict arises between their responsibilities as HCC

members and household or livelihoods responsibilities, the lack of payment/material incentives means that HCC duties may temporarily be put aside.

> *We need incentives so that we have motivation to keep on carrying out our duties.* (HCC member, Bungwe, Rushinga District)

> *No one has ever openly grumbled about being in the committee. All seem happy, and anyway, if you no longer want to be in the committee you can retire, it's not a problem. No one has ever done that so far.* (Opinion leader, Makhulela, Bulilima District)

> *The HCC is recognised by the community but they haven't realised how big it is since we don't have identification, such as uniforms.* (HCC Chairperson, Madlambudzi, Bulilima District)

> *Yes they are recognised but time like farming season they will be busy with their fields just like everyone else so their interaction at the clinic will be minimum.* (Opinion leader, Bungwe, Rushinga District)

Assumption 20: Community evidence and feedback on MNCH service quality and accountability will contribute to positive changes in regard to policies, practices and institutional behaviour, as a result of decision-makers at district and other levels using evidence and feedback generated by community level monitoring to effect significant improvements

This assumption does not hold. This assumption relates to the issue of whether or not evidence and feedback on MNCH services is likely to reach decision-makers through the appropriate channels, and what is likely to be done with this evidence once it reaches them. As we have discussed in Section 5.4, communities and HCC members are not clear about the channels and mechanisms they can use to voice their complaints.

Assumption 21: Local service providers have sufficient decision-making authority to effect real and sustainable changes

This assumption partially holds. Across both the qualitative study districts, perceptions of local service providers' decision-making authority are mixed. Where respondents feel that service providers have little authority, it is largely attributed to the fact that expenditure decisions require the DHE's approval, and only minor decisions can be made by the nurses on the ground at the facility. Above, in Section 5.3, we provide further discussion of decision-making regarding health facility resources.

Assumption 22: Government officials sufficiently understand the programme as a result of evidence-based advocacy (consisting of lobbying and dialogue) and therefore provide the necessary support rather than block progress

This assumption holds. Programme activities concerning evidence-based advocacy had not started at the time of the baseline study. However, discussions indicate that in both districts where the qualitative study was conducted, government officials at the district level support and participate in activities to build the capacity of HCCs to influence decisions.

> *Government understands the programme because they approve the existence of the HCC and they provide training for the members, who in turn are carrying out their duties.* (Sister in Charge, Madlambudzi, Bulilima District)

Government support the programme because they always come and have meetings with us and check the progress of our work, particularly District Health Executive Team sent District Nursing Officer to educate us as HCC members. (HCC Chairperson, Rusambo, Rushinga District)

Summary of analysis of programme effectiveness

The factors of the programme implementation that may contribute to the overall effectiveness of the programme include:

- it is making use of existing mechanisms for change at community level—communities’ positive attitudes towards mobilising to improve MNCH services, and community leaders’ strong endorsement of MNCH-related activities; and
- there are early signs of a political will to increase the level of feedback from community level that reaches decision-makers.

The programme risks being less effective if it fails to:

- strengthen (or address contextual factors that weaken) the ability of frontline service providers to make decisions;
- set and enforce standards regarding how HCCs can be more representative of the communities they represent; and
- significantly increase awareness of the mandate and responsibilities of HCCs among communities and HCCs, and address constraints on HCCs’ abilities to achieve their objectives.

7 Assessing the efficiency and sustainability of the programme at endline

In Section 5 and Section 6 we presented our baseline assessment of the impact, relevance and effectiveness DAC criteria. In this section we outline the approach we will take to assessing the efficiency and sustainability of the programme. As this is a baseline report there are no preliminary findings to include here we use this opportunity to discuss the methodology to be used at endline.

7.1 Efficiency

Most of the substantive work on the VfM component will be carried out at the same time as the endline data collection. However, during this phase of the evaluation we have worked to finalise the VfM methodology. This is so as to ensure that we have established with SC the feasibility of the proposed data requirements.

These discussions have highlighted the importance of being clear about the purpose of this VfM analysis, as distinct from that being undertaken as part of the MNCH Annual Reviews that Oxford Policy Management (OPM) is undertaking. In regard to the Annual Reviews, which cover all components of the DFID MNCH programme, two indicators have been agreed for the ‘Strengthening Community Participation in Health’ programme:

- annual cost per person supported by each HCC; and
- percent of community members who report satisfaction with the quality of MNCH services provided in target facilities in the past year.

For this evaluation we will undertake a more detailed VfM analysis than that included in the Annual Reviews, given the limited evidence on the impact and VfM of community accountability programmes. To the extent possible, this analysis will cover all VfM domains and the overarching question of cost-effectiveness. It will incorporate the two Annual Review VfM indicators in the VfM framework.

An updated set of VfM indicators and a summary of the methodology for assessing them is provided in Annex Q.

7.2 Sustainability

At this early stage of implementation of the programme, as expected we do not have findings on sustainability. Instead, here we present our proposed approach to assessing the sustainability of the programme.

We provisionally propose to use the framework given below to assess the programme’s responsiveness to operational and contextual factors that affect sustainability, and financial, technical and managerial preparedness for continuing activities after the conclusion of the programme.

Table 13 Sustainability framework

	Is there capacity (existing/created) in:			
Ensuring continuity of:	Financing (who finances and extent of co-financing?)	Technical capacity, including people (district staff, at community level) and resources (e.g. training materials)	Managerial capacity (district staff)	Policy, political interest and support
Ongoing operations (are there any recurrent costs etc.?)				
Maintenance of staff and HCC capacities in existing facilities (e.g. training new staff as a result of turnover of staff)				
Rollout of similar activities across the programme districts (including collaboration)				
National rollout/policy change (particularly in response to evidence and feedback generated by the programme)				

8 Discussion and conclusions

8.1 Summary of findings

This section summarises the baseline situation of all key outcomes that are expected to change as a result of the programme, and provides a discussion of the implications of the findings for the programme’s design, ToC and implementation. The outcomes are presented in the order in which they appear in the ToC. Finally, we also discuss the implications of the baseline findings for the evaluation.

Key baseline findings

Here we summarise the baseline situation of all key outcomes that are expected to change as a result of the programme.

Quality and functionality of HCCs

There is significant variability in regard to the quality and functionality of HCCs. Most, though not all, HCCs meet regularly between themselves and with the communities. Despite the relatively high proportion of HCCs meeting with communities, there is a significant lack of awareness in the communities about the existence and function of the HCCs, so we suggest that this should be a key area of focus for the programme. There is a reasonable level of minute keeping across HCCs, though there is room to bring all HCCs up to the same level. The level of engagement with the DHE is low, and the programme should aim to improve this.

Knowledge of rights and entitlements

Even though few people are aware of the Patient’s Charter *per se*, there is reasonable knowledge about rights and entitlements. The main sources of information regarding patient rights are facility staff and general knowledge shared amongst community members. Approximately three-quarters of ANC patients and carers of under-fives know that services are meant to be free. This information is most commonly obtained from facility staff or friends and relatives, rather than HCC/HLF/Community Health Workers.

Decision-making regarding community and health facility resources

The vast majority of facilities have an operational plan and almost all HCC members report that their HCC was involved in the development of the current operational plan for the health facility. The health facilities’ staff and the HCC are the primary decision-makers regarding spending of facilities’ income, and most HCC respondents said that they feel the health facility expenditure is in line with their priorities, though all expenditure is approved at district level.

Complaints and monitoring mechanisms at health facilities

Only about half of all facilities have a formal mechanism (such as client surveys, complaint or suggestions boxes) to collect patient feedback, and these are not used very much. Furthermore, if they are unhappy about something at the facility, only 59% of ANC patients and carers of under-fives report that they would complain (mostly to the nurse in charge).

Both qualitative and quantitative data shows that if they would not complain it is generally because they do not know where to go to make a complaint or they are afraid of reprisals from health facility staff if they do.

Quality of health facilities

The evaluation primarily relies on secondary data sources to measure the technical quality of health facilities, but these sources were not available in time for this report. However, a small number of indicators in our quantitative survey measure the quality of facilities, and these show some promising signs. For example, all ANC patients interviewed had an ANC card and almost all facilities are now not charging for MNCH services. However, most facilities still have poor infrastructure, including lack of staff accommodation, lack of water and electricity, and lack of transport at facilities; small facilities do not have any/enough maternity beds.

Perceived quality of care

How one perceives the quality of services depends on one’s expectations of quality. Therefore, perceived quality changes when expectations change, and perceived quality can change even when the actual quality of the services does not change. Perceived quality is important for this programme because the programme aims to increase community members’ expectations of the quality of services to which they are entitled, and to increases the community members’ voices in the governance of the health facilities. It then seeks to enable community members to use their increased expectations to demand better services and it is hoped that this will lead to an improvement in the technical quality of the services, and that this, in turn, will lead to increased utilisation of services. Therefore, over the life of this programme we could expect that perceived quality will initially fall as expectations are raised and then perceived quality may rise if quality of services improves.

Despite the commonly mentioned and significant problems regarding the quality/availability of basic infrastructure at the health facilities, community members report very high levels of satisfaction with the health care provided at the primary health care centres, community respondents largely describe health facility structures as being ‘adequate’, and they report high levels of trust in the health workers. There is a sense that facilities’ staff are doing their best within their means, though there were some reports of negative staff attitudes in the qualitative interviews. The satisfaction levels are lowest when service users were asked about the convenience of getting to the facility, the amount of time waiting to be seen and the ease of obtaining medicines.

MNCH service utilisation

Utilisation of ANC and PNC services increased steadily from early 2013 to mid-2014, while the number of children being vaccinated has remained approximately constant. Some service providers and decision-makers attribute the increase in ANC and PNC visits to HTF and RBF funds and to improved community participation and outreach.

The main barriers to utilisation of MNCH services identified are cultural barriers, mainly in relation some segments within the Apostolic church (in total, members of the Apostolic church constitute 33% of Christians in Zimbabwe). Distance to the facility was also a key barrier. Of less importance in terms of increasing utilisation is the quality of facilities. While staff attitudes were often cited as a reason for non-use, poor physical infrastructure was not.

While it is often reported that there is poor physical infrastructure (lack of mothers’ shelter, electricity, water etc.), or a shortage of staff, this was not often given as a reason for not attending. There is a sense of resignation that the facilities are doing the best with the resources they have, and a recognition of the fact that quality has improved significantly since the low point in 2008.

8.2 Implications of key baseline findings for the programme

The findings outlined above show that perceived service quality is not reported as a major factor in determining utilisation levels. We have also found that most users report satisfaction with the quality of current services, often ‘factoring in’ an allowance for the circumstances in which they are delivered. These findings undermine two key assumptions in the programme ToC and raise the very real concern that, even if outputs are delivered as planned, service utilisation levels will not increase as a result.

We recommend that the programme consider whether it should address other barriers to service utilisation in addition to those addressed in the current design. This may mean greater consideration of factors other than a knowledge of rights and processes to increase voice alone. It might also mean giving more attention to the role of HLFs in addressing these areas, in addition to the HCCs.

Key areas for consideration identified in this baseline evaluation, include:

- cultural barriers: the programme can further support HLFs and HCCs in their role of sensitising community members about the importance of using MNCH services instead of relying on traditional medicines or religious practices;

- religious barriers: as the objection to the use of MNCH services is a powerful barrier, reinforced by deeply entrenched beliefs of some Apostolic church members, the programme could consider if there are ways to transform the levy of punitive sanctions by chiefs and traditional leaders into a positive motivation to utilise MNCH services;

- distance: the programme is not able to provide short-term solutions to the issue of distance, though this may be a subject that can be addressed in the longer-term, as grievances and advocacy campaigns that make MNCH needs more widely known reach higher level decision-makers; in the meantime, the programme could support greater outreach by existing facilities into the communities; and

- negative staff attitudes: the programme is well placed to improve the relationship between frontline service providers and community members, using HCCs to minimise tensions between nurses and community members who bring complaints. HCCs can also play a role in monitoring the occurrence of reprisals against service users who bring grievances/lodge complaints. The programme could design interventions to raise awareness among service providers of the benefits of critical feedback so that they view it as a learning mechanism rather than as a threat.

For the programme to improve community participation in health facility governance it needs to:

- focus on providing community members with knowledge that has a practical value, which they can act on to assert their right to access quality services;

- improve community awareness of the existence and roles of the HCCs and clarify the distinction (or non-distinction) between Ward Health Teams/Committees and HCCs, as awareness of both these points is currently low;

- train HCCs and CMs to better understand their roles. Whilst HCCs are largely aware of their role as mobilisers, the baseline evaluation found that greater understanding is needed about their role of bringing grievances to the health facility, of meeting with communities (not just village heads), and also their role of requesting and contributing more substantially during meetings with the DHE. It would also be worthwhile to reinforce efforts to make sure the HCCs are not captured by influential elites, but are representative of the diverse communities they serve;

- train HCCs to put in place complaints mechanisms, respond to fear of victimisation/reprisal, train community members on how, where and with whom to register their complaints. Most people said they would not complain because they do not know where to go to make a complaint, and they are worried about what might happen if they do; those that do complain usually do so to the nurse in charge; and

- consider if the programme implementers' HCC training needs to do anything differently in order to have a sustained effect on key areas of interest. There currently does not appear to be a significant difference between HCCs who have already been trained and those who have not been trained along our HCC outcomes of interest, so either the previous training did not cover the areas of interest, or if it did, the training does not appear to have had a significant effect.

8.3 Implications of the baseline findings for the evaluation

About 20% of ANC patients and carers of under-fives have already received training (mostly from staff at the health facility), while 80% of HCCs have received training (mostly from the District Health Team, other MoHCC staff and staff at the health facility). Furthermore, some elements of the programme began implementation in some districts before the baseline study could be conducted. Yet, despite both these factors, there do not appear to be any significant differences between baseline and comparison groups. This means that we have a good comparison group for the evaluation. It also means that, especially in the case of HCCs, the evaluation will be measuring the effect of additional HCC training, rather than of any HCC training compared with none.

The preliminary verification process of the HMIS data has revealed the existence of considerable discrepancies between what we observed in the facility registers, what is recorded in the facility level tally forms and the official HMIS data. Given that our ability to measure impact at endline will be highly dependent on the reliability of our data sources, we will mitigate the risk that the HMIS database is not accurate by conducting the same HMIS verification survey again; this will provide us with an alternative measure of the utilisation of MNCH services in the facilities of interest.

We have found that some of the assumptions underpinning the ToC do not hold. We will discuss these and the implications of the baseline findings with the SC and CWGH. We propose to work together to revise the ToC diagram, descriptions and assumptions following

the analysis of our baseline data. At the endline, we will assess the programme against the revised ToC.

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Annex A Original Terms of Reference

1. Introduction

DFID wishes to contract an Independent Evaluator either company or consortium) to fulfil the following three objectives:

- **To peer review the already externally contracted Health Transition Fund evaluation (covers the first three components of the Maternal, New born and Child Health Programme (see Background) and assess the degree to which impacts identified can be attributed to DFID funding and whether it is likely that credible and robust evidence will be identified under the HTF evaluation to answer the key questions of interest to DFID (see questions in Section 4).**
- Develop an appropriate and feasible methodology and carry out an in-depth evaluation of the demand and accountability for services through greater citizen engagement component of the Maternal, New born and Child Health Programme.
- Based on evidence drawn from the above evaluations and the programme monitoring systems, complete draft annual reviews, a project completion report and provide additional evidence required to allow DFID Zimbabwe to meet UK accountability requirements pertaining to all components of the programme.

2. Recipient

The recipient of the services will be DFID Zimbabwe.

3. Evaluation purpose, objectives and scope

The purpose of the evaluation is to assess the impact of the programme attributable to DFID. Key questions for the evaluation related to the first three components are:

- What attributable results have been achieved vis-à-vis programme targets?
- What contribution has been made to improving development partner coordination in the health sector?
- How can the appropriateness of support modalities and approaches taken be improved in future?
- Has value for money been achieved and how could it be further improved?
- Has the programme been well managed, given the resource limitations?
- How can sustainability of health sector support be improved, given the realities, context and current tolerance of risk?

Within the framework of the Development Assistance Committee Criteria for Evaluating Development Assistance, the following are priorities:

4. Effectiveness

- The extent to which the planned outcomes and impact were achieved and the major factors influencing the achievement
- The added value of the community accountability component
- The extent to which the outcomes and impact have benefited women and the poor

5. Efficiency

- The timeliness of activities and outputs
- The cost of the quantified gains from community accountability
- The cost per Disability Adjusted life years (DALY) saved
- A comparison of unit costs to the programme with other relevant comparators
- The cost per maternal and child death averted

6. Impact

- Quantification of the impact achieved (positive and negative) that can be attributed to DFID funding and changes that were direct and indirect. Outline the plausible causal chain for major results, with reference to the theory of change, below.

7. Sustainability

- The extent to which the programme benefits will continue and over what timeframe
- The extent to which the programme implementers made all reasonable efforts to maximise sustainability and the likely effectiveness of these efforts
- The influencing and other necessary factors that will sustain programme benefits and the likelihood that these factors will be in placed within what time frame
- The extent to which the programme is aligned to Government of Zimbabwe systems in terms of policy alignment, joint planning, use of Government service delivery mechanisms and personnel.
- **The HTF (first component) will be evaluated independently (see annex 1 for HTF evaluation questions). Within the scope of work above, the role of the DFID Evaluator will be to a) quantify DFID attribution; and b) advise DFID on quality assurance of the HTF evaluation process. The DFID evaluator will review all HTF evaluation methodological and reporting outputs and provide comments (tracked when useful) and recommendations on these to DFID. The purpose of this DFID evaluation is to complement the HTF evaluation, by evaluating the remaining programme components, but also provide an internal advisory peer review/quality assurance function of the HTF evaluation on behalf of DFID.**
- **It is anticipated that the evaluation questions set out thus far can be answered drawing on evidence from the HTF evaluation and monitoring system. The consultant should assess the feasibility of doing this based on the probable evidence which will be available and in cases where there is not sufficient evidence agree with DFID or, through DFID, the Steering Committee/evaluation contractor for the HTF evaluation on amendments to what the HTF evaluation covers/reports.**

8. In-depth Evaluation

There is limited evidence on the impact and value for money of community accountability. Once the implementer is contracted the proposal will be shared with the Evaluator. Conduct an in-depth evaluation for the fourth component that will answer the following research questions:

What difference did the community accountability component make during the life of the programme, and for whom? Impact should be disaggregated by gender, age group and poverty level. Difference is in terms of accountability to the client, transparent decision making regarding community and health facility resources, utilisation, service delivery outputs and client outcomes.

- To what extent are these differences likely to endure, post programme?
- Was it good value for money (eg cost per additional child immunised, cost per DALY averted)? How could VFM (Value for Money) have been improved?
- What were the most plausible causal pathway(s) to successful outcomes?
- What were the defining interventions, if any, which made the most difference?

- What worked and why?
- Was best practice followed?
- To what extent did the implementer analyse the political economy of the relevant context/implementing environment and was this used optimally?
- To what extent did the implementer overcome collective action problems, differential status, and asymmetrical knowledge?
- What else could have been done that would have likely resulted in greater benefits?

9. Governance, coordination and reporting

There will be an Evaluation Steering Group, comprising the DFID Health Adviser, DFID Health Senior Programme Manager, DFID Governance Adviser and DFID Social Development Adviser. Representatives from other key donor agencies and the Ministry of Health and Child Welfare will be invited. The EU is likely to be a member as it wishes to co-fund the in-depth evaluation of the community accountability component.

The DFID Evaluator may be invited to advise the HTF Evaluation Subcommittee directly at times.

The findings from this evaluation will inform the design and implementation of future funding from DFID and other partners, as well as inform policy, strategy and approaches to community accountability in particular. The timing of decisions points that the evaluation will inform will vary among the stakeholders who will use the evaluation findings. DFID is likely to have already designed its new health programme, but the evaluation findings will influence its implementation.

10. Methodology

The DFID Evaluator is expected to provide a clear description of the methodology to be used to deliver on the above scope of work, specify baseline data to be collected and indicate how follow up data will be collected over the duration of the programme. Programme process should be assessed as well as outcomes. Key stakeholders should be consulted.

Given the pooled nature of the HTF, it is not feasible for the independent evaluation contractor to analyse contributions made by different development partners. It is envisaged that this analysis would apportion results to DFID according to the proportion of HTF funding provided by DFID. However, the consultant will also need to document and analyse the value of non-financial elements, such as policy dialogue.

In peer reviewing the quality of the HTF evaluation, the evaluation consultant will (i) be expected to make explicit the standards used in assessing the quality of the evaluation and (ii) assess the robustness and credibility of the results and the main limitations of the analysis in terms of both internal and external validity.
The evaluation consultant will be expected to replicate the analysis carried out by the HTF evaluator and so verify the findings and examine their robustness of findings. To allow this, DFID will ensure that the consultant has access to (i) the estimation data and code and (ii) code book.

The in-depth evaluation should involve non-intervention groups and the selection of areas should take into consideration the other health initiatives implemented in Zimbabwe that may affect results. An outline of the main sources of funding to the health sector that may be of relevance:

Global Fund (GF) – recently submitted Concept Note for around $100 million per year for 3 years includes ART, Prevention of Mother To Child Transmission (PMTC), HTC, male circumcision and behaviour change. Some activities will be in transmission hot spots, others nationwide. Most activities will be at the health facility level and supporting systems, but some may involve community health worker training.

United States Government (USG) funds programmatic components very similar to the GF Concept Note and is around $88 million per year.

The HTF is described elsewhere in the ToRs and will cover 44 districts with the Health Services Fund which provides grants to health facilities (see additional background below). Additionally, the 2013 activities include training community health workers.
Grants to the remaining 18 districts are provided by World Bank as part of its performance based funding programme. This has a community accountability and participation component.

The evaluation consultant is expected to develop a theory based impact evaluation approach in this component, reflecting our expectation that the evaluation provide evidence on both internal and external validity. DFID's understanding of theory of change is at http://r4d.dfid.gov.uk/pdf/outputs/mis_spc/dfid_toc_review_vogelv7.pdf.
Overall, given the range of questions asked, a mixed methods design will be proposed.

For the quantitative component, by preference, the feasibility of using a quasi-experimental design should be considered, bearing in mind that opportunities for the evaluation consultant to influence programme design and delivery mechanisms and selection of participants under this component will be limited and the power calculations for sample size needed to reflect the levels of disaggregation implied by the theory of change may make the sample size (for both treatment and comparison) unaffordable. Non-intervention groups and the selection of areas should take into consideration the other health initiatives implemented in Zimbabwe that may affect results, such as the performance based financing project funded by the World Bank. Finally, the implication that for programmes trying to increase the participation and empowerment of marginalized groups the most likely shape of such programmes' impact over time is a J curve (things get worse before they get better) should be considered.

The Evaluator should set out how they will ensure the study is ethically sound and with which relevant ethical protocols it will comply. Endorsement by a local ethical committee may be required and this should be sought by the Evaluator, as necessary and appropriate.

For all components, the DFID Evaluator will assess VfM of this component through measurement and comparative analysis of VFM indicators according to the DFID guidelines, and cover Economy, Efficiency and Effectiveness (different framework to the DAC criteria).

DFID Zimbabwe will be reporting centrally towards achievement of corporate result targets using various mechanisms such as the Lives Saved Tool (LiST). The Evaluator will assist in this reporting, such as providing the data and clarifying any questions.

11. Logistics and procedures

The Evaluator will be expected to supply their own logistic requirements including office space and transport.

The Evaluator is expected to undertake the evaluation independently and all inputs including staff for survey design, data collection and analysis, and report production should be in the agreed financial proposal.

The Evaluator should provide the output in a form that can be published, not least on the DFID website, but also in relevant journals, as appropriate.

It is expected that the evaluation should conform to OECD-DAC principles of accuracy and credibility, and to the evaluation principles set out in the UK's 2009 policy on evaluation for international development. The Evaluator should set out how they will ensure the study is ethically sound and with which relevant ethical protocols it will comply. Endorsement by a local ethical committee may be required and this should be sought by the Evaluator, as necessary and appropriate.

12. Outputs

Outputs are expected to include:

- An inception report and work plan including study design an M&E plan, in-depth evaluation research protocol with draft tools, main risks and challenges and how to manage them, suggested revisions to indicators/targets, draft VFM indicators, and proposed analytical methods by month 3 of the contract. The DFID Evaluator can propose changes to the evaluation questions early in the inception phase and include the revised questions in the inception report. Drafts will be submitted by month 2 for comment by the Steering Committee.
- Evidence of adhering to ethical protocols and procedures;
- A baseline survey report for the **in-depth evaluation** within 2 months of finalisation of the inception report;
- A **publication and dissemination** strategy by month 5 of the contract;
- Standalone report on the findings of the **in-depth evaluation** (within 3 months of the end of the programme)
- Standalone report on the programme evaluation to supplement the Project Completion Report (at end of programme, along with the PCR)
- Draft annual reports and PCR in DFID format (except the first annual report due in May 2013 that has already been completed).
- Six-monthly updates in between formal reviews on the progress of the evaluation.
- Ad hoc comments on outputs from the HTF evaluation implementer (within 10 days of receipt).

Ownership of all data collected will lie with DFID and arrangements for longer term storage and accessibility of any data generated will be agreed during the Inception Phase between DFID and the Evaluator.

13. Skills/experience required

Team Leader with experience of successfully managing evaluations using mixed methods. Skills within the core team should include:

- Strong and proven background in quasi experimental designs and their application;
- Strong skills in qualitative research;
- Demonstrable capacity to design, implement and analyse surveys within time and budget; and

Understanding and familiarity with health systems reform/accountability reform and gender/poverty analysis

14. Timing

The duration of the contract is expected to be from September 2013 to March 2016. All timings for outputs will need to be agreed with the Evaluation Manager and coordinated with the HTF evaluation activities.
Attached key documents

1. Business case
2. EGFAP proposal
3. HTF TORs
4. HTF proposal
5. HTF plan for 2013
6. DFID Ethics Principles

15. Duty of Care

The SP (Service Provider) is responsible for the safety and well-being of their Personnel (as defined in Section 2 of the Contract) and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the SP on security status and developments in-country where appropriate. DFID will provide the following:

- All SP's Personnel will be offered a security briefing by the British Embassy on arrival. All such Personnel must register with their respective Embassies to ensure that they are included in emergency procedures.
- A copy of the DFID visitor notes (and a further copy each time these are updated), which the SP may use to brief their Personnel on arrival.

The SP is responsible for ensuring appropriate safety and security briefings for all of their Personnel working under this contract and ensuring that their Personnel register and receive briefing as outlined above. Travel advice is also available on the FCO website and the SP must ensure they (and their Personnel) are up to date with the latest position.

This Procurement will require the SP to operate in conflict-affected areas and parts of it are highly insecure. Travel to many zones within the region will be subject to travel clearance from the UK government in advance. The security situation is volatile and subject to change at short notice. The SP should be comfortable working in such an environment and should be capable of deploying to any areas required within the region in order to deliver the Contract (subject to travel clearance being granted).

The SP is responsible for ensuring that appropriate arrangements, processes and procedures are in place for their Personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the Contract (such as working in dangerous, fragile and hostile environments etc.). The SP must ensure their Personnel receive the required level of training and safety in the field training prior to deployment.

Tenderers must develop their Tender on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix developed by DFID (see Annex 1 of this ToR). They must confirm in their Tender that:

- They fully accept responsibility for Security and Duty of Care.
- They understand the potential risks and have the knowledge and experience to develop an effective risk plan.
- They have the capability to manage their Duty of Care responsibilities throughout the life of the contract.

If you are unwilling or unable to accept responsibility for Security and Duty of Care as detailed above, your Tender will be viewed as non-compliant and excluded from further evaluation.

Acceptance of responsibility must be supported with evidence of capability and DFID reserves the right to clarify any aspect of this evidence. In providing evidence Tenderers should consider the following questions:

i. Have you completed an initial assessment of potential risks that demonstrates your knowledge and understanding, and are you satisfied that you understand the risk management implications (not solely relying on information provided by DFID)?

ii. Have you prepared an outline plan that you consider appropriate to manage these risks at this stage (or will you do so if you are awarded the contract) and are you confident/comfortable that you can implement this effectively?

iii. Have you ensured or will you ensure that your staff are appropriately trained (including specialist training where required) before they are deployed and will you ensure that on-going training is provided where necessary?

iv. Have you an appropriate mechanism in place to monitor risk on a live / on-going basis (or will you put one in place if you are awarded the contract)?

v. Have you ensured or will you ensure that your staff are provided with and have access to suitable equipment and will you ensure that this is reviewed and provided on an on-going basis?

vi. Have you appropriate systems in place to manage an emergency / incident if one arises?

16. Background

DFID Zimbabwe is in the early stages of implementing a £74 million MNCH Programme that ends December 2015 and has four components:

1. Contribution to the Health Transition Fund, a pooled fund managed by UNICEF that supports MCH service delivery, human resources, commodities and decentralised planning and funding;
2. ARV procurement through USAID implemented by John Snow International
3. Paediatric ARV treatment through the Elisabeth Glaser Paediatric AIDS Foundation

4. Supporting demand and accountability for services through greater citizen engagement (implementer to be confirmed).

The project will contribute to

- Preventing 1,840 women dying related to childbirth
- Saving 30,700 under five lives
- Halving the prevalence of under-nutrition
- Providing ARVs to 65,000 people annually

This will be achieved through increases in

- deliveries with a skilled birth attendant,
- four antenatal visits,
- immunisation coverage for under 5s,
- coverage in treatment of neonatal sepsis, pneumonia, diarrhoea and malaria;
- exclusive breastfeeding,
- trained midwives,
- availability of medicines,
- doctors able to provide c-sections

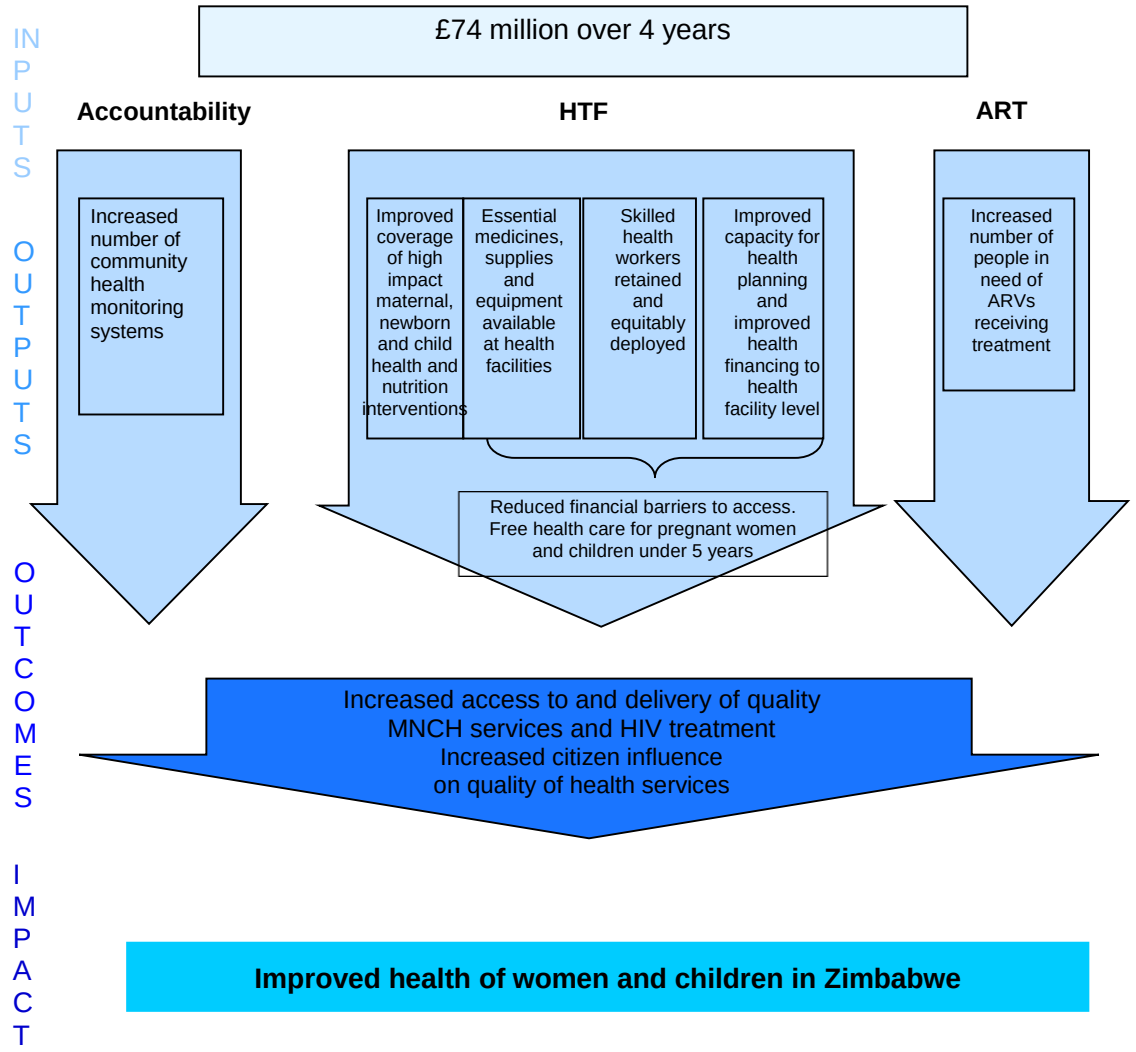
and a decrease in key health worker vacancies.

17. Theory of Change

Theory of Change from the Maternal and Newborn Child Health Business Case

i) Intervention logic/Theory of Change

The chart below illustrates the expected theory of change highlighting the contribution of each component.



Additional Background

Zimbabwe is seriously off track to meet its health related MDGs and the health of mothers and children has significantly declined. A turbulent economic and political decade has interrupted many of the gains made in the first 20 years of independence. Maternal mortality increased drastically from 168/100,000 in 1990 to 960/100,000 in 2011.

DFID's programme primarily focuses on addressing the following challenges:

- High maternal mortality - 960/100,000 DHS 2010/11

- HIV is still the major cause of maternal deaths and the second major cause of child deaths.
- 47% of women have experienced physical and/or sexual violence (DHS 2005/6).
- Despite the good contraceptive prevalence rate and low stock out rates for family planning commodities below 5%, there has been no fall in the unmet need for family planning (FP) since 1999. It remains stagnant at 13%. It is estimated that 30% of maternal deaths result from unintended pregnancies.
- Zimbabwe's population is very young and faces significant reproductive health challenges. 62% of Zimbabwe's total population is below 24 years and 21.3% are in the reproductive age group of 15 to 24. Rural young women aged 15-19 years are twice as likely to fall pregnant than their urban counterparts signifying greater barriers to access to family planning for this group. HIV prevalence among 15-24 year olds is three times higher among women than men.[38]
- Equity data demonstrates considerable disparities between rich/poor and urban/ rural settings. On average, 43% of lowest 2 quintiles lack access to basic health services across ten key health indicators, up from 26% in 1999 (UNICEF 2010)

The Government of Zimbabwe launched a five-year National Health Strategy in 2009 but lacks the resources to implement it. According to 2011 UN reports, Zimbabwe currently spends US$9 per capita on health, significantly less than the US$34 recommended by the Ouagadougou Declaration. The MOHCC is highly dependent on external funds to maintain and improve service delivery. The Health Sector Investment Case 2010-2012 identified lack of resources as the single 'major challenge facing the health sector'.

Health Transition Fund - £50 million

In support of the national health sector strategic plan and in response to the health sector investment case, a four-year multi–donor pooled fund, known as the Health Transition Fund (HTF), has been established to support the Ministry of Health and Child Welfare (MoHCW) to achieve the highest possible level of health care and quality of life for all Zimbabweans.

The HTF pool fund contributors are; DFID, EU, CIDA, IRISH Aid, Norwegian Government, Swiss Technical Cooperation, Swedish government. The fund is managed by UNICEF. The Ministry of Health and Child welfare in consultation of the different departments and sub-national management bodies will take the lead to identify priority areas of the health system that need to be supported through the HTF. The HTF steering committee is responsible for the oversight and decision making role of the HTF.

The HTF steering committee is co-chaired by the Permanent Secretary of the MOHCW and one of the funding partners of the pool fund. The steering committee members are composed of MOHCW, funding partners to the HTF, representative of international civil Society and local Civil organizations, representatives of WHO, UNFPA, UNAIDS, USAID, World Bank and Global Fund. UNICEF is a member and serves as the secretariat of the HTF Steering Committee. The HTF has been established to support the MoHCW to address the following four thematic areas:

Thematic area one: Maternal, Newborn, Child health and Nutrition

The support areas include:

1) Maternal and new-born health: enhancing emergency obstetric and new-born care capacity of the country through training, particularly increasing midwifery production
2) Child health : Improve the quality of care for preventive and curative interventions at all levels;

[38] DFID's other health programme covering Sexual and Reproductive Health addresses family planning and violence against women.

3) Strengthening the community health service delivery system for MNCH through supporting community health workers
4) Maternal, new-born and Child health nutrition though training and provision of supplies

Thematic area two: Medical Products, Vaccines and technologies (medicines and health commodities)

Support areas include:
- Provision of selected essential medicine and medical supplies
- Procurement of vaccines and injection materials and cold chain equipment for immunization
- Emergency obstetric and newborn care equipment and consumables;
- Ready to use therapeutic and supplementary nutrition
-

Thematic area three: Human Resource for Health

The most important support areas of this thematic area include:
- Strengthen Human Resource for Health planning and management
- Ensure health worker retention scheme is maintained and resourced
- Support to the Health Worker Retention Scheme
- Retention Allowances to doctors in district hospitals
- Retention allowances to practicing midwives and nurses in maternity departments
- Retention Allowances for critical posts

Thematic area four: Health policy, planning and finance (Health Service Fund)

The support area is mainly providing financial support to peripheral health facilities including all district and rural hospitals, district health management offices and primary health centres through the existing health financing system known as the health service fund. This will be accompanied by strengthening planning, monitoring and evaluation.

UNICEF will contract out the evaluation of the HTF (tender process almost complete at the time of writing). Evaluation criteria and in-depth questions to be assessed for the HTF Evaluation are in Annex 1. An Evaluation Subcommittee, of the main Steering Committee,will commission and oversee the evaluation.

ARV procurement - £18 million.
Managed by USAID, and administered by John Snow International, the funds will be used for procurement, shipping, clearing and delivery of ARVs to Natpharm Warehouse. Once at Natpharm, USAID will take responsibility for storage and delivery to health facilities,

Paediatric ARV treatment through the Elisabeth Glaser Paediatric AIDS Foundation - £2 million
EGPAF is implementing a mulit-donor funded, strategic programme framework to expand integrated PMTCT and paediatric care and treatment services. DFID's funding will contribute to a) training, supportive supervision and mentoring on integrated paediatric HIV diagnosis and treatment at all levels; and b) strengthening management, coordination, leadership and accountability for paediatric HIV care and treatment services at the national level.

Demand and accountability for services – £2 million
This entails supporting demand and accountability for services through greater citizen engagement and community monitoring (implementer to be confirmed). This will involve a) raising awareness of local communities of their rights and entitlement to health, together with reference to the Patient's Charter and development of a complaint's mechanism; b) strengthening community health committees and introducing score cards; c) facilitating citizen

engagement with health providers; and d) inform, facilitate and encourage feedback from the community leading to changes in policy and institutional behaviour. Interventions will target 36 districts, and will likely be co-funded with another donor (EU). DFID plans to fund implementation in 18 districts, with coverage within districts approximately 20%. The community accountability component is meant to complement the Health Services Fund (Thematic Area Four within the HTF).

ANNEX 1 - SUMMARY RISK ASSESSMENT MATRIX

(COMMERCIAL IN CONFIDENCE)

DFID Overall Project/Intervention

Project/intervention title: Maternal and New-born Child Health in Zimbabwe -Community Accountability

Location: HARARE

Date of assessment: 16 June 2013

Theme	**DFID Risk score**
	National
OVERALL RATING[39]	**3**
FCO travel advice	1
Host nation travel advice	unknown
Transportation	3
Security	3
Civil unrest	2
Violence/crime	3
Terrorism	1
War	1
Hurricane	1
Earthquake	1
Flood	1
Medical Services	2
Nature of Project/ Intervention	**3**

1 Very Low risk	2 Low risk	3 Med risk	4 **High risk**	5 Very High risk
Low		**Medium**	**High Risk**	

NB: This is an assessment of the current situation. The situation in Zimbabwe may possibly change over the life of the programme.
Post Security assessment for Zimbabwe is currently at C(c)3F

[39] The Overall Risk rating is calculated using the MODE function which determines the most frequently occurring value.

Annex 2

Request for Proposal ZIM/2012/015-0
Evaluation Criteria and In-Depth questions to be assessed for the final HTF Evaluation

Evaluation criteria and in depth questions to be assessed for the final HTF evaluation

In drawing together the Final Impact Evaluation, the Institution or the team of consultants will conduct detailed analysis in the four thematic areas. This in-depth analysis will be presented as stand-alone annexes. The preparatory phase will allow the development of an evaluation framework showing how in-depth area analysis will support the synthesis of information for the overall report, and how different methods and respondents will be deployed to explore topics to answer evaluation criteria.

Evaluation criteria	**In depth areas for analysis**
1. Impact *The extent to which the objectives of the Health Transition Fund have been achieved as intended and its contribution to the overall HTF goal.*	**In depth question 1:** **What changes have resulted as an impact of the HTF, including an equity and gender analysis?** *1. Direct and indirect results, outcomes and impact of the Health Transition Fund* *2. Who has benefitted, particularly in terms of gender equity and vulnerable populations* *3. Assessment that change has occurred; whether change can be attributed to the HTF* *4. What are the plausible scenarios if there was no HTF* *5. Evaluating the monitoring and evaluation arrangement, reflection on ability to conduct an impact evaluation; appropriateness of the monitoring and evaluation arrangements, and key lessons for future funding* *6. The extent to which the objectives of the HTF has been achieved as intended and its contribution to the overall HTF goal*
2. Relevance *The extent to which the objectives of the program are consistent with beneficiaries requirements, country needs, global priorities and funding partners' policies*	**In depth question 2:** *The HTF relevance to the operating context and situational changes. This will focus on four main areas:* *1. Consistency of objectives of the program with beneficiaries requirements, country needs, global priorities and funding partners' policies* *2. Appropriateness of governance arrangements; alignment; consistent with aid effectiveness principles in a country that is coming out of crisis and moving towards development. Flexibility and adaptability to risk identification and management*

	3. Facilitation or constraint by external factors; program design, management, governance arrangements; participation of relevant stakeholders *4. Whether the impacts have made a difference in terms of governance and funding partners development programs*
3. Effectiveness *How far the project results were attained and pecificobjectives are achieved*	**In depth question 3:** **Are we doing things right?** *1. Effectiveness in reaching the target populations and vulnerable groups* *2. Whether the program is effective in terms of improving MNCH and other social gains* *3. How unintended results have affected the outcomes and could have been foreseen and managed*
4. Efficiency – value for money and sound management *How well the HTF transformed the available resources into the intended outputs and outcomes in terms of quantity, quality and timeliness of delivery*	**In depth question 4:** **Has the HTF delivered value for money?** Considering the HTF as a whole, and the four thematic areas: *1. Whether the incremental benefits outweighed the incremental costs (costbenefit);* *2. The overall rate of return; including a sensitivity analysis of reasonable variations in the assumptions* *3. Whether it yielded a better return than comparable programs, including an analysis as far as possible of unit costs per beneficiary reached with key interventions* *4. Whether it provided the best return possible from this type of funding mechanism and of interventions (value for money)*
5. Sustainability *Whether the positive outcomes of the project and the flow of benefits are likely to continue after HTF ends.*	**In depth question 5:** **Will changes last?** *1. Ownership of objectives and achievements* *2. Policy support and the responsibility of beneficiary* *3. Institutional and technical capacity of implementing partners* *4. Extent to which the target group were involved in design and implementation* *5. Financial and economic sustainability* 6. *How cross cutting issues such as gender equity, governance and accountability were addressed*

Annex B Changes to the TOR agreed during inception

During the inception phase OPM and DFID agreed a restructuring, clarification and simplification of the main evaluation questions, which were then reformulated around the standard DAC criteria. The revised evaluation questions are shown in Annex D.

We agreed that we would focus the VfM analysis on the cost-effectiveness of the intervention in increasing service utilisation and user satisfaction rather than on final outcome DALY measures. The revised VfM indicators are shown in Annex P.

We also agreed that primary data on the following would be collected: perceived quality of care; quality and functionality of health centre committees; knowledge of rights and entitlements; and decision making regarding health facility resources. Concomitantly, we will rely on secondary data sources for: service utilisation; and the technical quality of health facilities. We will largely measure service utilisation through the HMIS and Health Transition Fund results-based financing data and disbursements but we will cross-check the HMIS by comparing with the observations in the registers at the facilities we survey. This analysis, which we call HMIS verification, is shown in Annex W.

Finally, the Terms of Reference hypothesise that the most likely shape of the programme’s impact over time is a J curve (i.e. things get worse before they get better). We assume this relates to user satisfaction outcomes and perceived quality of health care outcomes, rather than outcomes such as service utilisation or knowledge of rights and entitlements because the program may raise citizen’s expectations on what they can expect from health facilities and thus reduce satisfaction and perceived quality. To measure if the programme impact follows a J curve, we would need at least three observations over time, and likely more. In the cases where we will rely on primary data, we will only have two observations at baseline and endline; therefore we will not be able to measure if impact follows a J curve. Where we have secondary data that includes three or more observations, we will be able to examine if outcomes follow such a curve. This will be assessed using the HIMS and RBF data.

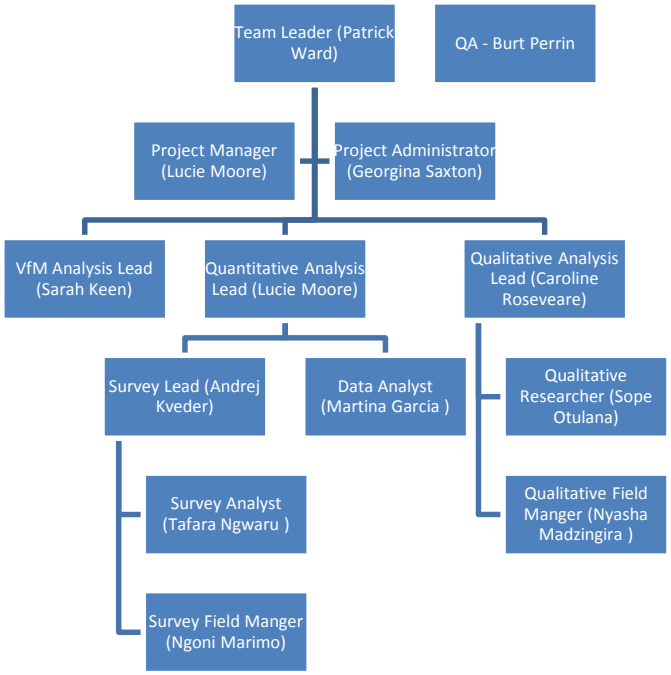
Annex C The evaluation team

Patrick Ward, OPM Team Leader, provides overall direction for the evaluation: patrick.ward@opml.co.uk

The main OPM contact point is the Project Manager, Lucie Moore: lucie.moore@opml.co.uk

Please see the team organogram below:

Figure 8: The evaluation team



Patrick is the evaluation team leader and has overall responsibility for design, analysis and results. **Lucie** is the overall project manager and also led the quantitative component of the evaluation, including the design and testing of the Health Facility Survey tools and the quantitative components' analysis and report writing. **Andrej** had overall responsibility for the Health Facility Survey, contributed to the design of the Health Facility Survey tools, and led the training of the data collectors and the data cleaning. Tafara supported the training of the enumerators, quality assured the data collection and data entry, and supported the data cleaning. **Ngoni** managed the in-country data collection team. **Martina** worked with Lucie on the data analysis of the Health Facility Survey and the analysis of the HMIS data. **Caroline** led the quantitative component of the evaluation, including the design of the qualitative tools, as well as reviewing the report. **Sope** led the qualitative analysis and report writing. Sope was supported by Nyasha, who also managed the qualitative data collectors. **Sarah** has overall responsibility for the VfM analysis.

Below are the pen portraits for members of the team:

Team Leader: Patrick Ward is the Director of OPM's Statistics, Evidence and Accountability Programme and therefore brings outstanding experience of leading complex

mixed methods evaluations for DFID. He has more than 15 years of experience in the production and use of social statistics for monitoring and evaluation in various sectors, including health, nutrition, education and social protection. Patrick has extensive experience of leading impact evaluations and using quasi-experimental methods, randomised controlled trials and other approaches. For example, he is currently Team Leader for a DFID impact evaluation of the WINN nutrition programme in Nigeria. He has world-class experience of the design, management and analysis of large quantitative surveys for official statistics and national monitoring processes, including monetary and non-monetary poverty measures, and has experience of supporting the development of national capacity in social statistics and household surveys throughout Africa and Asia. He is currently the M&E Technical Adviser for the Independent Monitoring and Evaluation of State Level Programmes in Nigeria (with a total budget of over £400 million) and recently acted as Team Leader for a DFID Uganda mixed methods impact evaluation on Social Assistance for Empowerment. In recent years he has also acted as team leader for two Kenyan impact evaluations of cash transfer programmes (for DFID and UNICEF). Patrick has broad health evaluation experience including in MNCH, as he is currently the Evaluation Manager for a major evaluation of two DFID Results Frameworks in RMNCH and Malaria. He worked as Team Leader for DFID on a six-year project to monitor and evaluate health sector reform in Nigeria and provided oversight to the fourth evaluation of the Lady Health Workers Programme in Pakistan. He has experience of service delivery and public expenditure tracking surveys of health facilities, for example as part of an education and health evaluation in Bangladesh, and he also worked for the World Bank in the Maldives on M&E of a human development programme.

Project Manager and Quantitative Analysis Lead: Lucie Moore works in the Monitoring and Evaluation team at OPM. Her area of expertise is quantitative research, including randomised controlled trials and quasi-experimental impact evaluations, econometric analysis and survey design and management. She holds an MPhil in Economics from the University of Oxford, where she was a Clarendon Scholar, a BCom (Hons) in Economics from the University of Melbourne, and a BSc in Mathematics & Statistics from the University of Melbourne. Lucie is currently leading the quantitative component of an impact evaluation of the Child Development Grant Programme in Nigeria, an unconditional cash transfer programme for pregnant women and mothers with young children. She has also worked on the quantitative component of the impact evaluation of a five-year, £50 million child nutrition programme, which is operating in five states in northern Nigeria. Prior to joining OPM, she worked as a consultant for the World Bank on the randomised impact evaluation of a cash transfer project in Malawi, and for Innovations for Poverty Action on the design of a randomised impact evaluation of a water sanitation project in Bangladesh.

Qualitative Analysis Lead: Educated to doctoral level in Development Studies and qualified in law, as well as an experienced Law and Social Development professional, **Caroline Roseveare** has worked for over 25 years across the governance, social development, and justice and security sectors, specialising recently in accountability and gender. She has expertise in the design and implementation of evaluation methodologies using a comprehensive range of M&E tools, including perception surveys, impact and risk assessment, and programme audit. She has undertaken extensive work to mainstream gender, diversity and human rights into programme evaluation and design. Her research and knowledge management experience is broad, covering the full range of qualitative skills: from survey design, data collection and analysis, to report writing. She maintains a strong focus on participatory approaches to build the research and M&E capacities of national

(state and non-state) partners, including those living in conflict-affected states. Having lived in southern Africa for more than a decade, Caroline has subsequently worked with extremely vulnerable communities, all over the world, to enhance voice and institutional accountability. Recently Caroline has been team leader for a multi-agency evaluation of Woman and Child Protection Systems for the Government of Namibia (2011–2012), a review of access to justice for survivors of violence in Sierra Leone (2011–2012), and for a Sierra Leone Police Team to develop a M&E Framework to ensure compliance and spread best practice through Standard Operating Procedures (2010–2011). Previously she led and managed global evaluations of Oxfam’s gender and disability rights work and annual impact assessments for the ‘Right to be Heard’ and ‘Overcoming Discrimination’ programmes (2000–2002).

VfM Analysis Lead Sarah Keen works in the M&E portfolio at OPM. Her areas of expertise include both quantitative and qualitative research including mixed-method evaluations, cost–benefit analysis, and survey design and management. Prior to joining OPM she worked as a senior consultant in the Measurement and Evaluation team at New Philanthropy Capital, a London-based think tank and consultancy dedicated to helping funders and charities to achieve a greater impact, and as a research associate for the Centre for Microfinance/J-PAL, managing a research study, which included a large-scale household survey, about the importance of social networks to the uptake of microfinance in southern India. She has also been an intern at DFID. She holds an MSc in Economics for Development from the University of Oxford and a BA (Hons) in Economics from the University of Cambridge.

Survey Lead Andrej Kveder has extensive experience in data collection methodology, design, implementation and optimisation of fieldwork procedures and contacting strategies. Andrej is particularly interested in issues relating to data quality and in assuring high levels of data accuracy, including data harmonisation across measurement instruments, countries and time, as well as in standardisation of data documentation. Before joining OPM, Andrej worked as the project manager and survey methodologist of the Generations and Gender Programme, a large-scale, internationally comparative longitudinal survey, at the Netherlands Interdisciplinary Demographic Institute and UNECE. He also worked as consultant on data harmonisation at the Max Planck Institute for Demographic Research, as consultant on data quality for the Illicit Drugs Unit of the Institute of Public Health of Republic of Slovenia, as researcher at the Socio-medical Institute of the Scientific Research Centre of the Slovenian Academy of Sciences and Arts, and as project manager and consultant at VALICON, a marketing, consulting and research firm. He holds a PhD in Sociology (survey methods), an MA in Communication Studies (methods) and a BA in Sociology (social informatics) from the University of Ljubljana, Slovenia.

Survey Analyst Tafara Ngwaru is a Zimbabwean national, working as a Consultant in OPM’s South Africa office. Tafara holds a PhD in Economics from the University of Cape Town and his area of interest is the use and application of scientific and quantifiable research methods to solve social problems, especially in health, education and social services. For his PhD, he explored various statistical relationships between social lifestyle variables, socio-economic status and HIV among individuals in Zimbabwe, Lesotho and Swaziland using large household survey data. His dissertation highlighted some of the novel differences among these epidemics and can assist policy-makers in developing highly tailored and suited interventions for the countries involved. Prior to joining OPM, Tafara worked in management consulting. He has experience working in the health, financial services and mining sectors and has done extensive strategy consulting work within the public sector for provincial and local government. Some of the projects he has worked on

include the remapping and restructuring of a provincial healthcare system in South Africa, strategy development and implementation for local and provincial government (and the private sector) and policy design for local government. His specific roles on these projects have included conducting benchmarking exercises, financial analyses and projections, process mapping, feasibility analyses, report writing, and small-scale survey design.

Survey Field Manager Ngoni Marimo has over five years of experience in international development in Africa, gained from work experience with a wide range of donor and partner organisations including DFID, the Overseas Development Institute and the World Bank and various NGOs. He has gained experience in the monitoring, evaluation and impact assessment of development projects and programmes, has developed and managed M&E frameworks in a number of African countries and has experience carrying out research, evaluation and impact assessment studies. Ngoni has multi-sectoral experience including in health, where he has worked on the Equity and Quality of Care MNCH Survey funded by the World Bank and DFID's National Action Plan for Orphans and Vulnerable Children. He has strong research, data processing, quantitative and qualitative skills, gained from a wide range of work experience.

Qualitative Researcher Sope Otulana is an Assistant Consultant in OPM's Social Development portfolio. Prior to joining OPM she worked on child labour issues at the International Labour Organization, conducting secondary research and providing inputs on qualitative methodology to impact evaluations and thematic studies on institutional analysis, poverty and vulnerability, and on gender issues in the Philippines, Pakistan, the Dominican Republic and Tanzania. As a research assistant at the Institute of Development Studies, Sope contributed to research and evaluations on a range of topics including pastoral livelihoods, gender equality, and social protection. Her particular interests lie in social inclusion and voice and accountability, and she is presently contributing to qualitative research on citizen engagement in Mozambique, as well as to cash transfer evaluations in Kenya and Uganda.

Qualitative Field Manager Nyasha Madzingira is a Zimbabwean national with over 18 years' experience in HIV and AIDS development work. She is a PhD holder and an expert in HIV and AIDS programme design, implementation and evaluation; research evaluation; material development; capacity development; mainstreaming gender; and project management. Dr Madzingira is an expert in quantitative and qualitative data collection and analysis methodologies, with experience in basic research, baseline surveys, rapid assessments, and KAPB surveys. She also has vast experience in research tools design, carrying out of surveys, needs assessments, mid-term and end-of-project reviews/evaluations of HIV and AIDS programmes/projects. Recently she has carried out a mapping exercise on HIV prevention strategies in southern Africa, culminating in the design of a Business Case for the DFID Southern Africa Regional HIV Prevention Programme 2013 to 2015. She has also carried out an evaluation (using the OECD-DAC criteria) of the Tripartite Partnership in Health, HIV & AIDS Programme 2006–2012 for Irish Aid Lesotho. Most of her consulting work has been in eastern and southern Africa.

Quality assurance is provided by Burt Perrin, an independent consultant based in France, who has over 35 years' practical experience in evaluation, policy development and strategic planning. Burt is recognised as a leader in the international evaluation community. For example, until recently he was Vice President, currently Senior Advisor, of the International Organization for Cooperation in Evaluation (IOCE) and Secretary-General of the European Evaluation Society. Moreover, in recognition of his exceptional contribution to

the Society and to evaluation, he has been awarded its only honorary lifetime membership. He was a founding director of the Canadian Evaluation Society and a founding member of the American Evaluation Association. He has published on a wide variety of topics. Burt works extensively as a quality assurance expert for a variety of organisations, commenting both on evaluation systems and on the quality of specific evaluations (and the syntheses of individual evaluations). He also advises on the design and management of evaluation processes and systems, as well as regarding M&E plans, designs and methodologies. Burt is also a peer reviewer for a variety of international journals, is a former member of the Editorial Board of the *American Journal of Evaluation*, and is currently on the editorial board of the *Canadian Journal of Program Evaluation*.

Burt’s obsession is with making evaluation useful, to aid in improved strategies, policies and programmes that result in improved lives for people, communities and society. Burt takes a methodologically diverse and practical approach to his work, involving to the extent possible a collaborative approach with his clients. Consistent with his emphasis on making information of all forms useful – and used – Burt is also a recognised expert in knowledge management.

Annex D Overall evaluation framework and evaluation questions

DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
RELEVANCE To what extent are the objectives of the programme still valid? Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives? Are the activities and outputs of the programme consistent with its intended impacts and effects?	**Baseline**	
	What is the context within which the programme is being implemented? - Has the context changed since the design? How might this affect the objectives of the programme? **How is the programme design (and any implementation to date) consistent with the overall goal and the attainment of its objectives within this context?** - What are the demand-side (user) constraints to the programme successfully achieving its goals (Assumptions 1–4) - What are the supply-side constraints to the programme successfully achieving its goals? (Assumptions 5 & 6) - What are the perceptions of HCC constraints and strengths/opportunities by community members and HCC members (Assumption 4)	Separate FGDs with women (including adolescent girls) and men Interviews with frontline health service providers, HCC heads and MNCH decision-makers FGDs with members of HCCs Document review
	Endline	
	Were the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives? - What are the demand-side (user) constraints to the programme successfully achieving its goals? (Assumptions 1–4) - What are the supply-side constraints to the programme successfully achieving its goals? (Assumptions 7 & 8) - What are the perceptions of HCC constraints and strengths/opportunities by community members and HCC members (Assumptions 6 & 9–14)	As above plus: Document review: programme design, annual reviews, Government of Zimbabwe policy documents
EFFECTIVENESS	**Baseline**	
	To what extent have preliminary activities and outputs been achieved? (Assumptions 1–17)	

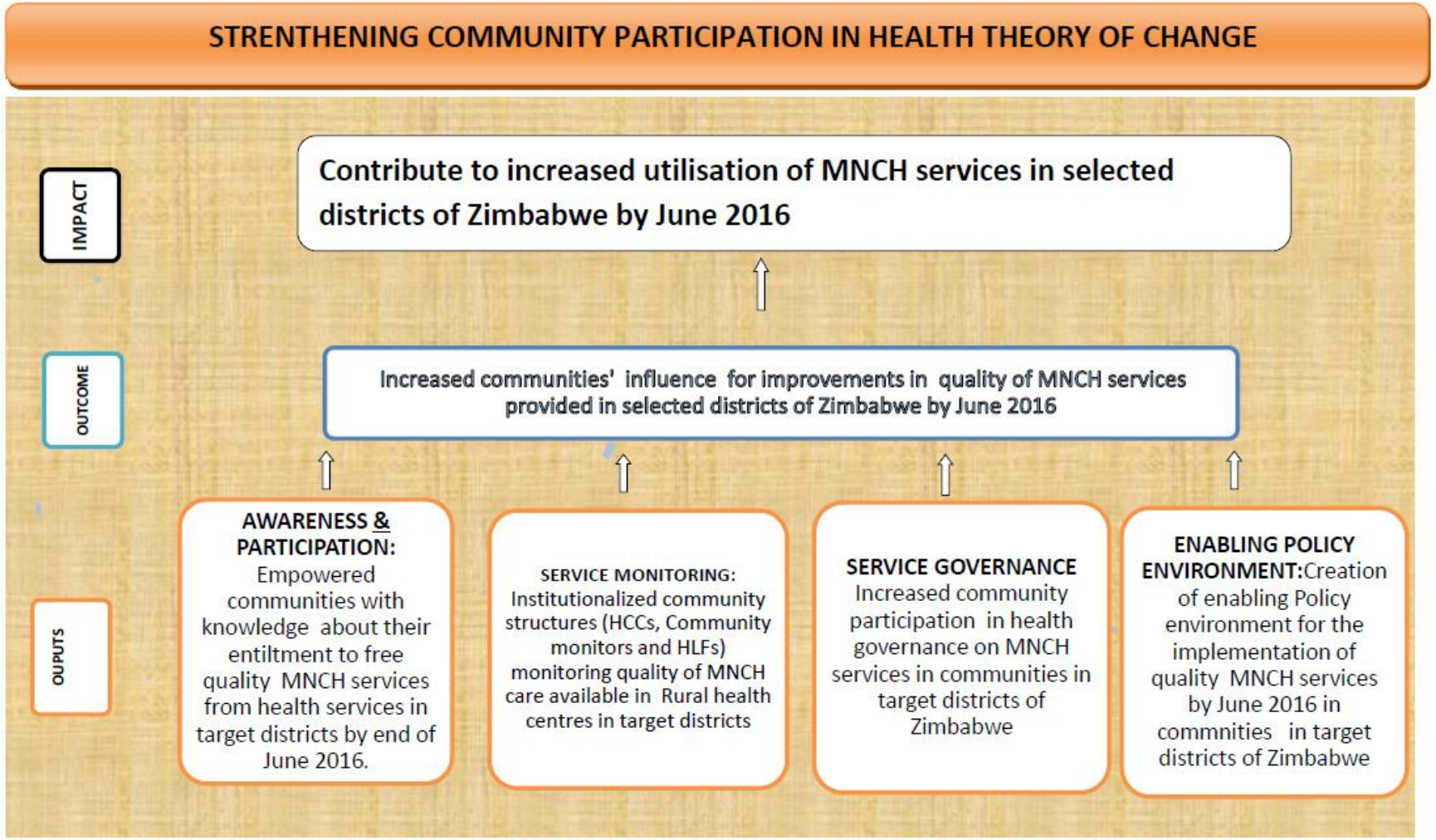
DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
What worked well and what worked less well and why? What were the major factors influencing the achievement or non-achievement of the objectives?		FGDs with members of HCCs
	Endline	
	What worked and why? - To what extent were the intended outputs and outcomes of the programme achieved? (Assumptions 1–17) **What were the major factors influencing achievement or non-achievement of the objectives?** - What is the link between user feedback and changes in practice/policy? (Assumption 1–17) - How has the programme contributed to increased awareness of and ability to use accountability mechanisms among different groups? (Assumptions 1–4) **Were there any unexpected effects?** (Assumptions 1–17) - What, if any, unanticipated effects (positive or negative) has the programme had on gender norms/community dynamics/decision-making processes? (Assumptions 1–4 & 7–9)	Sources specified by indicator in logframe Key informant interviews with key officials at facility, district and provincial levels FGDs with male and female community members, including adolescent girls, will allow unexpected preliminary quantitative results to be probed
EFFICIENCY Was it good VfM? How could VfM have been improved?	**Baseline**	
	Not assessed at baseline	
	Endline	
	Was it good VfM? **How could VfM have been improved?**	Implementing partner programme expenditure accounts Financial reports to DFID Key informant interviews with stakeholders

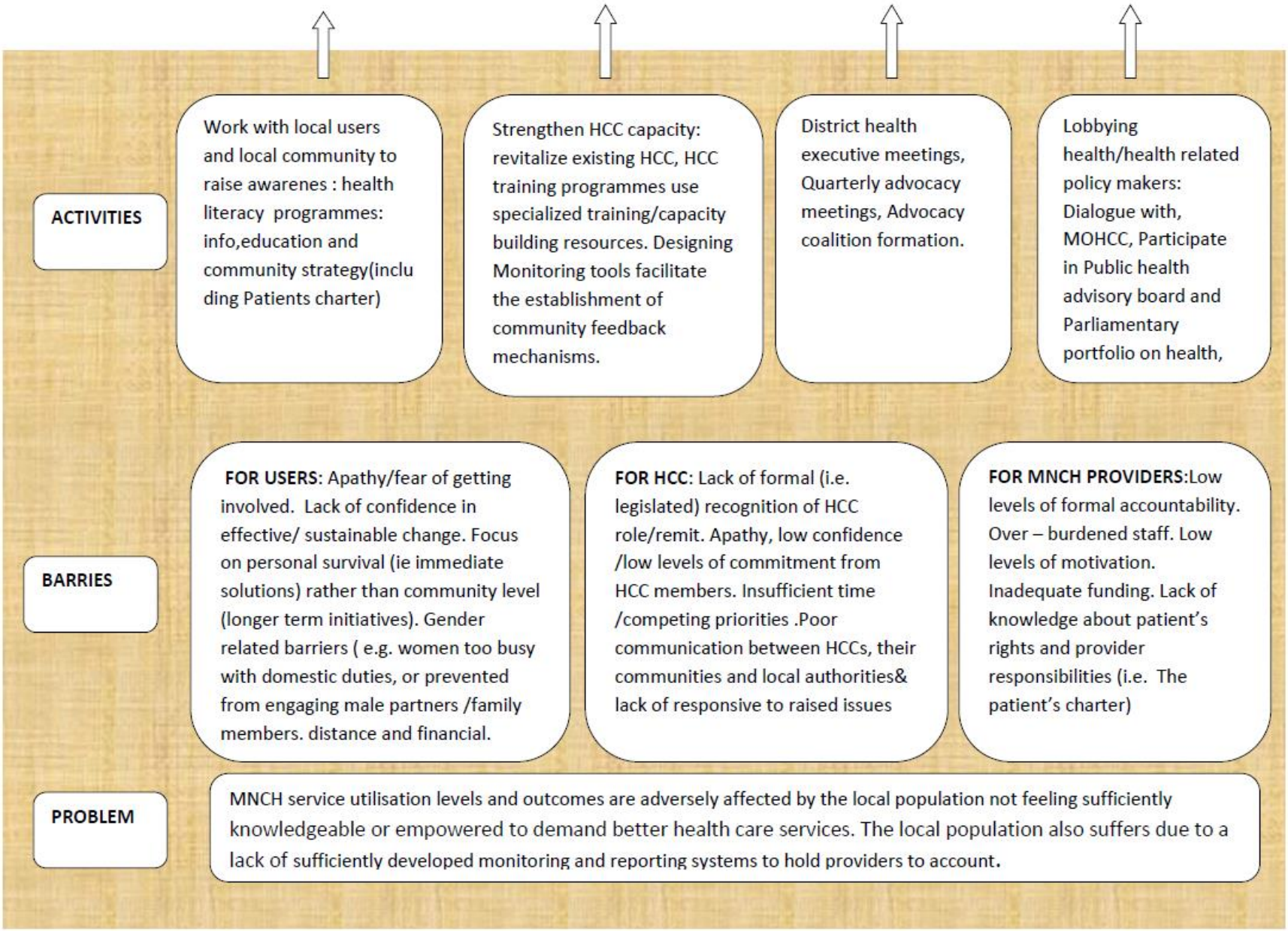
DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
		Key output indicator data from impact evaluation
IMPACT What was the causal effect and contribution of the programme on the expected outputs, outcomes and impact along its theory of change?	**Baseline**	
	What is the pre-programme current level of: 1. Service utilisation 2. Technical quality of health facilities 3. Perceived quality of care 4. Quality and functionality of HCCs 5. Knowledge of rights and entitlements 6. Decision making regarding community and health facility resources (Assumptions 1–17)	HMIS and HMIS Compilation ANC and Under 5 Exit Survey Head of facility survey and HCC Survey Fieldwork observation Crown Agents RBF Survey
	Endline	
	What was the causal effect and contribution of the programme on: 1. Service utilisation (impact) 2. Technical quality of health facilities (outcome) 3. Perceived quality of care (outcome) 4. Quality and functionality of HCC (output) 5. Knowledge of rights and entitlements (output) 6. Decision-making regarding community and health facility resources (output) **What was the contribution of the programme to the mechanisms and processes which produced observed results?** - What particular mechanisms to ensure vertical and horizontal accountability are in place? **What unexpected outcomes and impacts have occurred?** - What, if any, costs do community members perceive to result from their participation in the accountability initiative? **What impacts do different community members and decision-makers prioritise, and why?** - Which programme interventions have made the most/least difference to the accountability of health providers and to community members' ability to influence their quality of services?	HMIS and HMIS Compilation ANC and Under 5 Exit Survey Head of facility survey and HCC Survey Fieldwork observation Crown Agents RBF Survey FGDs with male and female community members, including adolescent girls will allow unexpected preliminary quantitative results Key informant interviews with key officials at district

DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
	- What do key informants perceive to be the most significant positive changes the programme has contributed to? (Assumptions 1–17)	and provincial levels to be probed FGDs with members of HCCs
SUSTAINABILITY To what extent and how do programme strategies support the long-term sustainability of achievements, and should anything be done to strengthen these strategies?	**Baseline**	
	What factors need to be in place for the benefits of the programme to be sustained, and are they in place? (Assumptions 1–17)	Interviews with: frontline health service providers; HCC heads; and MNCH decision-makers at district level FGDs with members of HCCs
	Endline	
	To what extent are any programme benefits likely to continue and over what timeframe? - What factors need to be in place for the benefits to be sustained, and are they in place? (Assumptions 1–17) **How likely are the institutional arrangements under MNCH to continue beyond the lifetime of the programme?** (Assumptions 9 & 15–17) - Will HCCs continue to support monitoring initiatives beyond the external funding and without external technical support? - Will facilities continue to use service monitoring approaches? - Have government officials and policy-makers supported the adoption and mainstreaming of methodologies for monitoring developed and disseminated by the programme? **What are the main enabling and constraining factors that affect the long-term effectiveness and sustainability of HCCs in the monitoring of service delivery (e.g. in the enabling environment, capacity and resources, degree of networking, etc.)?** (Assumptions 10–14)	Interviews with frontline health service providers & MNCH decision-makers at district and provincial level will allow unexpected preliminary quantitative results to be probed FGDs with members of HCCs FGDs with groups of community members disaggregated by gender

DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
	Has the programme successfully leveraged further funding?	Key informant interviews with HCC heads

Annex E SC and CWGH programme theory of change diagram


STRENTHENING COMMUNITY PARTICIPATION IN HEALTH THEORY OF CHANGE
IMPACT
Contribute to increased utilisation of MNCH services in selected districts of Zimbabwe by June 2016
OUTCOME
Increased communities' influence for improvements in quality of MNCH services provided in selected districts of Zimbabwe by June 2016
OUPUTS
AWARENESS & PARTICIPATION: Empowered communities with knowledge about their entiltment to free quality MNCH services from health services in target districts by end of June 2016.
SERVICE MONITORING: Institutionalized community structures (HCCs, Community monitors and HLFs) monitoring quality of MNCH care available in Rural health centres in target districts
SERVICE GOVERNANCE Increased community participation in health governance on MNCH services in communities in target districts of Zimbabwe
ENABLING POLICY ENVIRONMENT:Creation of enabling Policy environment for the implementation of quality MNCH services by June 2016 in commnities in target districts of Zimbabwe


ACTIVITIES
Work with local users and local community to raise awarenes : health literacy programmes: info,education and community strategy(including Patients charter)
Strengthen HCC capacity: revitalize existing HCC, HCC training programmes use specialized training/capacity building resources. Designing Monitoring tools facilitate the establishment of community feedback mechanisms.
District health executive meetings, Quarterly advocacy meetings, Advocacy coalition formation.
Lobbying health/health related policy makers: Dialogue with, MOHCC, Participate in Public health advisory board and Parliamentary portfolio on health,
BARRIES
FOR USERS: Apathy/fear of getting involved. Lack of confidence in effective/ sustainable change. Focus on personal survival (ie immediate solutions) rather than community level (longer term initiatives). Gender related barriers (e.g. women too busy with domestic duties, or prevented from engaging male partners /family members. distance and financial.
FOR HCC: Lack of formal (i.e. legislated) recognition of HCC role/remit. Apathy, low confidence /low levels of commitment from HCC members. Insufficient time /competing priorities .Poor communication between HCCs, their communities and local authorities& lack of responsive to raised issues
FOR MNCH PROVIDERS:Low levels of formal accountability. Over – burdened staff. Low levels of motivation. Inadequate funding. Lack of knowledge about patient’s rights and provider responsibilities (i.e. The patient’s charter)
PROBLEM
MNCH service utilisation levels and outcomes are adversely affected by the local population not feeling sufficiently knowledgeable or empowered to demand better health care services. The local population also suffers due to a lack of sufficiently developed monitoring and reporting systems to hold providers to account.

ASSUMPTIONS	Lack of Corruption, fraud and misuse of funds. Retention of qualified personnel, No strike by the civil service.. MOHCC and RDC's work together to effectively administer HTF funds. HTF funds adequate to improve service delivery Political stability, Economic stability promoting Government efforts to finance the health sector., Non politicization of Health service fund. Community and MOHCC acceptance of CBMI board.

E.1 OPM comments on the ToC

We here outline observations about the limitations of the articulation of the programme's ToC, which were first identified during the inception process. These comments relate to how the ToC is captured on paper rather than commenting on the plausibility of the theory itself.

- Underlying assumptions are not documented from the SCF ToC. SC has taken the first steps towards identifying the key assumptions underpinning how they expect the programme to create change in the 'Barriers' section. However, there are a number of problems with this approach:
    - Using the title 'Barriers' does not readily allow consideration of the positive or negative dynamics and relationships between actors and their context;
    - The barriers look only at the potential constraints faced individually by users, HCCs and service providers without explicitly considering the interaction of these actors. The ToC should also include the barriers faced by opinion leaders, decision-makers and other relevant actors, as the programme has identified among its core outputs the changes it hopes to enact in the policy enabling environment
    - Generally, assumptions about the actors and context deserve greater consideration and need to be made more explicit.
- The link is not clear between the problem as it is stated and the barriers identified in the ToC, particularly those of HCCs and service providers.
- The mechanisms for change are not clearly articulated. 'Activities' could be further developed to (more) explicitly explain how they relate to each output. For example, the activity 'District Health Executive meetings, quarterly advocacy meetings, advocacy coalition formation' is not clearly linked to the 'Service Governance' output of increased community participation, and it is not clear how the activity is linked with other activities. As another example, the mechanisms that enable awareness-raising activities to lead to the participation of 'empowered communities' are not clearly expressed in the ToC above.
- The uniting concept in the programme's ToC is that more aware, better informed and engaged communities will actively contribute to improvements in the quality and accountability of MNCH services, which will in turn lead to increased utilisation of MNCH services. The actually improvement of MNCH service quality should be an outcome preceding the impact. (Or, alternatively, an impact itself, with increased utilisation as a super-impact).

E.2 Assumptions behind the ToC

To support the ToC diagram, we have developed a narrative that discusses the major assumptions underpinning the programme ToC.

On the demand side, the programme assumes that: community members lack knowledge about their rights and entitlements to MNCH services (assumption 1) and that this lack of

knowledge is a major barrier to both their utilisation of MNCH services (assumption 2) and a major barrier to their participation in activities to influence improvements in MNCH quality standards (assumption 3). By addressing this lack of knowledge through health literacy programmes (including patients' charter), the programme aims to create a more informed and diverse constituency of community members who are aware of their rights and entitlements and will access the MNCH services they need and participate in actions to improve their quality and governance: they will be able to 'challenge the status quo', rather than accept 'poor standards and bad practices' (Strengthening Voice and Accountability for Improved Maternal, Newborn and Child Health Services in Zimbabwe' End of Inception Period Report). This also relies also on different community members (e.g. by gender, age, ethnicity, political views, livelihood type, wealth status, etc.) being willing, motivated and confident to engage in community-level programme activities (assumption 4) so that diverse voices and views are represented. It also assumes that poor quality of MNCH services is a major barrier to utilisation of MNCH services (assumption 5).

The programme further assumes that 'opinion leaders' (such as traditional and religious leaders) will give their support to awareness-raising around community rights and entitlements to MNCH services (assumption 6), even if this might be perceived to be against their interests in some way (e.g. possibly it will mean a loss of influence within the community, or lead to changes that are against particular traditional social norms, etc.). Evidence from the programme shows that in some districts, traditional beliefs and practices are known to hinder pregnant mothers and their children from accessing early treatment (November 2013 Monthly Progress Report, p. 5). It is also assumed that community monitors have sufficient capacity (e.g. time, resources, etc.) to effectively monitor MNCH service quality (assumption 7) and that, in doing so, they can play pivotal roles in collecting feedback and evidence from community members to ensure that the needs of those with less voice are taken into account by MNCH service providers and decision-makers (assumption 8).

On the supply side, it is assumed that political will exists at national level to improve service quality, client satisfaction and health services (assumption 9). While the current government has increased control and the centralisation of power and is very sensitive to criticism, it also sees delivering services to the population as a national development priority.

At the same time, the programme aims to affect the supply side at the local level by improving the sensitivity of local-level frontline MNCH service providers. A key assumption here is that local-level service providers will be willing to engage with service users in order to improve MNCH service quality and accountability provided they do not feel threatened by service user feedback (assumption 10). It is also assumed that the role of HCCs is formally recognised by the relevant authorities and the communities they serve (assumption 11). The ToC also assumes that the policy environment is weak and does not enable or support the implementation of quality MNCH services (assumption 12).

Concerning the interface between demand and supply (i.e. service providers and service users/potential users), it is assumed that the existing processes and structures (HCCs, community monitors and HLFs) that monitor quality of MNCH care are not institutionalised (assumption 13), and that as a result there is limited or no community participation in health governance of MNCH services (assumption 14).

It also assumes that, once institutionalised, HCCs will only be able to play their intended roles effectively if their functions, mandate and roles are clear and widely understood within

the HCCs and the communities they represent (assumption 15); that their membership is representative of the diverse communities they serve (assumption 16); and that as different social groups face a range of barriers to MNCH service utilisation, they are responsive to and act on the voices of all community members, including those groups usually excluded (assumption 17). There is an assumption that the programme will be able to address and reduce the existing social norms and power relations embedded in communities that mean HCCs could be vulnerable to domination and capture by powerful elites (assumption 18). Additionally, the ToC assumes that the participation of members in HCC activities will not be limited by lack of motivation for volunteerism (assumption 19).

In terms of supply-side responsiveness, key assumptions underpinning the ToC are that community evidence and feedback on MNCH service quality and accountability will contribute to positive changes in policy, practice and institutional behaviour through decision-makers at district and other levels using evidence and feedback generated by community-level monitoring to effect significant improvements (assumption 20). However, the expected transition from local-level monitoring and feedback to longer-term changes in performance and impact is underpinned by the assumption that local service providers have a) sufficient decision-making authority to effect real and sustainable changes and b) sufficient local capacity and resources to make the changes they recognise as being necessary (assumption 21).

One would expect that certain types of behaviour change (such as absenteeism, aggressive/disrespectful/sexually exploitative behaviour, petty corruption and forms of favouritism/social exclusion) and service organisation (e.g. service hours, facilities hygiene and cleanliness) could be influenced and some level of resources redirected quite quickly. However, there are likely to be severe constraints to longer-term and more substantive change at the facility level in the form of decision-making and resource blockages that are beyond the authority and influence of the frontline service providers. Even where decision-makers and budget holders at higher levels have authority and act accountably, they themselves may be highly constrained by budget envelopes that are committed to recurrent expenditure (salaries) with little scope for discretionary spending elsewhere in the system. Also, national-level centralised arrangements for the provision of basic goods for health (e.g. drugs and medical supplies services) will hamper significant changes in a number of service areas.

Where change requires policy decisions to be made at a higher level, the programme ToC assumes that government officials sufficiently understand the programme through and as a result of evidence-based advocacy (comprised of lobbying and dialogue) and provide the necessary support rather than block progress as a result (assumption 22).

Annex F Programme Logframe

PROJECT NAME	Strengthening Voice and Accountability for Improved Maternal, Newborn and Child Health Services in Zimbabwe							
IMPACT	Impact Indicator 1		Baseline 2013	July- Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
Contribute to increased utilisation of MNCH services in 21 selected districts of Zimbabwe by June 2016 (14 supported by DFID and 7 EC)	% Increase of births at target health facilities delivered by a skilled birth attendant in the past year greater than unsupported/control sites	Planned	TBC	0%	N/A	2%	5%	
		Achieved						
			Source:					
			Baseline and Endline : OPM					
	Impact Indicator 2		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% Increase of women who attended at least four antenatal care visits in target health facilities in the past year greater than unsupported/control sites	Planned	TBC	N/A	N/A	5%	10%	
		Achieved						
			Source:					
			Baseline and endline: OPM					
	Impact Indicator 3		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% Increase of children under one year that have received measles vaccination in the past year greater than unsupported/control sites	Planned	-	N/A	N/A	2%	5%	
		Achieved						
			Source:					
			Baseline : MOHCW Head Office Health Management Information System 2012/Crown Agents					
	Impact Indicator 4		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
		Planned	TBC	N/A	N/A	2%	5%	

	Increase in number of OPD cases of children under 5 seen in the past year within the targeted catchment population greater than unsupported/control sites	Achieved						
			Source					
			Baseline and endline: OPM					
	Impact Indicator 5		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% point increase in output based disbursement to supported RHC greater than the unsupported/control facilities	Planned	TBC	N/A	N/A	2%	5%	
		Achieved						
			Source					
			Baseline: Crown agents/ RBF database					
OUTCOME	Outcome Indicator 1		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	Assumptions
Increased communities' influence for improvements in quality of MNCH services provided in 21 selected districts of Zimbabwe by June 2016 (14 DFID and 7 EC).	% of formally recorded complaints in target facilities signed-off by the DHE/ RDC as fully addressed in the past year	Planned	0	N/A	N/A	50%	70%	
		Achieved						
			Source					
			District level feedback database, HCC Meeting minutes, District Level Advocacy Meeting					
	Outcome Indicator 2		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% of community members (score card respondents) report satisfaction with quality of MNCH services (ANC, PNC,FP,Immunisation, routine maternal and newborn best practices and management of obstetric complications) provided in target facilities in the past year	Planned	0	N/A	N/A	60%	70%	
		Achieved						
			Source					
			Score card					
	Outcome Indicator 3		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
		Planned	0		N/A	102	166	

	% increase in quality of care composite score on HSF quality assessment in the past year compared to control sites [5]	Achieved						
			Source					
			Crown Agents Report on Quality of Care indicators,					
INPUTS (£)	DFID (£)		Govt (£)			Other (£)	DFID SHARE (%)	
INPUTS (HR)	DFID (FTEs)							
OUTPUT 1	Output Indicator 1.1		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	Assumption
Empowered communities with knowledge about their entiltment to free quality MNCH services from health services in 21 target districts by end of June 2016.	% of score card respondents awareness of the provisions of the patients charter within the targetted catchment population in the past year	Planned	0	N/A		60%	70%	Good relationships between MOHWC and community. MOHWC and RDC's work together to effectively administer HTF funds. HTF funds adequate to improve service delivery
		Achieved						
			Source:					
			Scorecard,					
	Output Indicator 1.2		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% of score card respondents are aware of the user fee policy within targeted catchment population in the past year	Planned	0	N/A	N/A	61%	70%	
		Achieved						
			Source					
			Scorecard,					
	Output Indicator 1.3		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% of MNCH service users who are utilising the feedback mechanisms within the targeted catchment population past year	Planned	0	N/A	N/A	30%	40%	
		Achieved						
			Source					
			HCC Feedback Register, District Level Database.					
	Output Indicator 1.4		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	

	% of score card respondents aware of MNCH services that they are entilted to at RHC level within targetted catchment area in the past year	Planned	0	N/A		60%	70%	
		Achieved						
			Source					
			Scorecard					
	Output Indicator 1.5		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% of the district population supported by the project	Planned	40%	N/A	40%	40%	40%	
		Achieved						
			Source					
			MoHCC RHC Catchment population estimates					
INPUTS (£)			Govt (£)			Other (£)	DFID SHARE (%)	
INPUTS (HR)	DFID (FTEs)							
OUTPUT 2	Output Indicator 2.1		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	Assumptions
Institutionalized community structures (HCCs, Community monitors and HLFs) monitoring quality of MNCH care available in 166 Rural health centres (102 DFID, 64 EC) in 21 districts (14 DFID, 7 EC)	Number of HCCs achieving a government approved standard of functionality within the targetted catchment area in the past year	Planned	0	N/A	0	102	166	Political stability , Economic stability promoting Government efforts to to finance the health sector., Non politicisation of Health service fund. Community and MOHWC accpetance of CBMI board
		Achieved						
			Source:					
			Checklist designed by SC, Project Reports by the PECs, HCCs minutes,					
	Output Indicator 2.2		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	Number of HCC's with a functioning complaints and feedback mechanism established within the targetted catchment area in the past year	Planned	0	N/A		102	166	
		Achieved						
			Source:					
			Project Reports by the PECs, HCCs minutes,					
	Output Indicator 2.3		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
		Planned	0%			102	166	

	Number of HCCs analysing status on MNCH services using the community score card in the past year	Achieved						
			Source:					
			Community Score Card Report, HCC Feedback Form, HCCs minutes					
	Output Indicator 2.4		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	% of complaints raised and actioned within the targetted catchment area in the past year	Planned	0%			50%	80%	
		Achieved						
			Source:					
			HCC complaints feedback register and quaterly reports to DHE, District level database.					
	Output Indicator 2.5		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	Number of HCCs are updating MNCH services utilisation status on CBMI board in target communities on MNCH in the past year [1]	Planned	0			102	166	
		Achieved						
			Source:					
			HCC complaints feedback database and quaterly reports to DHE.					
IMPACT WEIGHTING (%)								RISK RATING: HIGH
INPUTS (£)	DFID (£)		Govt (£)			Other (£)	DFID SHARE (%)	
INPUTS (HR)	DFID (FTEs)							
OUTPUT 3	Output Indicator 3.1		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	Assumption
Increased community participation in	Number of HCCs advocating for issues affecting MNCH Services	Planned	0	N/A		102	166	Lack of Corruption, fraud and misuse of funds., Retention of
		Achieved						
			Source:					

health governance on MNCH services in 166 communities HCCs (102 DFID, 64 EC) in 21 districts of Zimbabwe (14 DFID, 7 EC)			Minutes of meetings					qualified, No strike by the civil service.
	Output Indicator 3.2		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	MNCH policies and practices influenced by advocacy over the past year	Planned	0	N/A		1	2	
		Achieved						
			Source:					
			Quarterly Advocacy Meetings, Minutes of meetings)					
	Output Indicator 3.3		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	Number of coalitions/partnerships established to advocate for improvement of MNCH services at local level in the past year	Planned	0	N/A		5	10	
		Achieved						
			Source					
			Data source: Advocacy strategy action plan, stakeholder mapping Project records (reports by the PEC and outputracker), Minutes of meetings					
	Output Indicator 3.4		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	Number of District advocacy meetings between HCCs with the District Health Executive in the past year	Planned	0	N/A		56	84	
		Achieved						
			Source:					
			Minutes of meetings					
IMPACT WEIGHTING (%)	DFID (£)		Govt (£)			Other (£)	DFID SHARE (%)	
	DFID (FTEs)							
INPUTS (HR)								
OUTPUT 4	Output Indicator 4.1		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	Assumption

Creation of enabling Policy environment for the implementation of quality MNCH services by June 2016 in 166 commnities (102 DFID, 64 EC) in 21 districts of Zimbabwe	Number of newspaper publications on user fee removal & issues for MNCH service in the past year	Planned		N/A		4	8	
		Achieved						
			Source: Baseline					
			Project records/(Output tracker, monthly reports ,Newspaper articles file)					
	Output Indicator 4.2		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	Number of pre and post budget meetings held at national level to discuss position paper on MNCH issues in the past year	Planned	0		N/A	2	4	
		Achieved						
			Source					
			Conference Meeting Reports, Project Records(monthly, quarterly reports ,Output tracker)					
	Output Indicator 4.3		Baseline 2013	Milestone Dec 13	Milestone June 14	Milestone June 15	Target Jun 16	
	Availability of Statutory instrument for the legal recognition of HCCs	Planned	0		N/A		1	
		Achieved						
		Source						
		Project Records(monthly, quarterly reports ,Output tracker)						
IMPACT WEIGHTING (%)								
								RISK RATING: HIGH
INPUTS (£)	DFID (£)		Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
INPUTS (HR)	DFID (FTEs)							
Footnotes:								
1. CBMI - Community Based Monitoring Information board - this is a board that will be displayed either outside or inside the								

RHC to display information on key indicators over time so that the community can clearly see the performance of the RHC								

2. Unsupported/control RHC are 70 health facilities lying outside the the target catchment area for the project selected by OPM as being as close as possible in nature to the selected 70 treatment sites that they will base their evaluation on. The ability to show a difference between control and treatment sites is dependent on the fact that this programme is the only differnce between control and treatment sites and that no other interventions start in the control sites over the life of the project

3. Targets for impact indicators will be reviewed once baseline data is available and once we have greater clarity on OPM’s evaluation design and methods for selecting control and treatment sites.

4. Initial review of HMIS data shows that there are inacuracies in the data. Our ability to measure the impact indicators will therefore be dependent on OPM and Crown Agents work to verify the accuracy fo the data

5. Outcome Indicator 3 may need to be reviewed once we see the data that is available from Crown Agents on this and see if it is feasible to measure

6. Ouput indicator 4.2 and 4.3 is riding on partner activities which are now subject to availability of non DFID funding.

7. The ability to measure indicators on the community feedback mechanisms will be dependent on the acceptance of the MOHCC at district level to maintain a feedback database

Indicators where OPM will collect baseline data

Inidicators where SC will collect baseline data. Data for indicators 1.1, 1.2 and 1.4 will be collected the first time the scorecard is administered. Baseline data will be complete by Dec 14. For Impact indicator 5 the data will be collected once Crown Agents have completed their verification exercise in August 14

Annex G Risks of the evaluation

This annex outlines the risks to the successful implementation of the evaluation that were identified during our inception phase and provides an update on each at the current time.

1. **Project expenditure data might not be available in a suitable format for analysis and relevant benchmarks might not be identified for the VfM analysis.** The team will review the availability of programme expenditure data in 2014 to identify constraints and, for DFID-supported programmes, explore if appropriate data might be compiled.

Baseline update: The data sources for a few components of the VfM analysis are still being verified. Specifically, an appropriate method for estimating volunteer time is still being discussed with SC and the counter-verification of Outcome Indicator 3 is still being conducted by Crown Agents. The team will work with these partners over the next three months to confirm that data is available from these proposed sources.

2. **Methodological and practical limitations may not be fully recognised by users and findings may then be taken out of context.** The evaluation faces a number of limitations that should contextualise the findings and the degree of certainty attached to them. The team will endeavour to ensure they are communicated along with summary findings.

Baseline update: no update

3. **Political factors in both Zimbabwe and the UK might affect the extent to which key decision-makers are receptive to evaluation findings and able to respond to them.** It is not clear what the team could do to address this beyond keeping informed about relevant changes in policy and the political environment and delivering findings in a way that resonates with contemporary concerns.

Baseline update: no update

4. **The programme has already had a significant effect by the time the baseline data is collected.** As there was a delay in contracting the evaluators, SC and CWGH have begun implementation of the programme. Therefore, the baseline survey will not be a true measure of key outcome indicators before the programme started. This means that the estimates of impact may be underestimated by the evaluation. This risk only applies to outcomes where we rely on primary data. In the case where we are using secondary data to measure key outcome indicators, we will source data from a time before the programme actually did start.

Baseline update: As shown in Annex S, there does not appear to be significant differences between treatment and comparison facilities at the time of our baseline measurement. The programme roll-out began in April 2014 before the baseline data was collected in July/August 2014. This happened as a result of a delay in contracting the evaluation team and the programme implementers needing to begin operations in order to meet their own deadlines. The risk of having baseline data collection take place after the programme has begun is that the baseline may not accurately measure the pre-intervention outcomes. However, given the nature of the programme and the way that it is gradually rolled out across and within districts, there was very little chance for the programme to influence key indicators in the four months between when operations began and when the baseline data were collected. As the programme begins by establishing memoranda of understanding with the MoHCC and then establishing and training HCCs, the main area that may have been

impacted was around the existence of HCCs. Indicators that were further along the casual chain such as those around the quality and utilisation of health facilities are very unlikely to have been impacted in such a short time. Moreover, where we use secondary data sources to measure impact this problem is not relevant as we can use baseline data from pre-April 2014.

5. **We will not be able to find appropriate comparison health facilities.** As discussed above, identifying the true causal effect of the programme relies on being able to identify a set of counterfactual 'comparison' health facilities that are similar to the health facilities where the programme is being implemented. The programme selected health facilities in conjunction with provincial government health officials. They purposefully selected health facilities that served large populations. Moreover, in some cases, health facilities that were hard to reach or had particularly high maternal mortality rates or child mortality rates were deliberately selected. As the programme purposefully selected health facilities, the risk is that the most similar comparison facilities that we can find are consistently different from the intervention 'treatment' facilities. To mitigate this risk, where possible given the data availability and quality we will match using these and more variables. We will use our baseline data to measure how similar the treatment and comparison facilities are and if treatment and comparison facilities are consistently different along key outcome indicators, we will use the 'difference-in-differences' approach described to control for this difference. The difference-in-differences methodology assumes that any differences observed at baseline still exist at endline.

Baseline update: As shown in Annex S there do not appear to have been significant differences between treatment and comparison facilities at the time of our baseline measurement.

6. **Treatment is rolled out in comparison facilities, or treatment and comparison are differentially subject to other interventions**. As discussed above, in order to evaluate and attribute the impact of the programme, it is necessary to observe a comparison group that is similar to the treatment group in all respects other than being a recipient of the programme. If the comparison group do in fact receive the intervention, then it is not possible to attribute any observed changes in the treatment group to the programme. Furthermore, if either the treatment or comparison group are *differentially* subject to another intervention then again the comparison group will not be similar to the treatment group in all respects other than being a recipient of the programme and so we will not be able to attribute observed differences to the programme. We will mitigate this risk by maintaining a close working relationship with SC and CWGH in order to make sure that the programme does not expand to comparison facilities before the endline data collection and to understand other interventions that may roll out in health facilities.

Baseline update: Since we conducted our health facility survey in July/August 2014, some of the facilities where SC and CWGH are working have changed as a result of their consultations with MoHCC. Our analysis in this report reflects the revised allocation of treatment facilities and, fortunately, the changes do not appear to have significantly impacted on the similarity of treatment and comparison facilities. The balance tables shown in Annex S use the most recent (February 2015) allocation of facilities and there do not appear to be significant differences between treatment and comparison facilities.

7. **Data quality from external secondary sources is poor or data are difficult to obtain**. The evaluation will rely on four key sources of secondary data (HMIS, Vital Medicine Availability Health Survey, Crown Agents RBF Survey, and 2011 Needs Assessment questionnaire from the National Integrated Health Facility Assessment

(NIHFA)). If the data quality of the HMIS and NIHFA data is poor then our ability to match treatment and comparison facilities will be limited. If the other sources of data are poor then we will have fewer reliable sources of data with which we can measure impact. We will mitigate the risk that the HMIS data are poor by conducting a verification survey, where we will verify the quality of the HMIS data by collecting the raw data from health facility attendance registers. As we will rely on secondary data sources from the MoHCC to identify appropriate comparison health facilities, the timeliness of the baseline is dependent on being able to receive these data. We requested the data in the first week of May and but as of June 11 we have not yet received it. We will be very specific about the required variables in our request so as it minimise any delays. We appreciate DFID’s support in requesting the data from the Ministry.

Baseline update: Overall we were able to acquire both the NIHFA and the HMIS data for the purposes of sampling, sample matching and HMIS data verification work. The Ministry extended their full cooperation in providing us with the required data. The NIHFA dataset and the initial yearly HMIS data for 2013 were received in time to ensure the timely start of the baseline survey. The more detailed HMIS data (i.e. the monthly estimates for all the health facilities in the designated districts of Zimbabwe for 60 out of the specified 70 indicators) were received with a significant delay. Data were only available as of October 2014. The detailed HMIS data were, however, made available for the complete reference period January 2013–June 2014, which included live data for the active calendar year. The NIHFA data were very rich in information, although the data provided were not complete, so we used multiple imputation techniques in order to prepare the data for the propensity score matching analysis. The storage of the information was not optimal for information retrieval as all of the variables were stored in alphanumeric (string) format accompanied with often missing or scarce labelling. The documentation of NIHFA survey provided basic guidance for information retrieval, but was lacking in terms of the exhaustive presentation and organisation of content. The names of facilities given in the HMIS and the NIHFA sources often do not match perfectly. There are a number of facilities that are part of HMIS and have not been covered by the NIHFA survey. Likewise, there are a number of facilities covered in the NIHFA data that do not seem to have a matching counterpart in the HMIS dataset. As the NIHFA did not use the HMIS unique facility identifiers the matching of the facility data in the two datasets is less effective than desirable as it is necessary to resort to manual matching of the facilities by their names. The fact that the NIHFA survey did not use the exact names of the facilities as they appear in the HMIS presented an additional impediment to the merging of the two datasets.

8. **Spillovers**. This is the risk that the comparison health facilities end up at least partially receiving the treatment through the sharing of information or resources. This could happen if some people in the treatment communities who are trained on their rights and entitlements share this information with people living in comparison communities. Another way that spillovers could occur is if members of a treatment HCC who are trained by the programme pass on that information to a comparison HCC. Finally, spillovers could occur where the treatment affect district level staff or policy. As our comparison facilities will be selected from within the same districts as treatment facilities, comparison facilities may be exposed to the programme through any effect it has at the district level. We will measure spillovers by assessing exposure to treatment in the comparison group at endline.

Baseline update: No update

9. **The small sample size of the qualitative component of the evaluation fails to engage sufficient citizens or service providers**. Although the risk of this is low, we have designed and will implement the selection of sites in a manner which will be

informed by the preliminary findings of the quantitative survey to maximise the relevance and usefulness of the focus group and interview data.

Baseline update: Due to revisions to the timeline of the quantitative survey data collection and analysis, the qualitative study was not able to use findings from the survey to inform the sampling of facilities. The qualitative sample of facilities was derived using the quantitative sampling frame, discussions with the implementing partner on the context of project facilities, and secondary data on nationwide providers of MNCH services. Regarding engagement with sufficient citizens and service providers, the qualitative component of the evaluation held FGDs and KIIs with the planned number of respondents across the prospective respondent types, including male and female community members, service providers and decision-makers.

10. **There would be bias in the qualitative component of the evaluation findings if only a narrow set of views from service users and providers is heard**: A sampling strategy that ensures that the views of a broad set of users and providers are heard is used, including more vulnerable, hard to reach and socially excluded groups, with a gender balance. The evaluation team will also need to ensure that the data they gather directly from stakeholders are from as diverse a set of stakeholders as possible in order to get multiple perspectives on the evaluation questions.

Baseline update: The baseline qualitative findings include the perspectives of both users and non-users of MNCH services, a wide age range of men and women (including adolescent girls) and community leaders. In the study areas, respondents defined the socially excluded as predominantly belonging to the apostolic sect. As members of this group generally do not engage with activities pertaining to health services, the evaluation was not able to include their perspective through direct participation in FGDs, although some insight was gained from other community members’ views.

11. **Use of a theory-based approach and pre-defined indicators means the evaluation misses unexpected changes**: We will consider use of the Most Significant Change technique at the endline stage to ensure the evaluation captures unexpected/unintended impacts not contemplated in the theory of change.

Baseline update: At baseline, rather than unexpected changes (which will be the focus of the endline evaluation), we observed unexpected contextual factors, particularly around factors that influence what difference the programme is likely to be able to make and how—namely high user satisfaction, positive perceived quality of care, and some reports of issues with staff attitudes. At endline, we will consider use of the Most Significant Change technique and other tools which will ensure the evaluation captures unexpected/unintended impacts not addressed in the theory of change.

Annex H Quantitative data analysis to measure impact

At endline, the analysis using the quantitative data will provide measures of impact on the indicators that programme is aiming to improve. These are measures of service utilisation and quality of care, both perceived and technical. It will also provide information on whether some of the outputs are being delivered effectively and thus on possible mechanisms by which change has happened, if it has. This will include measures of users’ knowledge of their rights and entitlements and of the functionality of the HCC.

At endline, there are two options for analysing the impact of the programme with the data we are collecting.

The first option is to compare treatment and comparison groups at endline. This option requires that the treatment and comparison groups are the same at baseline. In Annex S, we show our balance tests, which assess the balance of our treatment and comparison groups (i.e. checks on whether the propensity score matching has succeeded in producing groups of communities and health facilities that do not systematically differ in terms of their average characteristics). The results show that the sample is balanced and thus the impact of the programme can be measured by a simple comparison of treatment and comparison groups at endline.

The second option (which would have been required had the treatment and comparison groups been systematically different in terms of their average characteristics) is to measure the impact of the programme using a ‘difference-in-differences’ method. This method measures both the treatment and comparison group before and after the intervention. The ‘before and after’ nature of difference-in-differences estimates means that any time-invariant characteristics that might, in addition to the intervention, have a potential influence on the impact indicators being measured are controlled for.

The difference-in-differences method relies on the assumption that treatment and comparison groups would have followed the same trend in the absence of treatment. This is called the parallel trend assumption. Where we have outcomes variables obtained from secondary data measured at least once before baseline, we will be able to examine the pre-intervention trend to test the validity of the parallel trend assumption.

Interrupted time series analysis might provide an additional source of evidence on service uptake indicators, using the HMIS data. This analysis makes use of the fact that there is a series of observations before and after the intervention, and so multiple data points for each facility. The team will explore the use of these data for obtaining alternative, more robust measures of impact.

Annex I Health Facility Survey power / sample size calculations

I.1 Power / sample size calculations

From our sample size calculations, we have determined that it is optimal to sample 140 health facilities in total, 70 from the treatment facilities and 70 from comparisons. With each facility we aimed to conduct on average 10 exit interviews of Carers of Under Fives, on average 10 exit interviews of ANC outpatients, 1 staff member and 1 HCC committee member from each facility thus yielding a net sample of 1400 Under Fives, 1400 ANC patients, 140 Head of Facilities and 140 HCC Committee Members.

Our sample size calculations show that we will be able to a 10 percentage point change in outcome variables obtained from exit interviews (e.g. percent of users who...). This means that if the programme has an effect that that results is less than a 10 percentage point change on an individual level outcomes of interest, we will not be able to measure the effect as significantly different from zero. We will be able to detect a 23 percentage point change in outcome variables obtained from facility level interviews (e.g. percent of facilities/HCCs that...).[40]

When results are disaggregated into two groups (for example gender or poorest/wealthiest) our sample size calculations show that we will be able to a 12 percentage point change in outcome variables obtained from exit interviews. When results are disaggregated into quintiles (for example wealth or age quintiles) our sample size calculations show that we will be able to a 17 percentage point change in outcome variables obtained from exit interviews.

These are quite large changes for the programme to effect for facility level variables. However, the programme logframe anticipates changes in some facility level measures of 100% (i.e. all supported facilities will improve). A very substantial increase in sample size would be required to significantly reduce the minimum detectable effect and this was not felt to be an appropriate use of the limited resources available. We discuss below some additional analysis that will help to estimate impact at the facility level that is not so constrained by sample size.

The sample size is driven by the power of detecting effects of the intervention. The number of health facility staff and users to be interviewed in each facility will be determined by the size of the effect the programme is anticipated to achieve. The optimal sample size should be derived by optimising the fieldwork costs and the power of required to estimate a plausible effect size. To obtain credible estimates of programme impacts, it is important to ensure that the sample chosen is large enough to capture the expected changes in the various indicators that will be measured. The purpose of the power calculations is to determine the sample size needed to detect expected changes in outcomes over the course of the evaluation.

For outcomes obtained from the under-five outpatient exit interviews and the ANC outpatient exit interviews, the number of health facilities and the number of each type of exit interview

[40] Note that in this instance, the fact that we are sampling from a relatively small total population might increase the precision of the estimates of impact, but this has not been assessed in these calculations to keep our estimates on the MDE conservative, It will be explored during the final data analysis phase by the use of the "correction for finite population".

per health facility is important. For outcomes obtained from the head of facility survey and health centre committee only the number of health facilities is import.

The intra-cluster correlation is a measure of how strongly people in the same cluster (health facility) resemble each other. Although it can be difficult to measure, failure to account for it at all can cause required sample sizes to be underestimated. This is because if people attending the same health facility are very much alike due to similarity in their surroundings and experiences, each additional observation contributes less unique information. A higher intra-class correlation (ICC) indicates that people in the same cluster are more similar. For health facility surveys, the intra-cluster correlation is generally thought to be smaller than for household surveys given the catchment area of a health facility is larger than a normal enumeration area. For these calculations we assume the ICC is 0.05 and also include estimates for an ICC of 0.1 as a precautionary measure.

The below sample size calculations show the required number of facilities assuming 10 and 20 exit interviews of each type per facility. Table 10 shows the number of facilities required to detect the effect size shown (change between baseline % and endline %) given 10 exit interviews of each type per health facility and an intra-cluster correlation of 0.05. For example, from the first line, to detect a change in an outcome from 40% at baseline to 45% at endline, we would need to a sample size of 570 facilities. Table 11 shows the same calculations for 20 exit interviews of each type per heath facility. Tables 12 and 13 show the same calculations, assuming a very high ICC, which we include as a precautionary check.

Table 14 10 exit interviews per facility, ICC=0.05

EXIT INTERVIEWS

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX

NO FACILITIES PER TREATMENT GROUP	NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	ENDLINE %	ICC
285.00	570.00	10.00	2850.00	0.40	0.45	0.05
73.00	146.00	10.00	730.00	0.40	0.50	0.05
33.00	66.00	10.00	330.00	0.40	0.55	0.05
19.00	38.00	10.00	190.00	0.40	0.60	0.05
291.00	582.00	10.00	2910.00	0.50	0.55	0.05
73.00	146.00	10.00	730.00	0.50	0.60	0.05
32.00	64.00	10.00	320.00	0.50	0.65	0.05
18.00	36.00	10.00	180.00	0.50	0.70	0.05
247.00	494.00	10.00	2470.00	0.60	0.65	0.05
67.00	134.00	10.00	670.00	0.60	0.70	0.05
29.00	58.00	10.00	290.00	0.60	0.75	0.05
16.00	32.00	10.00	160.00	0.60	0.80	0.05

Table 15 20 exit interviews per facility, ICC=0.05

EXIT INTERVIEWS

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX

NO FACILITIES PER TREATMENT GROUP	NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	ENDLINE %	ICC
213.00	426.00	20.00	4260.00	0.40	0.45	0.05
55.00	110.00	20.00	1100.00	0.40	0.50	0.05
25.00	50.00	20.00	500.00	0.40	0.55	0.05
14.00	28.00	20.00	280.00	0.40	0.60	0.05
217.00	434.00	20.00	4340.00	0.50	0.55	0.05
55.00	110.00	20.00	1100.00	0.50	0.60	0.05
24.00	48.00	20.00	480.00	0.50	0.65	0.05
14.00	28.00	20.00	280.00	0.50	0.70	0.05
204.00	408.00	20.00	4080.00	0.60	0.65	0.05
50.00	100.00	20.00	1000.00	0.60	0.70	0.05
22.00	44.00	20.00	440.00	0.60	0.75	0.05
12.00	24.00	20.00	240.00	0.60	0.80	0.05

Table 16 10 exit interviews per facility, ICC=0.1

EXIT INTERVIEWS

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX

NO FACILITIES PER TREATMENT GROUP	NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	ENDLINE %	ICC
416.00	832.00	10.00	4160.00	0.40	0.45	0.10
106.00	212.00	10.00	1060.00	0.40	0.50	0.10
48.00	96.00	10.00	480.00	0.40	0.55	0.10
27.00	54.00	10.00	270.00	0.40	0.60	0.10
425.00	850.00	10.00	4250.00	0.50	0.55	0.10
106.00	212.00	10.00	1060.00	0.50	0.60	0.10
47.00	94.00	10.00	470.00	0.50	0.65	0.10
26.00	52.00	10.00	260.00	0.50	0.70	0.10
399.00	798.00	10.00	3990.00	0.60	0.65	0.10
97.00	194.00	10.00	970.00	0.60	0.70	0.10
42.00	84.00	10.00	420.00	0.60	0.75	0.10
23.00	46.00	10.00	230.00	0.60	0.80	0.10

Table 17 20 exit interviews per facility, ICC=0.1

EXIT INTERVIEWS

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX

NO FACILITIES PER TREATMENT GROUP	NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	ENDLINE %	ICC
347.00	694.00	20.00	6940.00	0.40	0.45	0.10
88.00	176.00	20.00	1760.00	0.40	0.50	0.10
40.00	80.00	20.00	800.00	0.40	0.55	0.10
23.00	46.00	20.00	460.00	0.40	0.60	0.10

354.00	708.00	20.00	7080.00	0.50	0.55	0.10
88.00	176.00	20.00	1760.00	0.50	0.60	0.10
39.00	78.00	20.00	780.00	0.50	0.65	0.10
22.00	44.00	20.00	440.00	0.50	0.70	0.10
333.00	666.00	20.00	6660.00	0.60	0.65	0.10
81.00	162.00	20.00	1620.00	0.60	0.70	0.10
35.00	70.00	20.00	700.00	0.60	0.75	0.10
19.00	38.00	20.00	380.00	0.60	0.80	0.10

Together these tables show that the benefits of increasing the number of each type of exit interview per facility from 10 to 20 are minimal and that there are significant benefits to increase the number of facilities. We there for propose to increase the number of facilities that we will sample to 140 as compared with our tender where we proposed to visit 60 facilities.

Table 14 shows the effect size that we can expect to be able to detect by visiting 140 facilities for outcomes derived from exit interviews. As these calculations are done with an ICC of 0.1, and we actually expect the ICC to be lower, these estimates are conservative. The table shows that we will be able to detect changes are that greater than 10 percentage points. This means that if the programme has an effect that that results is less than a 10 percentage point change on an individual level outcome of interest, we will not be able to measure the effect as significantly different from zero.

Table 18 Minimum detectable effect size for proposed sample for outcomes from exit interviews

EXIT INTERVIEWS

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX

NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	DETECTABLE DIFFERENCE IF INCREASING OUTCOME	ENDLINE % IF INCREASING OUTCOME	DETECTABLE DIFFERENCE IF DECREASING OUTOME	ENDLINE 5 IF DECREASING OUTOME	ICC
140.00	10.00	700.00	10.00	7.00	17.00	5.00	5.00	0.10
140.00	10.00	700.00	20.00	9.00	29.00	8.00	12.00	0.10
140.00	10.00	700.00	30.00	10.00	40.00	9.00	21.00	0.10
140.00	10.00	700.00	40.00	10.00	50.00	10.00	30.00	0.10
140.00	10.00	700.00	50.00	10.00	60.00	10.00	40.00	0.10
140.00	10.00	700.00	60.00	10.00	70.00	10.00	50.00	0.10
140.00	10.00	700.00	70.00	9.00	79.00	10.00	60.00	0.10
140.00	10.00	700.00	80.00	8.00	88.00	9.00	71.00	0.10
140.00	10.00	700.00	90.00	5.00	95.00	7.00	83.00	0.10

Table 15 shows the effect size that we can expect to be able to detect by visiting 140 facilities for outcomes derived from head of facility interviews or health centre committee interviews. The table shows that we will be able to detect changes are that greater than 23 percentage points. This means that if the programme has an effect that that results is less than a 23 percentage point change on a health facility level outcome of interest, we will not be able to measure the effect as significantly different from zero. While this is a relatively large minimum detectable effect, it results from limitations in the number of health facilities

and we have more than doubled the number of health facilities we will sample as compared with our tender to address this as much as possible.

Table 19 Minimum detectable effect size for proposed sample for outcomes from head of facility interview or health centre committee interview

FACILITY INTERVIEWS

EXAMPLE INDICATOR: % OF FACILITIES WHERE HCC HAS OPERTATIONAL PLAN

NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	DETECTABLE DIFFERENCE IF INCREASING OUTCOME	ENDLINE % IF INCREASING OUTCOME	DETECTABLE DIFFERENCE IF DECREASING OUTOME	ENDLINE 5 IF DECREASING OUTOME
140.00	1.00	70.00	10.00	18.00	28.00	10.00	0.00
140.00	1.00	70.00	20.00	21.00	41.00	15.00	5.00
140.00	1.00	70.00	30.00	23.00	53.00	19.00	11.00
140.00	1.00	70.00	40.00	23.00	63.00	21.00	19.00
140.00	1.00	70.00	50.00	22.00	72.00	22.00	28.00
140.00	1.00	70.00	60.00	21.00	81.00	23.00	37.00
140.00	1.00	70.00	70.00	19.00	89.00	23.00	47.00
140.00	1.00	70.00	80.00	15.00	95.00	21.00	59.00
140.00	1.00	70.00	90.00	10.00	100.00	18.00	72.00

Table 16 shows the effect size that we can expect to be able to detect by visiting 140 facilities for outcomes derived from exit interviews, where results are disaggregated into two groups (for example gender or poorest/wealthiest). As these calculations are done with an ICC of 0.1, and we actually expect the ICC to be lower, these estimates are conservative. The table shows that we will be able to detect changes are that greater than 12 percentage points. This means that if the programme has an effect that that results is less than a 12 percentage point change on an individual level outcome of interest, we will not be able to disaggregate results by gender or wealthiest/poorest

Table 20 Minimum detectable effect size for proposed sample for outcomes from exit interviews where results are disaggregated into two groups of equal size (e.g. gender, poorest and wealthiest)

EXIT INTERVIEWS: DISAGRREGATED INTO TWO EQUAL SIZED GROUPS

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX (DISAGREEGATED BY POOREST AND WEATHIEST)

NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	DETECTABLE DIFFERENCE IF INCREASING OUTCOME	ENDLINE % IF INCREASING OUTCOME	DETECTABLE DIFFERENCE IF DECREASING OUTOME	ENDLINE 5 IF DECREASING OUTOME	ICC
140.00	5.00	350.00	10.00	9.00	19.00	6.00	4.00	0.10
140.00	5.00	350.00	20.00	11.00	31.00	9.00	11.00	0.10
140.00	5.00	350.00	30.00	12.00	42.00	11.00	19.00	0.10
140.00	5.00	350.00	40.00	12.00	52.00	12.00	28.00	0.10
140.00	5.00	350.00	50.00	12.00	62.00	12.00	38.00	0.10
140.00	5.00	350.00	60.00	12.00	72.00	12.00	48.00	0.10
140.00	5.00	350.00	70.00	11.00	81.00	12.00	58.00	0.10
140.00	5.00	350.00	80.00	9.00	89.00	11.00	69.00	0.10
140.00	5.00	350.00	90.00	6.00	96.00	9.00	81.00	0.10

Table 17 shows the effect size that we can expect to be able to detect by visiting 140 facilities for outcomes derived from exit interviews, where results are disaggregated into quintiles (for example wealth or age quintiles). As these calculations are done with an ICC of 0.1, and we actually expect the ICC to be lower, these estimates are conservative. The table shows that we will be able to detect changes are that greater than 17 percentage points. This means that if the programme has an effect that that results is less than a 17 percentage point change on an individual level outcome of interest, we will not be able to disaggregate results by quintiles.

Table 21 Minimum detectable effect size for proposed sample for outcomes from exit interviews where results are disaggregated into quintiles (e.g. wealth quintiles)

EXIT INTERVIEWS: DISAGRREGATED INTO QUINTILES

EXAMPLE INDICATOR: % OF USERS WHO ARE SATISFIED WITH XXX (DISAGREEGATED BY WEALTH/AGE QUINTILES)

NO FACILITIES	INTERVIEW PER FACILITY	TOTAL INTERVIEWS	BASELINE %	DETECTABLE DIFFERENCE IF INCREASING OUTCOME	ENDLINE % IF INCREASING OUTCOME	DETECTABLE DIFFERENCE IF DECREASING OUTOME	ENDLINE 5 IF DECREASING OUTOME	ICC
140.00	2.00	140.00	10.00	13.00	23.00	8.00	2.00	0.10
140.00	2.00	140.00	20.00	16.00	36.00	12.00	8.00	0.10
140.00	2.00	140.00	30.00	17.00	47.00	15.00	15.00	0.10
140.00	2.00	140.00	40.00	17.00	57.00	16.00	24.00	0.10
140.00	2.00	140.00	50.00	17.00	67.00	17.00	33.00	0.10
140.00	2.00	140.00	60.00	16.00	76.00	17.00	43.00	0.10
140.00	2.00	140.00	70.00	15.00	85.00	17.00	53.00	0.10
140.00	2.00	140.00	80.00	12.00	92.00	16.00	64.00	0.10
140.00	2.00	140.00	90.00	8.00	98.00	13.00	77.00	0.10

Our sample size calculations are done assuming data will be analysis comparing treatment and comparison groups at endline, as opposed to using a difference-in-differences method. The sample size requirements for a difference-in-differences analysis are different and depend on the correlation between baseline and endline outcomes. If the correlation is large then difference-in-differences requires a smaller sample size, where as if the correlation is small then difference-in-differences requires a larger sample size. It is very difficult to know in advance what the correlation will be but based on our experience in other surveys, and given we are visiting the sample health facilities at baseline and endline, our estimates indicate that the correlation is likely to be large enough so that our minimum detectable effects will be similar in the case of both types of analysis. However, we would like to point out that the sample size requirements for difference-in-differences can be larger, in which case the minimum effect sizes that we could detect will increase.

Annex J Health Facility Survey Sampling Strategy

For our health facility survey, we sampled treatment health facilities using systematic random sampling with probabilities proportional to size (PPS). Sampling was conducted in a single stage. Therefore, health facilities are considered to be primary and final sampling units. The sampling frame included all the treatment facilities in all of the 21 districts where the programme is operating. The sampling frame was implicitly stratified to account for the dispersion of the health facilities across districts where the programme is implemented. Additional we implicitly stratified by the district where the facility is situated and the annual volume of ANC patients. An explicit stratification based on the ANC patient volumes was also used. The facilities were classified in 3 groups according to size and the sampling step was calculated for each of the three groups separately.

We used probability proportional to size (PPS) sampling to ensure each person interviewed had a roughly equal probability of being sampled. In order to achieve the PPS sampling a running cumulative of the number of patients was estimated and used as the sampling queue. The sampling step was determined as

$$step = \frac{number\ of\ target\ facilities}{volume\ of\ all\ the\ patients\ across\ all\ eligible\ facilities}$$

A random start was determined, before applying the step selection of the facilities.

Comparison health facilities were derived from the matching process. The matching estimation used propensity score matching. The matching was based on the characteristics of the facilities as derived from the above mentioned secondary sources. The final selection of indicators used in the matching were: urban or rural designation of the facility, facility type, head of facility level, services offered by the facility (ANC, children u 5, HIV treatment), total catchment population, total number of adolescents (10-19 years) in catchment population, total volume of outpatients, ANC patients, PNC patients, deliveries, vaccinations, volume of pregnant women provided by ART and ARV prophylaxis and charges for services (routine ANC, PNC, family planning, sick child). The matching was one-to-one matching using the nearest neighbour method.

We used systematic random sampling to sample patients for exits interviews. The field teams received sampling forms and detailed instructions on how and when to perform the sampling of exit clients. In a low volume facility (a facility with daily expected volume of patients below 15) we sampled all patients, while in the facilities with larger volumes, within-facility sampling was performed. In larger volume facilities more interviews was conducted in order to compensate the potential lack of exit interviews from lower volume facilities.

As is usual practice when using a Propensity Score Matching method, we do not use sampling weights in this analysis because it is not possible to construct sampling weights when the comparison group is derived from a matching process.

Annex K Health Facility Survey Data Collection

The core of the quantitative fieldwork is a health facility survey. For baseline, we visited 147 health facilities and we will revisit the same facilities for endline. Our health facility survey has four survey instruments, as listed above under ‘primary data sources’ plus the HMIS Data Verification Survey.

All data collected tools were pre-tested twice and then again during training when the teams piloted the research protocols before the baseline research was conducted. The quantitative fieldwork team was recruited in Zimbabwe. The data collectors were Zimbabweans who are fluent in either Shona or Ndebele in order to fulfil the necessary language requirements to conduct the survey and to ensure that they were familiar with local customs and practices.

The structure of the quantitative fieldwork teams was based around approximately one field team per province (making seven field teams overall). Each field team comprised of one supervisor and two interviewers, one of whom had a health related background, as well as one driver. In addition, there were three independent field monitors who each covered two to three teams to ensure quality and consistency.

To ensure data quality, we trained the entire field team ourselves rather than relying on a “training of the trainers” approach. The training was intended to familiarise the field team with the research objectives, approach and to provide detail training on the data collection tools, including through testing in the field. To support the training and fieldwork, we prepared a field work manual, which laid out the fieldwork procedures and described the intended meaning of survey questions.

The data collection took take place on paper. The data was entered using a double data entry system. The data entry mask was programmed in CSPro, and incorporated all of the standard questionnaire routing and range checks. The data was further cleaned and checked using range and logical consistency checks in Stata[41].

[41] CSPro is a data entry software package and Stata is statistical software package used for cleaning and analysing survey data

Annex L Qualitative Data Collection

Methods of data collection addressed issues concerning differences in socio-economic status, power relations and asymmetrical knowledge by maintaining homogeneity of focus group participants. Conscious steps were taken to ensure that the experiences and perceptions of "hardest to reach" and most vulnerable community members were captured. The two research teams visited each district concurrently, spending five working days in each of the two districts. Data was collected mainly through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). Annex O provides a summary of each research instrument by respondent type.

Twelve FGDs comprising six to ten participants and eighteen KIIs were conducted at Provincial, District and Community level in the catchment areas of the participating and non-participating facilities in each field site. Audio recordings of the FGDs and individual interviews were made with participants' consent, and then transcribed and translated into English.

Focus Group Discussions were convened at community level with four types of respondent described above, comprising of homogeneous groups of men and women with similar background and experience. FGDs were carried out in both the main local languages, Ndebele and Shona, as relevant. Key informant Interviews were conducted at provincial, district, facility and community levels in both district.

The qualitative fieldwork team was recruited in Zimbabwe, and the six team members were Zimbabweans fluent in English, and either Shona and Ndebele. A lead national research consultant was primarily responsible for the training and quality of the data collected. Each field team was composed of:

- One team leader, primarily for conducting key informant interviews, liaising with facility staff and daily debriefing sessions with the team;
- One lead facilitator, primarily responsible for leading focus group discussions; and
- One note-taker, responsible for maintaining a written record of the attendance and content of focus group discussions

Both teams travelled together to qualitative study districts over the course of two weeks, with the lead national consultant and OPM consultant providing guidance and quality assurance for the first full week of data collection.

Annex M Analysis of qualitative data

The data analysis commenced during the daily debriefing sessions, in which common and unusual themes were identified and analysed, alongside difference between social groups. The daily debriefings also enabled the researchers to clarify issues and strengthen understanding by incorporating additional key questions into the next day of research. Each research team produced a district-level research report, which provided a summary of the research process and an analysis of key findings and contextual issues.

The data from each FGD and KII was then transcribed and, after a process of review and clarifications, imported into NVIVO[42]. A data coding framework was then developed, focusing on the key impact areas and emerging themes associated with the ToC assumptions, as well as constraining and facilitating factors related to effectiveness, relevance, and sustainability. Using NVIVO, data under each research theme was disaggregated and analysed by gender, district, sub-county, respondent type (community member, district-level decision maker, service provider, etc.) in order to identify differences in experiences and perceptions.

[42] Qualitative data analysis software.

Annex N Description of qualitative study sites

The table below presents the socio-demographic indicators of the two qualitative research districts and for Zimbabwe

Table 22 Socio-demographic indicators for Bulilma, Rushinga and Zimbabwe

Indicator	Bulilima	Rushinga	Zimbabwe
Population	90 561	74 040	13 061 329
Average household size	4.6	4.3	4.2
Literacy	93%	94%	96%
Economically active persons	12%	62.5%	67%
Maternal Mortality Ratio	741	424	525
Total Fertility rate	3.6	4.4	3.8
Infant Mortality rate	49/1000	65/1000	64/100
Proportion of dwelling units with electricity	5%	4.1%	44%
Proportion of households with safe drinking water	57%	81%	75%
Proportion of households with toilet facilities	47.7%	79.8%	76%

Source: Zimbabwe National Census, 2012

The following paragraphs contain brief descriptions of the qualitative study sites covered at baseline. Note that while the discussion contains some information which relate to the quality of facilities, Section 5.5 contains the key baseline findings on the quality of MNCH facilities as understood through the analysis of the baseline evaluation data.

Rushinga District

Rushinga District is one of the eight districts that make up Mashonaland Central Province. Three health facilities and surrounding communities were included in the study: Bungwe, Rushinga, and Rusambo.

- **Bungwe Rural Health Centre** (treatment facility) serves a community of about 3,000 people, most of whom are members of the apostolic faith. The facility is surrounded by homesteads which are sparsely spaced. On the Northern side of the clinic there is a secondary school and a dip tank. The facility serves fifteen villages. There is a Mozambican migrant population in this community. The Centre uses solar energy for electricity, and there is no water source inside the clinic yard. The clinic obtains its water supply from a borehole a few meters outside the Health Centre. The Health Centre is located some distance away from the main business Centre and from the district hospital which is about 28km away.

- **Rusambo Health Centre** (comparison facility) serves a catchment area of about 7000 people and an estimated 2,400 people use the facility. The majority of the

people using the facility live locally in Zimbabwe, though some are from Mozambique. The Health Centre is about 10km from the district hospital, with a good road network. There is tap water at the clinic and a dam nearby, however, for electricity the facility relies on a solar panel.

- **Rushinga Rural Health Centre** (treatment facility) serves a population of roughly 6,100 people, and is located at Rushing Growth Point, located about 20km from the district hospital. It is electrified, but there is no running water. The communities utilising the centre are of different social backgrounds, including Christians of Catholic, Protestant and Apostolic faiths, traditionalist and business people, who live in two wards located around the vicinity of the health facility.

Bulilima District

Bulilima district is one of the ten districts that make up Matabeleland South Province. Bulilima and Beitbridge rural are the only districts in the province that have no urban area. There is no district hospital, as such district level health providers are based in Mangwe district, adjacent to Bulilima. The health facilities included in the survey are Madlambudzi, Masendu (treatment centres) and Makhulela (comparison).

- **Madlambuzi Health Centre** (treatment facility) is located about 72 km from Plumtree, the local administrative centre for the surrounding three districts. The clinic has a catchment population of about 5,200 people. The main water source is a borehole within the clinic yard and solar is used for power.

- **Masendu Health Centr**e (treatment facility) is situated some 52km from Plumtree, and serves about 8,900 people. It is one of the two entities housed at Masendu Cultural Centre, the other being shopping centre. The Cultural Centre comprises a number of white painted chalets and a big shade where community members undertake income generating projects. Inside the yard there is a sub office of Registrar Generals office. The health centre has no running water.

Makhulela Health Centre (comparison facility) is a well-built clinic about 100km from Plumtree District Hospital, with a catchment area of 5,300 people in 5 villages in one ward. The centre has running water and is powered by solar electricity. Generally, the communities are living in poverty with noticeably low levels of illiteracy

Annex O Qualitative data collection tools and respondents

Tables 23, 24 and 25 below provide details of the tools used, and the number and type of respondents comprising the qualitative component of the evaluation in each district.

Table 23 Qualitative instruments by respondent type

Instruments by respondent type							
	Female community members	Male community members	Opinion leaders	District health workers	Health Centre Committee members	District officials	Provincial officials
FGDs	x	x	x		x		
KIIs				x	chairperson x	x	x

Table 24 Focus Group Discussions Convened

Group	Districts	
	Rushinga	Bulilima
Women in the community, including adolescents	3	3
Men in the community, including adolescents	3	3
Members of Health Centre Committees (HCCs)	3	3
Opinion Leaders	3	3
Total	12	12

Table 25 Key Informant Interviews Conducted

LEVEL	KEY INFORMANT	Rushinga	Bulilima
Provincial	Provincial Medical Director	1	0
	Provincial Nursing Officer	0	1
District	District Medical Officer	1	0
	District Nursing Officer	1	1
	District Pharmacist	1	0
	Community Nurse	1	1
	CEO of Rural District Council	1	1
	Social Services Officer of Rural District Council	1	1
Health Facility	Sister-in-charge	3	3
Community	Health Centre Committee (HCC) Chairpersons	3	3
	Village Health Workers (VHW)	5 (as a group)	3
	Community Monitors (CM)	0	0
	Health Literacy Facilitators (HLF)	0	1
TOTAL PER DISTRICT		18	15

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Annex P Value for Money indicators

Domain	How will it be assessed?	Data sources	Data collection methods	Suggested frequency of data collection	Data analysis methods	Evaluability issues	Rationale for data request
Costs of the Strengthening Community Participation in Health Programme	Milestone payments made by DFID to Save the Children Total value of contract for the programme with the EU	Quarterly Milestone and Financial Reports to DFID	Review of reports and follow up with relevant personnel as required	Save the Children is reporting quarterly to DFID; OPM can use these reports.	No analysis for this domain – total amount claimed and approved will be used as the cost of the programme from DFID’s perspective.	Save the Children holds a milestone contract with DFID; they have agreed set prices for the achievement of specific milestones. The actual cost to Save the Children of achieving those milestones is not reported to DFID. After discussion with DFID and Save the Children, we have agreed to use what is reported to DFID in our assessment.	Milestone payment data gives us the cost of the programme from the funders’ perspective. It is important for estimating cost efficiency and cost effectiveness ratios.

	Opportunity cost of the time that volunteers spend helping to implement the programme	Save the Children estimates on (1) number of volunteers and (2) average amount of time a month that they spend volunteering Local wage data	Review of monitoring data and follow up with key personnel	OPM can receive this data on an annual basis.	Multiplication of the number of volunteer hours by the opportunity cost of volunteers’ time, proxied by the local wage	Three types of volunteer help to implement the programme: 1) Health Centre Committee members 2) Community Monitors and 3) Health Literacy Facilitators. We are still establishing for which types of volunteers Save the Children monitor numbers and time spent.	This allows us to conduct the analysis from a broader (societal) perspective—to understand not just the (financial) costs to DFID, but the opportunity costs to volunteers.
	Out-of-pocket (OOP) expenditure by women and children accessing services—e.g. any user fees or transportation costs incurred in travelling to and from the facility	Expenditure and utilisation data from the Impact Evaluation (IE) surveys	As described in Section 3	Data from the baseline and endline IE surveys will be used HMIS data can be collected at the same frequency as per IE	Analysis of data to estimate the additional cost to women and children of accessing services (due to the programme)	None identified.	This allows us to conduct the analysis from a broader (societal) perspective—to understand not just the (financial) costs to DFID but the costs (both financial and opportunity) to intended beneficiaries.

Economy	Save the Children holds a milestone contract with DFID; they have agreed set prices for the achievement of specific milestones. The actual cost to Save the Children of achieving those milestones is not reported to DFID. **After discussion with DFID and Save the Children, we have agreed not to undertake a quantitative assessment of the Economy domain.** This is because milestones are typically programme-specific activities with a set price over the programme time period and, without.						
	Qualitative assessment of any cost savings	Implementing partners	Key informant interviews with implementing partners	At the end of the programme (during the PCR)	Assessment of evidence from key informant interviews.	If implementing partner staff leave the project, will need to ensure that institutional memory is strong enough for this information to be captured.	Without quantitative indictors, a qualitative assessment of economy allows something to be said for this domain.
Efficiency and cost efficiency	Annual cost per person supported by each HCC	Cost data from implementing partners Total catchment population data	This is an Annual Review VFM indicator; data will be taken from there	OPM can receive this data on an annual basis from the Annual Review process.	Calculation already done as part of the Annual Review. Benchmarking the results against similar programmes in other countries.	None identified.	This allows us to assess the efficiency of the programme,
	Qualitative assessment of how resources are managed	Implementing partners	Key informant interviews with implementing partners	At the end of the programme (during the PCR)	Assessment of evidence from key informant interviews.	If implementing partner staff leave the project, will need to ensure that institutional memory is strong enough for this information to be captured.	This allows us to assess the efficiency of the programme, supplementing the quantitative information with qualitative to understand in particular how

							context affects this domain.
Effectiveness	% increase in quality of care composite score on HSF quality assessment in the past year compared to comparison sites	Crown Agents RBF survey	Review of data from Crown Agents and follow up with key personnel	This data is available quarterly.	Benchmarking treatment sites to comparison sites	None identified.	This allows us to assess the effectiveness of the programme.
Cost effectiveness	Cost per result at outcome indicator level: e.g. cost per additional delivery by a skilled birth attendant and cost per additional child immunised	Cost data as above	As above	Cost data as above; outcome data from the baseline and endline IE surveys	Comparison of cost data against key outcome indicator data. Benchmarking the results against those from other programmes.	Design of impact evaluation means that we can be confident in attribution to the intervention.	This will allow us to assess the cost-effectiveness of the programme at the appropriate level of service utilisation, rather than extending all the way to lives saved. This would require a number of assumptions to be made given that the impact evaluation is
		Key outcome indicator data from impact evaluation: e.g. number of additional deliveries by a skilled birth attendant; number of	As described in Section 3				

		additional children immunised					not assessing impact on health outcomes.
Cost effectiveness (TBC)	Incremental cost effectiveness ratio	Cost data as above	As above		Modelling of mortality and morbidity averted using LiST and conversion to DALYs using standard assumptions.	This part of the VFM is **not** currently being proposed given that we do not know the impact on service utilisation. If there is a significant impact, then we will explore modelling cost per DALY using LiST. However, our confidence in these estimates will be caveated in that we will be modelling impact on lives saves, using standard assumptions about the effectiveness of the health interventions.	
		Service utilisation data from impact evaluation	As described in Section 3				
		Data required for LiST modelling (e.g. population structure, effectiveness of health interventions)	Default values in LiST				
Equity	Service utilisation, disaggregated by: Gender	Data from the Impact Evaluation (IE) surveys	As described in Section 3	Data from the baseline and endline IE surveys will be used	Disaggregation of key outcome indicator data by categories of interest	Gender, age and poverty level are being collected in the user survey but we may not have enough	This will allow us to assess the equity dimension of VFM—the extent to which

	Age Poverty level				(gender, age and poverty level)	power to disaggregate results. HMIS may be an alternative source of this but data quality has yet to be assessed.	benefits are distributed fairly.

Annex Q Evaluation Ethical Considerations and Datasets

Q.1 Evaluation Ethical Considerations

Conducting qualitative and quantitative field work requires high ethical standards to ensure that expectations are not raised, confidentiality is maintained and respondents are never forced to participate or encouraged to speak about subjects that may be traumatising. Our team draws on its wide experience of conducting qualitative and quantitative fieldwork to ensure that these standards are met, and adheres to ethical protocols in line with the OECD-DAC principles of accuracy and credibility and DFID's Ethics Guidance for Research and Evaluation.

An important consideration when seeking an individual’s participation in research, is to ensure that they understand exactly what is being done with the information they have provided. OPM has extensive experience of conducting mixed methods research with vulnerable people and we have ensured that the below-described standards are met throughout the impact evaluation.

Informed consent: means that potential respondents are given enough information about the research and researchers ensure that there is no explicit or implicit coercion so that potential respondents can make an informed and free decision on their possible involvement in the fieldwork.

Anonymity: given that research respondents share considerable amounts of personal information it is OPM’s responsibility to ensure that their confidentiality is maintained and personal information is protected. This is operationalized by ensuring that all datasets are anonymised, in the sense that all names of respondents are removed before the data is shared publically.

Ensuring the safety of participants: this means that the environment in which research is conducted is physically safe. The impact evaluation team achieved this by ensuring that fieldworkers are local to areas in which they are assigned. In addition fieldwork supervisors will support the fieldwork manager in monitoring local security concerns.

- The relationship between our work and the DFID Ethics Principles for Research and Evaluation (DFID, 2011) is outlined below.

1) We have obtained formal approval to undertake primary data collection from the Permanent Secretary of Ministry of Health and Child Care (MoHCC) as well as from the Provincial Medical Directors. For this study we have determined that formal ethics approval was not required from The Medical Research Council of Zimbabwe (MRCZ) because of the nature of the questions we ask and we do not collect any biological samples.

2) Our analysis is of sufficiently high standard that the findings can be reliably used for their intended purpose.

3) We avoid any harm to all participants. We seek to achieve this by ensuring that fieldworkers are local to areas in which they are assigned. In addition fieldwork supervisors support the fieldwork manager in monitoring local security concerns. The

team endeavoured to ensure that service disruptions at health centres are kept to a minimum by ensuring that staff are informed as early as possible of the exact dates of the qualitative fieldwork and were given advance knows about the KIIs. The sequencing of interviews and FGDs was organised in cooperation with community members to ensure the smooth running of the research and to minimise disruption to village life.

4) All participation in our evaluation is entirely voluntary. We practice informed consent meaning that potential respondents are given enough information about the research and researchers ensure that there is no explicit or implicit coercion so that potential respondents can make an informed and free decision on their possible involvement in the fieldwork. All participants are made aware of their right to withdraw from research/ evaluation and withdraw any data concerning them at any point without fear of penalty.

5) We ensure confidentiality of information, privacy and anonymity of all study participants. We full understand our responsibility to ensure that their confidentiality is maintained and personal information is protected. This will be operationalized by ensuring that all datasets are anonymised, in the sense that all names or other identifying information of respondents are removed before the data is shared publically. Audio recordings of the FGDs and individual interviews are be made with participants’ consent, and then transcribed and translated into English. The confidentiality and anonymity of FGD participants and key informants is be respected and maintained at all times by ensuring that nothing which is recorded can be ascribed to a particular individual, and the transcripts and recordings are be accessible only to the researchers on the team

6) We abide by all international human rights conventions and covenants to which the United Kingdom is a signatory, regardless of local country standards. We also take account of local and national laws in Zimbabwe.

7) We respect cultural sensitivities. FGDs are carried out in both the main local languages, Ndebele and Shona, as relevant and interpreters are only used if participants are uncomfortable with using these languages. We take account of differences in culture, local behaviour and norms, religious beliefs and practices, sexual orientation, gender roles, disability, age and ethnicity and other social differences such as class when planning studies and communicating findings.

8) As discussed in our communication and dissemination strategy, we share our results widely. Full methodological details and information on who has undertaken the work is given. While respecting confidentiality requirements, our primary data will be made public to allow secondary analyses.

9) We act independently from the programmes we are evaluating. We disclose any potential conflicts of interest that might jeopardise the integrity of the methodology or the outputs of research/ evaluation should any arise.

10) We ensure that women and socially excluded groups can freely and safely participate in our research.

Q.2 Evaluation Datasets

The data generated by the project will be the property of DFID. However, the e-Pact has exclusive rights of usage over the data for purposes of academic publication and research for a period of up to one year from the date of completion of the project and the deliverable of the endline report. During this period, DFID will not publish the full data set and will not share data with any 3rd parties for the purposes of academic research and publication. DFID may release limited data for programmatic purposes. While releasing limited data DFID will consult with the evaluation team, to ensure that the evaluation team's exclusive rights to academic research are protected and the released data is used for purposes other than academic research and publication ensuring that the academic research rights of the evaluation team are protected. At the end of the one year period, or after an earlier period mutually agreed between DFID and the evaluation team, the evaluation team will make the anonymised datasets publicly available. The evaluation team will duly acknowledge DFID financial support in any publications that result from the use of the said data.

Annex R Facilities where HCCs and community members had already received training at time of baseline

It is important to note that the survey questions did not ask when the training took place and so some of the training may not have occurred under this programme (i.e. under Strengthening Community Participation in Health) as the respondent may have been trained before this programme began.

9.1 Training of HCCs

80.69% of HCCs have received training. Of these 12.82% received training from Save the Children and 9.4% received training from CWGH. Of those trained by Save the Children or CWGH, 60% are from treatment facilities and 40% are from comparison facilities. The list of facilities is shown below.

Table 26: Facilities where HCC members report ever being trained by SC/CWGH in treatment group

Province	District	Health Facility	Trainer	SC/CWGH comment
Manicaland	Mutasa	TSONZO RURAL HOSPITAL	CWGH	
Mashonaland Central	Guruve	CHIPURIRO RHC	SC	
Mashonaland Central	Guruve	GOTA RHC	SC	
Mashonaland Central	Shamwa	NYAMAROPA	SC	
Mashonaland East	Goromonzi	BOSHA	CWGH	
Mashonaland West	Makonde	NYAMUGOMBA CLINIC	SC	
Mashonaland West	Mhondoro	MUKARATI CLINIC	CWGH	Trained by SC
Masvingo	Bikita	CHIRORWE RHC	SC	
Masvingo	Bikita	MUKORE	SC	
Masvingo	Bikita	NEGOVANO CLINIC	SC	
Masvingo	Bikita	ODZI	SC	
Masvingo	Masvingo	GURAJENA	SC	
Masvingo	Masvingo	MURINYE	SC	
Matabeleland South	Bulilima	MADLAMBUDZI CLINIC	CWGH	
Matabeleland South	Bulilima	MASENDU	SC and CWGH	
Midlands	Kwekwe	DENDERA RURAL HEALTH CENTRE	CWGH	Trained by CWGH

Table 27: Facilities where HCC members report ever being trained by SC/CWGH in comparison group

Province	District	Health Facility	Trainer	SC/CWGH comment
Mashonaland Central	Guruve	BAKASA	SC	

Mashonaland Central	Guruve	SHINJE CLINIC	SC	These facilities were not trained by SC/CWGH under this programme (i.e. Strengthening Community Participation in Health) but they may have been trained previously under different projects.
Mashonaland Central	Shamwa	MADZIWA RURAL HOSPITAL	CWGH	
Mashonaland West	Mhondoro	MURAMBWA RHC	CWGH	
Masvingo	Bikita	BIKITA RURAL HOSPITAL	CWGH	
Masvingo	Bikita	DEWURE 1	SC	
Matabeleland North	Hwange	LUKUNGUNI MISSION CLINIC	SC	
Matabeleland South	Bulilima	SOLUSI ADVENTIST CLINIC	CWGH	
Midlands	Kwekwe	DAMBRIDGE RHC	CWGH	

9.2 Training of community members

21.13% of ANC patients have received training. Of these 2.59% received training from Save the Children and 24.14% received training from CWGH. Of those trained by Save the Children or CWGH, 50% were interviewed in treatment facilities and 50% were in comparison facilities.

21.39% of U5 carers have received training. Of these 0.70% received training from Save the Children and 26.76% received training from CWGH. Of those trained by Save the Children or CWGH, 47.37% are from treatment facilities and 52.63% are from comparison facilities.

The facilities are shown below.

Table 28: Facilities where ANC patients have report ever being by SC/CWGH in treatment group

Province	District	Health Facility	Trainer	SC/CWGH comment
Manicaland	Makoni	CHIKOBVORE RHC	CWGH	
Manicaland	Mutasa	MANDEYA 2	CWGH	Trained after baseline survey
Manicaland	Mutasa	SACHISUKO CLINIC	CWGH	Trained after baseline survey
Mashonaland East	Goromonzi	BOSHA	CWGH	
Mashonaland Central	Rushinga	MUKOSA RHC	CWGH	Trained after baseline survey and by SC
Mashonaland West	Zvimba	RAFFINGORA RURAL HOSPITAL	CWGH	Trained after baseline survey and by SC
Masvingo	Masvingo	GURAJENA	CWGH	Trained after baseline survey and by SC
Masvingo	Masvingo	MURINYE	CWGH	Trained after baseline survey and by SC
Masvingo	Masvingo	SHUMBA RHC	CWGH	Trained after baseline

				survey and by SC
Matabeleland North	Hwange	NDLOVU CLINIC	CWGH	Not yet trained
Matabeleland South	Bulilima	MADLAMBUDZI CLINIC	CWGH	Trained after baseline survey
Matabeleland South	Insiza	SINGWANGO RHC	CWGH	Trained after baseline survey

Table 29: Facilities where ANC patients report ever being trained by SC/CWGH by SC/CWGH in comparison group

Province	District	Health Facility	Trainer	SC/CWGH comment
Manicaland	Buhera	GARAMWERA CLINIC	SC and CWGH	Not trained and no training planned
Mashonaland Central	Guruve	NEGOMO	SC and CWGH	
Mashonaland Central	Guruve	MATSVITSVI RHC	SC	
Midlands	Kwekwe	SIDAKENI	CWGH	
Masvingo	Masvingo	BERE CLINC	CWGH	
Masvingo	Masvingo	CHATIKOBO RHC	CWGH	
Midlands	Mberengwa	GWARAVA RURAL HEALTH CENTRE	CWGH	
Mashonaland East	UMP	NYAKASORO CLINIC	CWGH	
Mashonaland West	Zvimba	KUTAMA	CWGH	

Table 30: Facilities where Carers of under Fives report ever being trained by SC/CWGH in treatment group

Province	District	Health Facility	Trainer	SC/CWGH comment
Manicaland	Mutasa	MANDEYA 2	CWGH	No comment
Manicaland	Mutasa	ZINDI RHC	CWGH	Trained prior to baseline survey
Mashonaland Central	Rushinga	MUKONDE	CWGH	Trained after baseline survey
Mashonaland Central	Rushinga	MUKOSA RHC	CWGH	No comment
Mashonaland Central	Rushinga	NHAWA RHC	CWGH	Trained after baseline survey
Mashonaland East	Goromonzi	BOSHA	CWGH	No comment
Masvingo	Bikita	MURWIRA RHC	CWGH	
Masvingo	Masvingo	GURAJENA	CWGH	No comment
Masvingo	Masvingo	MUKOSI CLINIC	CWGH	No comment
Masvingo	Masvingo	SHUMBA RHC	CWGH	Trained after baseline survey
Matabeleland North	Hwange	MWEMBA CLINIC	CWGH	No comment
Matabeleland North	Hwange	NDLOVU CLINIC	CWGH	Not yet trained
Matabeleland South	Insiza	SINGWANGO RHC	CWGH	Trained after baseline survey

Matabeleland North	Hwange	MABALE CLINIC	CWGH	No comment
Midlands	Kwekwe	DENDERA RURAL HEALTH CENTRE	CWGH	
Midlands	Mberengwa	MATAGA	CWGH	Trained prior to baseline survey and by SC

Table 31: Facilities where Carers of under Fives report ever being trained by SC/CWGH in comparison group

Province	District	Health Facility	Trainer	SC/CWGH comment
Manicaland	Buhera	MURWIRA	CWGH	No comment
Manicaland	Buhera	NYASHANU MISSION CLINIC	CWGH	
Manicaland	Mutasa	HAUNA CLINIC	CWGH	
Manicaland	Mutasa	HAUNA CLINIC	CWGH	
Mashonaland Central	Guruve	NYAMHONDORO	CWGH	
Masvingo	Masvingo	BERE CLINC	CWGH	
Masvingo	Masvingo	CHATIKOBO RHC	CWGH	
Masvingo	Masvingo	CHATIKOBO RHC	CWGH	
Masvingo	Masvingo	CHATIKOBO RHC	CWGH	
Masvingo	Masvingo	NEMAMWA	CWGH	
Masvingo	Masvingo	NEMAMWA	CWGH	
Masvingo	Masvingo	NYAMANDE RHC	CWGH	
Masvingo	Masvingo	NYAMANDE RHC	CWGH	
Masvingo	Masvingo	NYAMANDE RHC	CWGH	
Matabeleland North	Hwange	LUKUNGUNI MISSION CLINIC	CWGH	
Midlands	Kwekwe	MAYORCA RURAL HEALTH CENTRE	CWGH	
Midlands	Kwekwe	MBIZO	SC and CWGH	

Annex S Quantitative Results – Balance Tables

S.1 How to read the tables in this section

The ‘N’ value.

Each table shows the ‘N’ value for each indicator. This indicates the number of observations in the sample on which that indicator is based. This gives an indication of how certain we can be about the estimate in question. The more respondents that answer a question, the more certain we can be that the estimate is real and that any differences identified are statistically significant

Significance stars.

As the selection of treatment facilities was not random, there may be some differences between the treatment and comparison groups. As described in Annex H, any differences between groups at the baseline will be factored out of the impact assessment using difference-in-difference methods.

A statistical test is used to assess if there are any real differences between treatment and comparison areas.

Any differences are marked in the tables with a series of asterisks:
* = significant at the 95% level
** = significant at the 99% level
*** = significant at the 99.9% level

This means that the more asterisks that are shown, the more likely that the observed difference is due to a real difference between the treatment and comparison groups rather than being due to chance. However, it’s important to note that be design, for 5% of test of the significance of the difference between two means, the difference will be shown as significant when actually there is no real difference between treatment and control.

It is important to note that, where results are not asterisked, this does not mean that there is no difference between the groups but rather that any difference cannot be asserted with such a high degree of confidence (95% or more).

S.2 Balance tables

Table 32: ANC patients’ indicators

	Control N	Control Mean	Control SD	Treatment N	Treatment Mean	Treatment SD	Difference in Means
Overall satisfaction							
Proportion of users who…							
Are very satisfied with the quality of care received during the visit at this facility	727	1	0.1	687	1	0.1	0
Satisfaction with health workers							
Proportion of users who…							
Completely trust the health workers in this facility	721	1	0.2	679	1	0.2	0

Believe that health workers in this facility are extremely thorough and careful	726	1	0.1	687	1	0.1	0
Trust in the skills and abilities of the health workers of this facility	723	1	0.1	683	1	0.2	0
Completely trust the health worker’s decisions about medical treatments in this	726	1	0.1	685	1	0.1	0
Believe that health workers in this facility are very friendly and approachable	726	1	0.2	682	1	0.2	0
Believe that health workers in this facility are easy to make contact with	719	1	0.2	681	1	0.2	0
Believe that health workers in this facility care about their health just as much or more than they do	719	1	0.1	677	1	0.2	0
Believe that health workers did a good job of explaining how to take care of their unborn baby	726	1	0.2	687	1	0.2	0
Believe that health worker spent a sufficient amount of time with them	727	1	0.2	687	1	0.1	0
Believe that health workers in this facility are often absent	704	0.1	0.2	649	0.1	0.2	0
Believe that health workers in this facility act differently toward rich people than toward poor people	673	0.1	0.3	635	0.1	0.3	0
Satisfaction with the facility and costs							
Proportion of users who…							
Believe that it is convenient to travel from their house to the health facility	726	0.8	0.4	686	0.8	0.4	0
Believe that the amount of time spent waiting to be seen by a health provider was reasonable	726	0.9	0.3	687	0.9	0.3	0
Believe that it is easy to get medicine that health workers prescribe	717	0.9	0.3	671	0.9	0.3	0
Believe that they had enough privacy during visit	726	1	0.1	687	1	0.1	0
Believe that the health facility is clean	726	1	0.2	681	1	0.2	0
Proportion of users who know of…							
HCC in their community	727	0.2	0.4	688	0.2	0.4	0
Proportion of users that were aware…							
Of the Patients' Charter	725	0	0.2	688	0.1	0.3	0*
Of free health services for women and children	724	0.7	0.4	687	0.7	0.5	0
Proportion of users that admit to knowing patient rights at the health facility	727	0.4	0.5	688	0.4	0.5	0
Proportion of users that received training on patient rights and entitlements, past 12 months	270	0.2	0.4	279	0.2	0.4	0

Of those who received training on patient rights and entitlements, proportion that received training by…							
By Health staff at health facility	55	0.7	0.5	61	0.6	0.5	0.1
By Community Working Group on Health	55	0.2	0.4	61	0.3	0.5	-0.1
By Other Ministry of Health staff	55	0.1	0.4	61	0.2	0.4	-0.1
By Other NGO	55	0.1	0.4	61	0.1	0.4	0
By District Health Team	55	0.1	0.2	61	0.1	0.3	0
By Save the Children	55	0.1	0.2	61	0	0	.1*
By Other	54	0.1	0.3	61	0.2	0.4	-0.1
Travel to health facility							
Distance travelled to health facility (km)	467	4.4	4.2	430	4.2	4.3	0.2
Proportion of users who travelled to the health facility nearest to them	714	1	0.2	673	0.9	0.2	0
Time take to travel to health facility by foot (minutes)	710	99.9	84.1	679	95.7	74.5	4.2
Proportion of users who declare the main reason for using this health facility is…							
Close to home	724	0.8	0.4	687	0.9	0.4	0
High quality care	724	0.2	0.4	687	0.1	0.3	0
No fees charged	724	0	0.1	687	0	0.1	0
Low cost	724	0	0.1	687	0	0.1	0
Respondent's socioeconomic information							
Respondent's age	727	25.6	6.5	686	25.2	6.5	0.4
Literacy							
Proportion of respondents who can read and write	727	0.9	0.3	688	0.9	0.3	0
Proportion of respondents who can read only	727	0	0.1	688	0	0.1	0
Proportion of respondents who can write only	727	0	0.1	688	0	0.1	0
Proportion of respondents who CANNOT read or write	727	0.1	0.3	688	0.1	0.2	0
Education							
Proportion of respondents with no education	726	0	0.1	687	0	0.1	0
Proportion of respondents with pre-school	726	0	0.1	687	0	0.1	0
Proportion of respondents with primary education	726	0.4	0.5	687	0.4	0.5	0
Proportion of respondents with secondary education	726	0.6	0.5	687	0.6	0.5	0
Proportion of respondents with tertiary education	726	0	0.1	687	0	0.1	0

Socioeconomic characteristics of the household							
Household size	727	5	2.2	688	5	2.1	0
Highest level of education attained by household head	704	2.6	0.9	676	2.6	1	0
Proportion of households whose source of drinking water is…							
Tube well or borehole	727	0.5	0.5	687	0.5	0.5	0
Protected well	727	0.2	0.4	687	0.2	0.4	0
Unprotected well	727	0.1	0.3	687	0.2	0.4	0
Surface water	727	0.1	0.3	687	0.1	0.3	0
Other*	727	0.2	0.4	688	0.1	0.3	0.1
Proportion of households whose toilet facility is…							
Ventilated improved latrine	726	0.4	0.5	687	0.4	0.5	0
No facility/bush/field	726	0.3	0.5	687	0.3	0.4	0
Pit latrine with slab	726	0.1	0.4	687	0.2	0.4	0
Pit latrine without slab/open pit	726	0.1	0.3	687	0.1	0.3	0
Other*	727	0.1	0.2	688	0	0.2	0
Proportion of households whose source of electricity is…							
A solar panel for power	726	0.6	0.5	688	0.6	0.5	0
A battery or generator for power	726	0.3	0.5	688	0.3	0.5	0
Electricity that is connected	726	0.1	0.3	687	0.1	0.3	0*
Proportion of households that have…							
A mobile telephone in working condition	727	0.8	0.4	688	0.8	0.4	0
A radio in working condition	726	0.6	0.5	688	0.6	0.5	0
A television in working condition	725	0.3	0.4	688	0.2	0.4	0
A refrigerator in working condition	727	0.1	0.2	688	0	0.2	0
A computer in working condition	727	0	0.2	688	0	0.2	0
A non-mobile telephone	727	0	0.1	688	0	0.1	0
Proportion of households in which a household member owns a…							
Wheelbarrow	725	0.4	0.5	688	0.5	0.5	0
Bicycle	726	0.4	0.5	688	0.4	0.5	0
Animal-drawn cart	725	0.3	0.4	688	0.3	0.5	0
Watch	726	0.2	0.4	688	0.2	0.4	0
Car or truck	726	0.1	0.2	688	0.1	0.2	0
Motorcycle	726	0	0.2	688	0	0.2	0
Tractor	726	0	0.1	688	0	0.1	0

Proportion of households whose source of energy is…							
Wood	725	0.9	0.3	687	1	0.2	0**
Electricity	725	0.1	0.2	687	0	0.2	0
Paraffin/kerosene	725	0	0.1	687	0	0.1	0
Proportion of households where cooking happens…							
In a separate building	725	0.8	0.4	686	0.8	0.4	0
In the house	725	0.1	0.3	686	0.1	0.3	0
Outdoors	725	0.1	0.3	686	0.1	0.3	0
Proportion of households where flooring material is…							
Cement	727	0.6	0.5	687	0.5	0.5	0
Earth/sand	727	0.2	0.4	687	0.3	0.4	0
Dung	727	0.2	0.4	687	0.2	0.4	0
Other*	727	0	0.1	688	0	0.1	0
Proportion of households where roofing material is…							
Thatch	727	0.5	0.5	687	0.6	0.5	-0.1
Asbestos	727	0.3	0.5	687	0.3	0.5	0
Metal	727	0.1	0.3	687	0.1	0.3	0
No roof	727	0	0.1	687	0	0.1	0
Proportion of households where exterior wall material is…							
Bricks	727	0.6	0.5	687	0.7	0.5	-0.1
Mud	727	0.2	0.4	687	0.2	0.4	0
Cement	727	0.1	0.4	687	0.1	0.3	0
Other*	727	0.1	0.3	688	0.1	0.3	0
Number of rooms in dwelling used for sleeping	727	2.1	1.1	688	2.1	1.1	0
Livestock							
Proportion of households that own any livestock	727	0.8	0.4	686	0.8	0.4	0
Food security							
Proportion of households who during the last 4 weeks went without any food to eat because of a lack of food	727	0.1	0.3	688	0.1	0.3	0*
Proportion of households who during the last 4 weeks went to sleep hungry because there was not enough food	727	0.1	0.3	688	0.1	0.2	0

Proportion of households who went a whole day and night without eating because there was not enough food	727	0.1	0.2	688	0	0.2	0
Banking							
Proportion of households with at least 1 member that has a bank account	726	0.2	0.4	688	0.1	0.3	0
Proportion of households with at least 1 member that owns a mobile save account	727	0.2	0.4	688	0.2	0.4	0
Hunger score							
Proportion of households that have little or no hunger	727	0.9	0.3	688	0.9	0.2	0
Proportion of households that have moderate hunger	727	0.1	0.3	688	0.1	0.2	0
Proportion of households that have severe hunger	727	0	0.1	688	0	0.1	0
If unhappy about the facility or its staff, proportion of users who…							
Who WOULD complain	727	0.6	0.5	688	0.6	0.5	0
Who WOULD NOT complain	727	0.4	0.5	688	0.4	0.5	0
Proportion of users who have been unhappy or unsatisfied with the facility or its staff, in the past 12 months.	727	0.1	0.3	688	0.1	0.3	0

Table 33: U5 carers' indicators

	Control N	Control Mean	Control SD	Treatment N	Treatment Mean	Treatment SD	Difference in Means
Overall satisfaction							
Proportion of users who…							
Are very satisfied with the quality of care received during the visit at this facility	828	1	0.1	683	1	0.2	0
Satisfaction with health workers							
Proportion of users who…							
Completely trust the health workers in this facility	825	1	0.2	682	1	0.2	0
Believe that health workers in this facility are extremely thorough and careful	825	1	0.2	683	1	0.2	0
Trust in the skills and abilities of the health workers of this facility	825	1	0.1	679	1	0.2	0
Completely trust the health worker’s decisions about medical treatments in this	825	1	0.1	682	1	0.1	0
Believe that health workers in this facility are very friendly and approachable	827	1	0.2	681	1	0.2	0
Believe that health workers in this facility are easy to make contact with	822	1	0.2	676	1	0.2	0

Believe that health workers in this facility care about their health just as much or more than they do	817	1	0.2	678	1	0.2	0
Believe that health workers did a good job of explaining how to take care of their unborn baby	826	1	0.2	680	1	0.2	0
Believe that health worker spent a sufficient amount of time with them	827	1	0.2	682	1	0.2	0
Believe that health workers in this facility are often absent	792	0.1	0.2	656	0.1	0.3	0
Believe that health workers in this facility act differently toward rich people than toward poor people	779	0.1	0.3	630	0.2	0.4	-.1**
Satisfaction with the facility and costs							
Proportion of users who…							
Believe that it is convenient to travel from their house to the health facility	828	0.8	0.4	682	0.8	0.4	0
Believe that the amount of time spent waiting to be seen by a health provider was reasonable	828	0.9	0.3	683	0.9	0.3	0*
Believe that it is easy to get medicine that health workers prescribe	816	0.9	0.3	668	0.9	0.3	0
Believe that they had enough privacy during visit	828	0.9	0.2	680	1	0.2	0
Believe that the health facility is clean	826	1	0.2	681	1	0.2	0
Proportion of users who know of…							
HCC in their community	830	0.3	0.4	683	0.3	0.5	0
Proportion of users that were aware…							
Of the Patients' Charter	828	0.1	0.2	681	0.1	0.3	0
Of free health services for women and children	827	0.8	0.4	683	0.8	0.4	0
Proportion of users that admit to knowing patient rights at the health facility	830	0.4	0.5	684	0.5	0.5	0
Proportion of users that received training on patient rights and entitlements, past 12 months	352	0.2	0.4	312	0.2	0.4	-0.1
By Health staff at health facility	67	0.7	0.5	75	0.6	0.5	0.1
By Community Working Group on Health	67	0.3	0.4	75	0.3	0.5	0
By Other Ministry of Health staff	67	0.1	0.3	75	0.2	0.4	0
By Other NGO	67	0.2	0.4	75	0.1	0.3	0.1
By District Health Team	67	0.1	0.2	75	0.2	0.4	-.1**
By Other*	67	0.1	0.3	75	0.1	0.2	0
Travel to health facility							

Distance travelled to health facility (km)	565	4.2	4.9	470	3.9	3.9	0.2
Proportion of users who travelled to the health facility nearest to them	818	1	0.2	682	1	0.2	0
Time take to travel to health facility by foot (minutes)	565	4.2	4.9	470	3.9	3.9	0.2
Proportion of users who declare the main reason for using this health facility is…							
Close to home	829	0.8	0.4	684	0.8	0.4	0
High quality care	829	0.1	0.4	684	0.1	0.3	0
Other	830	0.3	0.4	684	0.3	0.5	-.1**
Respondent's socioeconomic information							
Respondent's age	828	28.1	8.2	684	28.2	8.3	-0.2
Literacy							
Proportion of respondents who can read and write	829	0	0.2	683	0	0.2	0
Proportion of respondents who can read only	827	0.9	0.3	680	0.9	0.3	0
Proportion of respondents who can write only	827	0	0.2	680	0	0.1	0**
Proportion of respondents who CANNOT read or write	827	0	0.1	680	0	0.1	0
Education							
Proportion of respondents with no education	827	0.1	0.3	680	0.1	0.3	0
Proportion of respondents with pre-school	830	0	0.2	683	0	0.2	0
Proportion of respondents with primary education	830	0	0.1	683	0	0	0
Proportion of respondents with secondary education	830	0.4	0.5	683	0.4	0.5	0
Proportion of respondents with tertiary education	830	0.6	0.5	683	0.6	0.5	0
Socioeconomic characteristics of the household							
Household size	829	5.4	2.1	684	5.5	2.1	-0.2
Highest level of education attained by household head	806	2.7	0.7	651	2.6	0.8	.1*
Proportion of households whose source of drinking water is…							
Tube well or borehole	829	0.5	0.5	684	0.5	0.5	0
Protected well	829	0.2	0.4	684	0.2	0.4	0
Unprotected well	829	0.1	0.3	684	0.1	0.3	0
Surface water	829	0.1	0.3	684	0.1	0.3	0
Piped into dwelling	829	0	0.2	684	0	0.1	0
Piped to yard/plot	829	0	0.2	684	0	0.2	0

Other*	830	0.1	0.2	684	0	0.2	0
Proportion of households whose toilet facility is…							
Ventilated improved latrine	829	0.4	0.5	684	0.4	0.5	0
No facility/bush/field	829	0.3	0.4	684	0.2	0.4	0
Pit latrine with slab	829	0.2	0.4	684	0.2	0.4	0
Pit latrine without slab/open pit	829	0.1	0.3	684	0.1	0.3	0
Flush to piped sewer system	829	0.1	0.2	684	0	0.1	0**
Flush to septic tank	829	0	0.1	684	0	0.1	0
Proportion of households whose source of electricity is…							
A solar panel for power	829	0.5	0.5	684	0.6	0.5	0
A battery or generator for power	829	0.3	0.5	684	0.3	0.5	0
Electricity that is connected	829	0.1	0.4	683	0.1	0.3	.1**
Proportion of households that have…							
A mobile telephone in working condition	829	0.8	0.4	684	0.8	0.4	0
A radio in working condition	829	0.6	0.5	684	0.6	0.5	0
A television in working condition	829	0.3	0.5	684	0.2	0.4	0.1
A refrigerator in working condition	829	0.1	0.3	684	0	0.2	0**
A computer in working condition	829	0	0.2	684	0	0.1	0**
A non-mobile telephone	829	0	0.1	684	0	0.1	0*
Proportion of households in which a household member owns a…							
Wheelbarrow	828	0.4	0.5	683	0.5	0.5	0
Bicycle	828	0.4	0.5	684	0.4	0.5	0
Animal-drawn cart	828	0.3	0.5	684	0.3	0.5	0
Watch	828	0.2	0.4	684	0.2	0.4	0
Car or truck	828	0.1	0.3	684	0.1	0.2	0**
Motorcycle	828	0	0.2	684	0	0.1	0***
Tractor	828	0	0.1	684	0	0.1	0
Proportion of households whose source of energy is…							
Wood	828	0.9	0.3	683	0.9	0.2	0
Electricity	828	0.1	0.3	683	0	0.2	.1**
Paraffin	828	0	0.1	683	0	0.1	0
Proportion of households where cooking happens…							
In a separate building	827	0.8	0.4	683	0.8	0.4	0
In the house	827	0.1	0.3	683	0.1	0.3	0
Outdoors	827	0.1	0.3	683	0.1	0.3	0

	827	0.6	0.5	683	0.6	0.5	0
Proportion of households where flooring material is…	827	0.2	0.4	683	0.2	0.4	0
Cement	827	0.1	0.4	683	0.2	0.4	0
Earth/sand	827	0	0.1	683	0	0.1	0*
Dung	827	0.8	0.4	683	0.8	0.4	0
Ceramic tiles	827	0.1	0.3	683	0.1	0.3	0
Proportion of households where roofing material is…							
Thatch	828	0.5	0.5	684	0.6	0.5	0
Asbestos	828	0.4	0.5	684	0.3	0.5	0
Metal	828	0.1	0.3	684	0.1	0.3	0
Cement	828	0	0.1	684	0	0.1	0
Proportion of households where exterior wall material is…							
Bricks	829	0.6	0.5	683	0.7	0.5	0
Mud	829	0.1	0.3	683	0.2	0.4	0
Cement	829	0.2	0.4	683	0.1	0.3	.1**
Other*	830	0.1	0.3	684	0.1	0.3	0
Number of rooms in dwelling used for sleeping	830	2.2	1.1	684	2.2	1.1	0
Livestock							
Proportion of households that own any livestock	829	0.8	0.4	684	0.8	0.4	0
Food security							
Proportion of households who during the last 4 weeks went without any food to eat because of a lack of food	830	0.1	0.3	682	0.1	0.3	0
Proportion of households who during the last 4 weeks went to sleep hungry because there was not enough food	830	0.1	0.3	682	0.1	0.3	0
Proportion of households who went a whole day and night without eating because there was not enough food	830	0.1	0.3	682	0.1	0.3	0
Banking							
Proportion of households with at least 1 member that has a bank account	830	0.2	0.4	683	0.2	0.4	0
Proportion of households with at least 1 member that owns a mobile save account	830	0.2	0.4	683	0.2	0.4	0
Hunger score							
Proportion of households that have little or no hunger	830	0.9	0.3	684	0.9	0.3	0

Proportion of households that have moderate hunger	830	0.1	0.3	684	0.1	0.3	0
Proportion of households that have severe hunger	830	0	0.1	684	0	0.1	0
If unhappy about the facility or its staff, proportion of users who…							
Who WOULD complain	830	0.6	0.5	684	0.6	0.5	0
Who WOULD NOT complain	830	0.4	0.5	684	0.4	0.5	0
Proportion of users who have been unhappy or unsatisfied with the facility or its staff, in the past 12 months.	830	0.1	0.3	684	0.1	0.3	0

Table 34: HCC members' indicators

	Cont. N	Cont. Mean	Cont. SD	Treat. N	Treat. Mean	Treat. SD	Diff. in Means
Proportion of health facilities that…							
Have an operational/annual plan	77	0.9	0.3	65	0.9	0.3	0
Proportion of HCC members that identify their HCC as…							
HCCs	79	0.8	0.4	66	0.9	0.3	-0.1
Sub Health committees	79	0	0	66	0	0.1	0
Ward Health committees	79	0.2	0.4	66	0.1	0.3	0.1
Other	79	0	0.1	66	0	0.1	0
Age in years of HCC	37	8.5	8.6	30	4	3.6	4.6***
Number of HCC members…							
Total	78	8.7	3.2	65	8.6	3	0.1
Male	79	4.7	2.1	66	4.7	2.1	0
Female	78	4	2.3	65	3.9	2	0.1
Proportion of HCCs with representation of…							
Nurse in Charge	79	1	0.2	66	1	0.2	0
Ordinary community members	79	0.9	0.3	66	0.9	0.2	0
Local political leader (e.g. councillor)	79	0.7	0.4	66	0.8	0.4	0
Traditional community leader	79	0.7	0.5	66	0.6	0.5	0.1
Community Health Worker	79	0.6	0.5	66	0.7	0.5	0
Church representative	79	0.6	0.5	66	0.5	0.5	0.1
Other Health Facility staff	79	0.4	0.5	66	0.5	0.5	-0.1
Government Extension workers	79	0.5	0.5	66	0.4	0.5	0.1
School headmaster/Health Master	79	0.4	0.5	66	0.5	0.5	-0.1
Youth Organisation	79	0.4	0.5	66	0.3	0.4	0.1
NGO/CSO	79	0.2	0.4	66	0.2	0.4	0

Proportion of HCCs with a…							
Chairperson	79	0.9	0.3	66	0.9	0.3	0
Vice chair	79	0.8	0.4	66	0.8	0.4	0
Treasurer	79	0.9	0.3	66	0.9	0.3	0
Secretary	78	0.9	0.3	66	0.9	0.3	0
HCC meetings							
Proportion of HCCs that have met to discuss health issues at least once in the past 12 months	77	1	0	66	1	0	0
Proportion of HCCs that keep minutes of their meetings in the past 12 months	76	1	0.2	66	1	0	0
HCC interaction with their local community							
Proportion of HCCs that have met with the community to get feedback in the past 12 months	79	0.8	0.4	66	0.9	0.3	-.1*
Proportion of HCCs that recorded their meetings with the community	63	0.7	0.5	60	0.7	0.5	0
HCC interaction with the DHE							
Proportion of HCCs that participate in district level meetings with the District Health Executive	79	0.5	0.5	66	0.6	0.5	-0.1
Proportion of HCCs that never kept up to date on health developments by DHE	78	0	0.2	65	0	0.2	0
Proportion of HCCs that rarely kept up to date on health developments by DHE	78	0	0.2	65	0.1	0.3	-.1**
Proportion of HCCs that sometimes kept up to date on health developments by DHE	78	0.2	0.4	65	0.2	0.4	0
Proportion of HCCs that often kept up to date on health developments by DHE	78	0.2	0.4	65	0.2	0.4	0
Proportion of HCCs that always kept up to date on health developments by DHE	78	0.5	0.5	65	0.4	0.5	0.1
HCC handbook							
Proportion of HCCs with a copy of HCC handbook	78	0.3	0.5	66	0.3	0.5	-0.1
Patient's Charter							
Proportion of HCCs with a copy of Patient’s charter	79	0.2	0.4	66	0.4	0.5	-.2**
Display MCNH stats							
Proportion of HCCs that display MNCH statistics, including current month	78	0.1	0.3	65	0.1	0.3	0
Proportion of HCCs that display MNCH statistics, but not for this month	78	0.2	0.4	65	0.2	0.4	0
Proportion of HCC that DO NOT record and display MNCH statistics	78	0.7	0.5	65	0.6	0.5	0

HCC reports on MNCH							
Proportion of HCCs that submit written reports on MNCH access	79	0.3	0.5	66	0.4	0.5	0
HCC monitoring							
Proportion of HCCs that monitor health facilities	79	1	0.2	65	1	0.2	0
Proportion of health facilities that record HCC monitoring visits	76	0.3	0.5	63	0.3	0.5	0
Funding raising							
Proportion of HCCs who in past 12 months had a plan to raise money	79	0.6	0.5	66	0.5	0.5	0.1
Proportion of HCCs that in past 12 months actually raised any money	79	0.3	0.5	66	0.3	0.4	0.1
Proportion of HCCs that implemented their own initiatives in the community to improve health.	78	0.7	0.5	66	0.7	0.5	0
Proportion of HCCs in which the following make the decision on finances…							
Chairperson	79	1	0	66	1	0.2	0
Vice Chairperson	79	0.6	0.5	66	0.4	0.5	0.1
Treasurer	79	0.8	0.4	66	0.8	0.4	0
Secretary	79	0.8	0.4	66	0.8	0.4	0
Health Workers	79	0.5	0.5	66	0.5	0.5	0
Proportion of HCCs that report decisions are made by one person.	79	0	0.2	66	0	0.2	0
HCC performance							
Proportion of HCC respondents that…							
Believe discussions held in HCC contribute to improvement of people’s health	79	1	0.1	66	1	0.1	0
Believe they need additional support to perform HCC duties effectively	79	1	0.2	65	1	0.2	0
Face challenges that affect delivery of responsibilities	78	0.8	0.4	65	0.9	0.3	-0.1
Proportion of HCCs in which current members have received training to help with their job.	79	0.7	0.4	66	0.9	0.3	-.1**
***Of those who have received training*, proportion of HCCs that have received training by…**							
District Health Team	59	0.8	0.4	58	0.7	0.5	.1*
Other Ministry of Health staff	59	0.5	0.5	58	0.5	0.5	0
Health staff at health facility	59	0.3	0.5	58	0.2	0.4	0.1
Other NGO	59	0.2	0.4	58	0.3	0.4	-0.1

Save the Children	59	0.1	0.3	58	0.2	0.4	-.1**
Community Working Group on Health	59	0.1	0.3	58	0.1	0.3	0
Crown Agents	59	0	0.1	58	0.1	0.3	-0.1
CORDAID	59	0	0.1	58	0	0.2	0
Other	59	0.1	0.3	58	0.1	0.3	0
Do not know	59	0.8	0.4	58	0.7	0.5	.1*
***Of those who have received training,* proportion of HCCs in which the training received was on…**							
Monitoring and tracking budgets	59	0.1	0.3	58	0.1	0.3	0
Functions of a health centre committee	59	0.7	0.5	57	0.7	0.5	0
Preparing and analysing budgets	59	0.7	0.5	58	0.6	0.5	0.1
Organizing and mobilizing communities for health	59	0.5	0.5	58	0.5	0.5	0
Mobilizing financial resources	59	0.4	0.5	58	0.5	0.5	-0.1
Communication skills	59	0.4	0.5	58	0.4	0.5	0
Training received, Developing health development plans	59	0.3	0.4	58	0.3	0.5	-0.1
Holding meetings	59	0.3	0.5	58	0.3	0.4	0
Implementing and monitoring health plans	59	0.3	0.4	58	0.2	0.4	0
How to work with health workers	59	0.3	0.4	58	0.2	0.4	0
Patients' rights and entitlements	59	0.2	0.4	58	0.3	0.4	-0.1
Advocating and negotiating health issues	59	0.2	0.4	58	0.3	0.4	-0.1
Writing or presenting reports	59	0.2	0.4	58	0.2	0.4	0
How to work with different stakeholders	59	0.2	0.4	58	0.2	0.4	0
Other health issues	59	0.1	0.3	58	0.2	0.4	-0.1
Health facility's operational plan							
Of those health facilities with an operational/annual plan, proportion of HCCs involved in the development of the health facility's operational/annual plan	71	1	0.1	58	1	0.2	0
Proportion of health facilities that received any money in the past 12 months from…							
RBF	77	0	0.2	64	0	0.2	0
HSF	77	0	0.2	64	0	0.2	0
HTF	77	0.9	0.2	64	0.9	0.3	0
None of them	77	0	0	64	0	0.1	0
Do not know	78	0	0.1	65	0	0.1	0
Of those that received money…							
Amount of funding received from HSF, HTF or RBF (USD)…							
In Q1 2013	52	2341.5	864.5	39	2775.1	1428.8	-433.6*
In Q2 2013	42	2054.9	734.1	25	2295.4	824.8	-240.5

In Q3 2013	49	2620.3	3052.1	24	2505.8	875.7	114.6
In Q4 2013	54	2408	1327.7	33	2618.4	1065.4	-210.4
Proportion of HCCs that were involved in determining how funds from RBF, HTF and HSF were used	77	1	0.2	63	0.9	0.2	0
Proportion of HCCs that feel expenditure by health facility was…							
Fully in line with priorities	75	0.8	0.4	63	0.8	0.4	0
Partly in line with priorities	75	0.1	0.4	63	0.2	0.4	0
Not at all in line with priorities	75	0	0.1	63	0	0.2	0
Banking							
Proportion of HCCs signatory to health facility's bank accounts	77	0.9	0.3	63	0.9	0.4	0
Proportion of HCCs with separate bank accounts	79	0.2	0.4	66	0.3	0.4	0
Proportion of HCC respondents who are…							
The Chairperson	79	0.6	0.5	66	0.7	0.5	-0.1
The Vice Chairperson	79	0.2	0.4	66	0.1	0.3	0
The Treasurer	79	0.2	0.4	66	0.2	0.4	0
The Vice Secretary	79	0	0.1	66	0	0.1	0
Other leadership	79	0	0.2	66	0	0	0*
Proportion of male HCC respondents	78	0.8	0.4	66	0.8	0.4	0
Proportion of HCCs that obtain information on patient opinion on quality care and overall	78	0.9	0.3	66	1	0.2	-0.1
Proportion of HCCs that keep a record of complaints about health facility from community in past 12 months	79	0.5	0.5	66	0.5	0.5	0
Proportion of HCCs with a mechanism to inform the health facility staff about patient opinion or complaints, apart from regular HCC meetings	79	0.6	0.5	66	0.6	0.5	0
Proportion of HCCs that report that health facility staff are…							
Not at all responsive to complaints	78	0	0.1	63	0	0.2	0
Rarely responsive to complaints	78	0	0.2	63	0.1	0.3	0
Often responsive to complaints	78	0.3	0.5	63	0.3	0.5	0
Very responsive to complaints	78	0.6	0.5	63	0.6	0.5	0.1
Proportion of HCCs that report that the DHE is…							
Not at all responsive to suggestions	77	0.1	0.2	64	0	0.1	0
Rarely responsive to suggestions	77	0.2	0.4	64	0.1	0.3	0.1
Often responsive to suggestions	77	0.4	0.5	64	0.4	0.5	0
Very responsive to suggestions	77	0.4	0.5	64	0.4	0.5	-0.1

Table 35: HOF's indicators

	Control N	Control Mean	Control SD	Treatment N	Treatment Mean	Treatment SD	Difference in Means
Population under health facility's catchment…	80	7653.4	7612.6	64	8157.3	3900.4	-503.9
Total population	27	3676.4	2340.6	18	3980.1	1788.6	-303.7
Male population	29	4170	3778.5	17	4630.4	1652.9	-460.4
Female population	72	1611.8	1099.7	52	1959.9	1102.8	-348.1*
Female 15-49 population	67	1049	707.5	52	1433.8	938.7	-384.8**
U5 population	75	222.4	161.5	53	284.4	246.8	-62
U1 population	80	7653.4	7612.6	64	8157.3	3900.4	-503.9
Proportion of health facilities headed by…							
Primary Care Nurse	80	0.5	0.5	67	0.5	0.5	0
State Registered Nurse	80	0.4	0.5	67	0.4	0.5	0
Nurse Midwife	80	0.1	0.2	67	0	0.2	0
State Certified Nurse	80	0	0.2	67	0	0.2	0
State Certified Maternity Nurse	80	0	0.2	67	0	0	0*
Other	80	0	0.1	67	0	0.1	0
Number of visits to community health workers for supervision purposes, past 3 months	79	4	3.9	66	3.6	3.5	0.3
Proportion of health facilities in which the following committees are set up…							
HCC	80	0.6	0.5	67	0.6	0.5	0
Sub Health committee	80	0	0.1	67	0	0	0
Ward health committee	80	0.1	0.3	67	0.1	0.2	0.1
HCC and Sub Health committee	80	0	0.2	67	0	0.1	0
HCC and Ward Health committee	80	0.2	0.4	67	0.3	0.5	-0.1
Sub Health and Ward Health committee	80	0	0	67	0	0	0
HCC, Sub Health, and Ward Health committee	80	0	0.1	67	0	0.2	0
No committee	80	0	0	67	0	0.1	0
Number of HCC meetings in the past 12 months	73	8.9	4.9	63	9.9	6.2	-1
Proportion of facilities in which HCC implemented a new initiative in the past 12 months	78	0.9	0.3	63	0.8	0.4	0
Proportion of facilities in which HCC conducted other roles apart from "new initiatives" in the past 12 months.	79	0.8	0.4	65	0.7	0.5	0.1

Proportion of health facilities with an operational plan…							
For current year, existent and seen	80	0.7	0.5	65	0.7	0.5	0
For current year, existent but not seen	80	0.2	0.4	65	0.2	0.4	0
For current year, non-existent	80	0.1	0.2	65	0.1	0.3	-0.1
Number of visits in the past 3 months from…							
HCC representative	79	7.6	12.1	67	6.4	6.7	1.2
Rural District Council representative	77	0.5	0.9	66	0.6	1.2	-0.1
DHE member	80	3.7	3.2	67	3.8	3.6	-0.1
Banking							
Proportion of health facilities with a bank account	80	0.9	0.3	67	0.8	0.4	0.1
Proportion of health facilities with a CBZ bank account	80	0.5	0.5	67	0.4	0.5	0.1
Proportion of health facilities with another type of bank account	80	0.3	0.5	67	0.3	0.5	0
Proportion of health facilities with a metropolitan bank account	80	0.1	0.2	67	0.1	0.3	0
Proportion of health facilities that received any money from HSF, RBF or HTF in past 12 months	80	1	0.1	66	1	0.1	0
Amount of funding received from HSF, HTF or RBF (USD)…							
In Q1 2013	68	1932.6	1132.5	58	1986.6	1718.4	-54
In Q2 2013	65	1841.5	1066.8	49	1350.2	1298.1	491.3**
In Q3 2013	64	2355.6	1105.9	51	1415.3	1303.3	940.3***
In Q4 2013	67	2205.5	912.1	51	2168.2	1650.7	37.3
Funding used for…							
Buying Supplies	79	1	0.2	65	0.8	0.4	.1**
Repairs	79	0.8	0.4	65	0.7	0.4	0.1
New infrastructure	79	0.6	0.5	65	0.7	0.5	0
Transportation	79	0.6	0.5	65	0.5	0.5	0.1
Environmental sanitation	79	0.4	0.5	65	0.5	0.5	-0.1
Food provision	79	0.4	0.5	65	0.4	0.5	-0.1
Security	79	0.3	0.4	65	0.3	0.4	0
Administrative Support	79	0.3	0.4	65	0.2	0.4	0.1
Sensitization / mobilizing community	79	0.1	0.3	65	0.1	0.2	0.1
Janitorial services	79	0.1	0.2	65	0.1	0.3	0
Support outreach teams	79	0.1	0.3	65	0.1	0.2	0
Training for community health workers	79	0	0.2	65	0	0.2	0
Other*	79	0.2	0.4	65	0.1	0.3	0

Proportion of health facilities in which the following are involved in deciding the use of funds…							
HF staff	79	0.9	0.3	65	0.8	0.4	0
HF head/in-charge	79	0.8	0.4	65	0.8	0.4	0
HCC	79	0.8	0.4	65	0.9	0.3	-0.1
MoH/ DHE team	79	0.3	0.4	65	0.2	0.4	0.1
Ward health committees	79	0.2	0.4	65	0.2	0.4	0
Community Health Workers	79	0.2	0.4	65	0.2	0.4	0
Community members	79	0.2	0.4	65	0.1	0.3	0.1
School head	79	0.1	0.3	65	0.1	0.2	0
Church leader	79	0.1	0.3	65	0	0.2	0
NGO staff	79	0	0.2	65	0	0.2	0
Other	79	0	0.2	65	0	0.2	0
Proportion of health facilities owned by…							
Council/local government	79	0.6	0.5	66	0.6	0.5	0
National Government	79	0.4	0.5	66	0.4	0.5	-0.1
Mission/faith based organisation	79	0.1	0.3	66	0	0	.1**
NGO	79	0	0.1	66	0	0	0
Proportion of health facilities in which a formal mechanism for HCC to receive complaints exits	80	0.5	0.5	66	0.6	0.5	-.2*

Annex T Quantitative Results – Context

T.1 How to read the tables in this section

The 'N' value.

Each table shows the 'N' value for each indicator. This indicates the number of observations in the sample on which that indicator is based. This gives an indication of how certain we can be about the estimate in question. The more respondents that answer a question, the more certain we can be that the estimate is real and that any differences identified are statistically significant

95% Confidence intervals (CI)

To give an indication about the precision of estimated values, 95% confidence intervals (CI) for the sample mean are presented. These intervals represent the range within which the true value of the mean is going to lie with 95% probability. Therefore, the 95% confidence interval on the mean tells you we are 95% confident that the true value of the mean is in our confidence interval.

T.2 Context tables

Table 36 Types of health facility property

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities owned by…				
Council/local government	0.57	145	0.49	0.65
National Government	0.38	145	0.30	0.46
Mission/faith based organisation	0.04	145	0.01	0.07
NGO	0.01	145	-0.01	0.02

Table 37 ANC patients: Travel to facility

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Distance travelled to health facility (km)	4.31	897	3.91	4.70
Proportion of users who travelled to the health facility nearest to them	0.96	1,387	0.94	0.97
Time take to travel to health facility by foot (minutes)	97.88	1,389	91.93	103.83
Proportion of users who declare the main reason for using this health facility is…				
Close to home	0.83	1,411	0.80	0.86
High quality care	0.13	1,411	0.10	0.16
No fees charged	0.02	1,411	0.01	0.02
Low cost	0.01	1,411	0.00	0.01

Table 38 ANC patients: Patient’s socioeconomic characteristics

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Respondent's age	25.40	1,413	25.04	25.76
Literacy				
Proportion of respondents who can read and write	0.88	1,415	0.87	0.90
Proportion of respondents who can read only	0.02	1,415	0.01	0.03
Proportion of respondents who can write only	0.02	1,415	0.01	0.03
Proportion of respondents who CANNOT read or write	0.08	1,415	0.06	0.09
Education				
Proportion of respondents with no education	0.01	1,413	0.01	0.02
Proportion of respondents with pre-school	0.00	1,413	0.00	0.01
Proportion of respondents with primary education	0.38	1,413	0.34	0.42
Proportion of respondents with secondary education	0.59	1,413	0.55	0.63
Proportion of respondents with tertiary education	0.01	1,413	0.01	0.02
Length of pregnancy in weeks	28.05	1,305	27.47	28.62

Table 39 ANC patients: Household’s socioeconomic characteristics

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Household size	4.97	1,415	4.82	5.12
Highest level of education attained by household head	2.64	1,380	2.57	2.72
Proportion of households whose source of drinking water is…				
Tube well or borehole	0.46	1,414	0.41	0.51
Protected well	0.17	1,414	0.14	0.20
Unprotected well	0.14	1,414	0.11	0.17
Surface water	0.10	1,414	0.07	0.13
Other*	0.14	1,415	0.10	0.17
**Other includes: Piped to yard/plot; Piped into dwelling; Unprotected spring; Public tap; Protected spring*				
Proportion of households whose toilet facility is…				
Ventilated improved latrine	0.41	1,413	0.36	0.45
No facility/bush/field	0.28	1,413	0.24	0.33
Pit latrine with slab	0.16	1,413	0.13	0.18
Pit latrine without slab/open pit	0.11	1,413	0.07	0.14

Other*	0.04	1,415	0.02	0.06
Other includes: Flush to piped sewer system; Flush to septic tank.				
Proportion of households whose source of electricity is…				
A solar panel for power	0.57	1,414	0.54	0.61
A battery or generator for power	0.33	1,414	0.30	0.37
Electricity that is connected	0.09	1,413	0.06	0.12
Proportion of households that have…				
A mobile telephone in working condition	0.79	1,415	0.76	0.81
A radio in working condition	0.59	1,414	0.56	0.62
A television in working condition	0.26	1,413	0.23	0.29
A refrigerator in working condition	0.05	1,415	0.03	0.06
A computer in working condition	0.03	1,415	0.02	0.04
A non-mobile telephone	0.01	1,415	0.01	0.02
Proportion of households in which a household member owns a…				
Wheelbarrow	0.44	1,413	0.40	0.47
Bicycle	0.36	1,414	0.33	0.40
Animal-drawn cart	0.28	1,413	0.24	0.32
Watch	0.23	1,414	0.21	0.26
Car or truck	0.06	1,414	0.05	0.08
Motorcycle	0.03	1,414	0.02	0.05
Tractor	0.01	1,414	0.00	0.02
Proportion of households whose source of energy is…				
Wood	0.93	1,412	0.91	0.95
Electricity	0.05	1,412	0.03	0.07
Paraffin/kerosene	0.01	1,412	-0.00	0.01
Proportion of households where cooking happens…				
In a separate building	0.79	1,411	0.75	0.82
In the house	0.13	1,411	0.10	0.16
Outdoors	0.08	1,411	0.07	0.10
Proportion of households where flooring material is…				
Cement	0.56	1,414	0.52	0.60
Earth/sand	0.24	1,414	0.21	0.28
Dung	0.18	1,414	0.15	0.22
Other*	0.01	1,415	0.01	0.02
Other includes: Wood planks; Ceramic tiles				

Proportion of households where roofing material is…				
Thatch	0.55	1,414	0.52	0.59
Asbestos	0.31	1,414	0.28	0.35
Metal	0.12	1,414	0.09	0.14
No roof	0.01	1,414	0.00	0.01
Proportion of households where exterior wall material is…				
Bricks	0.63	1,414	0.58	0.68
Mud	0.16	1,414	0.13	0.19
Cement	0.13	1,414	0.10	0.15
Other*	0.08	1,415	0.06	0.10
**Other includes: Cement blocks; Cane; Stone with mud; Stone with lime.*				
Number of rooms in dwelling used for sleeping	2.14	1,415	2.07	2.22

Table 40 ANC patients: Household's livelihood

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Livestock				
Proportion of households that own any livestock	0.81	1,413	0.77	0.84
Food security				
Proportion of households who during the last 4 weeks went without any food to eat because of a lack of food	0.11	1,415	0.08	0.13
Of those who went without any food to eat, proportion of households in which this situation occurred rarely	0.49	149	0.41	0.57
Of those who went without any food to eat, proportion of households in which this situation occurred sometimes	0.40	149	0.33	0.48
Of those who went without any food to eat, proportion of households in which this situation occurred often	0.11	149	0.06	0.15
Proportion of households who during the last 4 weeks went to sleep hungry because there was not enough food	0.07	1,415	0.05	0.09
Of those who went to bed hungry, proportion of households in which this situation occurred rarely	0.58	102	0.47	0.69
Of those who went to bed hungry, proportion of households in which this situation occurred sometimes	0.34	102	0.23	0.45
Of those who went to bed hungry, proportion of households in which this situation occurred often	0.08	102	0.02	0.13

Proportion of households who went a whole day and night without eating because there was not enough food	0.06	1,415	0.04	0.07
Of those who went a whole day and night without eating, proportion of households in which this situation occurred rarely	0.49	78	0.38	0.60
Of those who went a whole day and night without eating, proportion of households in which this situation occurred sometimes	0.44	78	0.32	0.55
Of those who went a whole day and night without eating, proportion of households in which this situation occurred often	0.08	78	0.01	0.14
Banking				
Proportion of households with at least 1 member that has a bank account	0.15	1,414	0.12	0.17
Proportion of households with at least 1 member that owns a mobile save account	0.19	1,415	0.16	0.22
Hunger score				
Proportion of households that have little or no hunger	0.92	1,415	0.90	0.94
Proportion of households that have moderate hunger	0.07	1,415	0.05	0.09
Proportion of households that have severe hunger	0.00	1,415	0.00	0.01

Table 41 Carers of under-fives: Travel to facility

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Referral				
Proportion of respondents who have come to HF directly on their own	0.97	1,511	0.96	0.98
Proportion of respondents referred by health worker in another HF	0.01	1,511	0.01	0.02
Proportion of respondents referred by friend/community member	0.01	1,511	0.00	0.02
Travel				
Proportion of respondents who travelled to a HF nearest to them	0.97	1,500	0.95	0.98
Distance travelled to HF (km)	4.06	1,035	3.70	4.42
Time take to travel to HF by foot (minutes)	90.18	1,494	84.53	95.83
Proportion of respondents whose main reason to come to this facility is…				
Close to home	0.81	1,513	0.78	0.84

High quality care	0.14	1,513	0.11	0.16
Other*	0.29	1,514	0.26	0.32
Other includes: Availability of drugs; Recommendation or referral; No fees charged				

Table 42 Carers of under-fives: Child's characteristics

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Child's age				
In completed years	0.97	1,514	0.89	1.04
In months	4.73	1,513	4.54	4.92
In days	4.54	1,509	3.89	5.18
Proportion of male children	0.49	1,513	0.47	0.52
Proportion of children who came to the facility due to…				
Cough/difficulty in breathing	0.26	1,513	0.23	0.29
Immunisation	0.26	1,513	0.22	0.29
Growth monitoring	0.19	1,513	0.16	0.22
Diarrhoea	0.07	1,513	0.06	0.09
Fever	0.07	1,513	0.06	0.08
Skin infection/puss wound	0.05	1,513	0.04	0.06
Vomiting	0.04	1,513	0.03	0.05
Other*	0.10	1,514	0.09	0.12
Other includes: Tonsillitis/sore throat; Otitis media/pain in ear; Injury				
***Of those children that came to the facility for other reason rather than growth monitoring and immunisation,* proportion of children for whom this visit is…**				
First visit	0.74	833	0.71	0.78
Return visit	0.23	833	0.20	0.26
Routine follow-up visit	0.03	833	0.02	0.04
Number of days since illness started	4.51	816	3.83	5.18

Table 43 Carers of under-fives: Carer's socioeconomic characteristics

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of respondents whose relationship with the child is…				
Mother/female primary care giver	0.96	1,486	0.95	0.97
Father/male primary care giver	0.01	1,486	0.01	0.02
Sibling (brother or sister)	0.01	1,486	0.00	0.01
Aunt/uncle	0.01	1,486	0.01	0.02
Respondent's age (in completed years)	28.14	1,512	27.67	28.61

Proportion of male respondents	0.04	1,512	0.03	0.05
Literacy				
Proportion of respondents who can read and write	0.88	1,507	0.86	0.90
Proportion of respondents who can read only	0.02	1,507	0.01	0.03
Proportion of respondents who can write only	0.02	1,507	0.01	0.03
Proportion of respondents who cannot read or write	0.08	1,507	0.06	0.09
Education				
Proportion of respondents with no education	0.03	1,513	0.02	0.04
Proportion of respondents with pre-school	0.00	1,513	-0.00	0.01
Proportion of respondents with primary education	0.36	1,513	0.33	0.40
Proportion of respondents with secondary education	0.58	1,513	0.55	0.62
Proportion of respondents with tertiary education	0.02	1,513	0.01	0.03

Table 44 Carers of under-fives: Household's socioeconomic characteristics

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Household size	5.44	1,513	5.31	5.57
Highest level of education attained by household head	2.64	1,457	2.59	2.69
Proportion of households whose source of drinking water is…				
Tube well or borehole	0.47	1,513	0.43	0.52
Protected well	0.20	1,513	0.16	0.23
Unprotected well	0.12	1,513	0.09	0.14
Surface water	0.09	1,513	0.06	0.11
Piped into dwelling	0.04	1,513	0.02	0.06
Piped to yard/plot	0.04	1,513	0.03	0.05
Other*	0.05	1,514	0.04	0.07
**Other includes: Public tap; Unprotected spring; Protected spring*				
Proportion of households whose toilet facility is…				
Ventilated improved latrine	0.41	1,513	0.37	0.45
No facility/bush/field	0.25	1,513	0.22	0.29
Pit latrine with slab	0.17	1,513	0.14	0.20
Pit latrine without slab/open pit	0.10	1,513	0.08	0.13
Flush to piped sewer system	0.04	1,513	0.02	0.07
Flush to septic tank	0.01	1,513	0.01	0.02

Proportion of households whose source of electricity is…				
A solar panel for power	0.55	1,513	0.51	0.58
A battery or generator for power	0.32	1,513	0.29	0.35
Electricity that is connected	0.11	1,512	0.08	0.15
Proportion of households that have…				
A mobile telephone in working condition	0.80	1,513	0.77	0.82
A radio in working condition	0.58	1,513	0.55	0.61
A television in working condition	0.27	1,513	0.24	0.30
A refrigerator in working condition	0.07	1,513	0.04	0.09
A computer in working condition	0.04	1,513	0.02	0.05
A non-mobile telephone	0.02	1,513	0.01	0.02
Proportion of households in which a household member owns a…				
Wheelbarrow	0.44	1,511	0.41	0.48
Bicycle	0.38	1,512	0.35	0.42
Animal-drawn cart	0.30	1,512	0.26	0.34
Watch	0.23	1,512	0.20	0.26
Car or truck	0.08	1,512	0.06	0.10
Motorcycle	0.02	1,512	0.01	0.03
Tractor	0.01	1,512	0.01	0.02
Proportion of households whose source of energy is…				
Wood	0.91	1,511	0.88	0.94
Electricity	0.07	1,511	0.05	0.10
Paraffin	0.01	1,511	0.00	0.01
Proportion of households where cooking happens…				
In a separate building	0.78	1,510	0.75	0.82
In the house	0.14	1,510	0.10	0.17
Outdoors	0.08	1,510	0.06	0.10
Proportion of households where flooring material is…				
Cement	0.60	1,510	0.56	0.65
Earth/sand	0.21	1,510	0.18	0.25
Dung	0.16	1,510	0.13	0.20
Ceramic tiles	0.01	1,510	0.00	0.02
Proportion of households where roofing material is…				
Thatch	0.53	1,512	0.49	0.57

Asbestos	0.33	1,512	0.30	0.37
Metal	0.12	1,512	0.10	0.14
Cement	0.01	1,512	0.00	0.01
Proportion of households where exterior wall material is…				
Bricks	0.64	1,512	0.60	0.69
Mud	0.14	1,512	0.10	0.17
Cement	0.14	1,512	0.11	0.16
Other*	0.08	1,514	0.06	0.10
**Other includes: Cement blocks; Stone with mud; Cane; Stone with lime; Wood planks*				
Number of rooms in dwelling used for sleeping	2.23	1,514	2.16	2.29

Table 45 Carers of under-fives: Household's livelihood

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Livestock				
Proportion of households that own any livestock	0.77	1,513	0.74	0.80
Food security				
Proportion of households who during the last 4 weeks went without any food to eat because of a lack of food	0.14	1,512	0.11	0.16
Of those who went without any food to eat, proportion of households in which this situation occurred rarely	0.55	205	0.48	0.63
Of those who went without any food to eat, proportion of households in which this situation occurred sometimes	0.34	205	0.28	0.40
Of those who went without any food to eat, proportion of households in which this situation occurred often	0.11	205	0.06	0.16
Proportion of households who during the last 4 weeks went to sleep hungry because there was not enough food	0.09	1,512	0.07	0.11
Of those who went to bed hungry, proportion of households in which this situation occurred rarely	0.55	137	0.47	0.63
Of those who went to bed hungry, proportion of households in which this situation occurred sometimes	0.35	137	0.28	0.42
Of those who went to bed hungry, proportion of households in which this situation occurred often	0.10	137	0.03	0.17

Proportion of households who went a whole day and night without eating because there was not enough food	0.08	1,512	0.06	0.10
Of those who went a whole day and night without eating, proportion of households in which this situation occurred rarely	0.57	115	0.48	0.67
Of those who went a whole day and night without eating, proportion of households in which this situation occurred sometimes	0.30	115	0.22	0.37
Of those who went a whole day and night without eating, proportion of households in which this situation occurred often	0.13	115	0.05	0.21
Banking				
Proportion of households with at least 1 member that has a bank account	0.18	1,513	0.15	0.20
Proportion of households with at least 1 member that owns a mobile save account	0.22	1,513	0.19	0.25
Hunger score				
Proportion of households that have little or no hunger	0.91	1,514	0.89	0.93
Proportion of households that have moderate hunger	0.09	1,514	0.07	0.10
Proportion of households that have severe hunger	0.01	1,514	0.00	0.01

Table 46 HCC members' characteristics

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCC respondents who are…				
The Chairperson	0.65	145	0.57	0.73
The Vice Chairperson	0.14	145	0.09	0.20
The Treasurer	0.17	145	0.11	0.23
The Vice Secretary	0.01	145	-0.01	0.03
Other leadership	0.02	145	-0.00	0.04
Proportion of male HCC respondents	0.78	144	0.71	0.85

Annex U Quantitative Results – Key Baseline Findings

U.1 How to read the tables in this section

The 'N' value.

Each table shows the 'N' value for each indicator. This indicates the number of observations in the sample on which that indicator is based. This gives an indication of how certain we can be about the estimate in question. The more respondents that answer a question, the more certain we can be that the estimate is real and that any differences identified are statistically significant

95% Confidence intervals (CI)

To give an indication about the precision of estimated values, 95% confidence intervals (CI) for the sample mean are presented. These intervals represent the range within which the true value of the mean is going to lie with 95% probability. Therefore, the 95% confidence interval on the mean tells you we are 95% confident that the true value of the mean is in our confidence interval.

U.2 Quality and functionality of HCCs

Table 47 Type of HCC set up at health facility

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities in which the following committees are set up…				
HCC	0.59	147	0.51	0.67
Sub Health committee	0.01	147	-0.01	0.02
Ward health committee	0.10	147	0.05	0.15
HCC and Sub Health committee	0.03	147	0.00	0.05
HCC and Ward Health committee	0.24	147	0.17	0.32
Sub Health and Ward Health committee	0.00	147	0.00	0.00
HCC, Sub Health, and Ward Health committee	0.02	147	-0.00	0.04
No committee	0.01	147	-0.01	0.02

Table 48 HCC constitution

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Age in years of HCC	6.49	67	4.74	8.24
Number of years since last HCC election	1.57	144	1.32	1.81
Number of HCC members…				
Total	8.68	143	8.17	9.19
Male	4.74	145	4.40	5.08
Female	3.97	143	3.61	4.32

Proportion of HCCs with representation of…				
Nurse in Charge	0.96	145	0.93	0.99
Ordinary community members	0.92	145	0.88	0.97
Local political leader (e.g. councillor)	0.75	145	0.68	0.82
Traditional community leader	0.67	145	0.59	0.75
Community Health Worker	0.66	145	0.58	0.73
Church representative	0.51	145	0.43	0.59
Other Health Facility staff	0.49	145	0.41	0.57
Government Extension workers	0.46	145	0.37	0.54
School headmaster/Health Master	0.41	145	0.33	0.49
Youth Organisation	0.33	145	0.25	0.41
NGO/CSO	0.18	145	0.12	0.24
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of HCCs with a…				
Chairperson	0.92	145	0.88	0.97
Vice chair	0.80	145	0.73	0.87
Treasurer	0.92	145	0.88	0.97
Secretary	0.92	144	0.87	0.96

Table 49 HCC meetings (reported by health facility)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of facilities in which a written record of HCC meetings:				
Kept and seen	0.94	145	0.90	0.98
Kept but not seen	0.04	145	0.01	0.07
Not kept	0.02	145	-0.00	0.04
Number of HCC meetings in the past 12 months	9.34	136	8.39	10.28

Table 50 HCC meetings (reported by HCC members)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs that have met to discuss health issues at least once in the past 12 months	1.00	143	1.00	1.00
Of those who have met to discuss health issues at least once, number of HCC meetings in the past 12 months	9.79	138	8.82	10.76
Proportion of HCCs that keep minutes of their meetings in the past 12 months	0.99	142	0.97	1.01
Of those that keep minutes of their meetings, proportion of HCCs with a physical copy of meeting minutes	0.83	137	0.77	0.90
Of those that keep minutes of their meetings, number of HCC meetings that were recorded in the past 12 months	8.89	112	7.99	9.80

Table 51 HCC interaction with community

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs that have met with the community to get feedback in the past 12 months	0.86	145	0.80	0.91
Of those that met with the community to get feedback, number of times that HCC met with the community to get feedback in the past 12 months	6.26	121	5.38	7.13
Proportion of HCCs that recorded their meetings with the community	0.71	123	0.63	0.79
Of those that recorded their meetings with the community, proportion of HCCs with a physical copy of meeting minutes with the community	0.31	85	0.21	0.41
Of those that recorded their meetings with the community, number of HCC meetings with the community that were recorded in the past 12 months	4.28	25	2.92	5.64

Table 52 HCC interaction with DHE

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs that participate in district level meetings with the District Health Executive	0.58	145	0.50	0.66
Of those that participate in meetings with the DHE, number of meetings with DHE in the past 12 Months	2.80	82	2.20	3.41
Proportion of HCCs that never kept up to date on health developments by DHE	0.04	143	0.00	0.07
Proportion of HCCs that rarely kept up to date on health developments by DHE	0.08	143	0.04	0.13
Proportion of HCCs that sometimes kept up to date on health developments by DHE	0.20	143	0.14	0.27
Proportion of HCCs that often kept up to date on health developments by DHE	0.22	143	0.15	0.29
Proportion of HCCs that always kept up to date on health developments by DHE	0.46	143	0.38	0.54

Table 53 HCC documentation

	Sample Mean	N	Lower 95% CI	Upper 95% CI
HCC handbook				
Proportion of HCCs with a copy of HCC handbook	0.32	144	0.24	0.40
Of those with a copy of HCC handbook, proportion of HCCs with a copy of HCC handbook, seen	0.46	46	0.31	0.61
Patient's Charter				

Proportion of HCCs with a copy of Patient’s charter	0.28	145	0.21	0.36
Of those with a copy of Patient's charter, proportion of HCCs with a copy of Patients' charter, seen	0.60	40	0.44	0.76
Display MCNH stats				
Proportion of HCCs that display MNCH statistics, including current month	0.12	143	0.07	0.17
Proportion of HCCs that display MNCH statistics, but not for this month	0.22	143	0.15	0.29
Proportion of HCC that DO NOT record and display MNCH statistics	0.66	143	0.58	0.74
HCC reports on MNCH				
Proportion of HCCs that submit written reports on MNCH access	0.35	145	0.27	0.43
Of those that submit written reports on MNCH access, number of MNCH access and service availability reports submitted in the past 12 months	4.85	47	3.75	5.95

Table 54 HCC's decision making scheme

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs in which the following make the decision on finances…				
Chairperson	0.99	145	0.97	1.01
Vice Chairperson	0.50	145	0.41	0.58
Treasurer	0.83	145	0.77	0.89
Secretary	0.79	145	0.72	0.85
Health Workers	0.52	145	0.43	0.60
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of HCCs in which the following make the decision on the management of community projects…				
Chairperson	0.92	145	0.87	0.96
Vice Chairperson	0.52	145	0.43	0.60
Treasurer	0.59	145	0.51	0.67
Secretary	0.59	145	0.51	0.67
Health Workers	0.46	145	0.38	0.54
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of HCCs in which the following make the decision on setting user fees…				
Chairperson	0.53	145	0.45	0.61
Vice Chairperson	0.39	145	0.31	0.47
Treasurer	0.50	145	0.41	0.58

Secretary	0.48	145	0.40	0.57
Health Workers	0.38	145	0.30	0.46
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of HCCs that report decisions are made by one person.	0.03	145	0.00	0.05
***Of those that report decision are made by one person,* proportion of HCCs in which this situation occurs.**				
Often	0.50	4	-0.42	1.42
Rarely	0.50	4	-0.42	1.42

Table 55 HCC activities: Implementation of new initiatives (reported by health facility)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of facilities in which HCC implemented a new initiative in the past 12 months	0.84	141	0.78	0.90
***Of those who implemented a new initiative,* the following initiative was implemented:**				
New infrastructure	0.69	118	0.60	0.77
Repairs	0.64	118	0.56	0.73
Buying supplies	0.34	118	0.25	0.43
Security	0.28	118	0.20	0.36
Environmental sanitation	0.25	118	0.17	0.33
Administrative support procurement	0.14	118	0.08	0.21
Gave in kind contribution	0.14	118	0.07	0.20
Food provision	0.11	118	0.05	0.17
Janitorial services	0.08	118	0.03	0.14
Transportation	0.08	118	0.03	0.14
Sensitization / mobilizing community	0.08	118	0.03	0.14
Other*	0.11	118	0.05	0.17
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Training for community health workers; Support outreach teams*				

Table 56 HCC activities: Implementation of new initiatives (reported by HCC members)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs that implemented their own initiatives in the community to improve health.	0.66	144	0.58	0.74
***Of those that implemented their own initiatives,* proportion of HCCs that implemented the following initiative…**				
New infrastructure	0.55	95	0.45	0.65
Repairs at the facility	0.42	95	0.32	0.52
Environmental sanitation	0.29	95	0.20	0.39
Security at the facility	0.27	94	0.18	0.36
Gave other in-kind con	0.21	95	0.13	0.29

Sensitization / mobilization	0.18	95	0.10	0.26
Buying new supplies	0.11	95	0.04	0.17
Transportation	0.09	95	0.03	0.15
Food provision	0.08	95	0.03	0.14
Training for community	0.08	95	0.03	0.14
Administrative support	0.07	95	0.02	0.13
Janitorial services	0.06	95	0.01	0.11
Support to outreach teams	0.06	95	0.01	0.11
Other*	0.15	95	0.07	0.22
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Verification of health; Training and awareness; Collecting data and reporting on the result; Design of the results financing scheme*				

Table 57 HCC activities: Other roles

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of facilities in which HCC conducted other roles apart from "new initiatives" in the past 12 months.	0.73	144	0.66	0.80
***Of those who conducted other roles apart from "new initiatives"*, the following role was conducted:**				
Sensitization / mobilizing community	0.35	105	0.26	0.45
Repairs	0.34	105	0.25	0.44
New infrastructure	0.30	105	0.22	0.39
Security	0.20	105	0.12	0.28
Environmental sanitation	0.18	105	0.11	0.26
Buying supplies	0.17	105	0.10	0.24
Support outreach teams	0.17	105	0.10	0.24
Janitorial services	0.14	105	0.07	0.21
Administrative support procurement	0.13	105	0.07	0.20
Gave in kind contribution	0.12	105	0.06	0.19
Training for community health workers	0.10	105	0.05	0.16
Transportation	0.09	105	0.03	0.14
Food provision	0.09	105	0.03	0.14
Verification of health facility's MNCH results	0.04	105	0.00	0.08
Other*	0.13	105	0.07	0.20
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Training/Awareness on RBF financing; Training/Awareness on RBF activities; Training/Awareness on RBF design.*				

Table 58 HCC activities: Monitoring

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs that monitor health facilities	0.97	144	0.94	1.00
Of those that monitor health facilities, number of HCC visits for monitoring purposes in the past 12 months	15.86	120	13.77	17.94

Proportion of health facilities that record HCC monitoring visits	0.31	139	0.23	0.39
Of those that record HCC monitoring visits, proportion of health facilities with a physical copy of HCC monitoring visits	0.58	43	0.43	0.74
Of those that record HCC monitoring visits, number of monitoring visits recorded	9.60	25	7.31	11.89
***Of those that make visits to health facilities for monitoring*, proportion that monitor the following…**				
Delivery of services	0.75	139	0.68	0.82
Progress against the operational plan	0.68	139	0.60	0.76
Cleanliness of the facility	0.68	139	0.60	0.76
State of infrastructure	0.58	139	0.50	0.67
New purchases	0.43	139	0.35	0.52
Budget	0.35	139	0.27	0.43
Procurement transparency	0.34	139	0.26	0.42
Whether waiting maternity patients have food	0.21	139	0.14	0.28
User fees	0.14	139	0.08	0.19
Copy of Patient's charter	0.10	139	0.05	0.15
Other	0.12	145	0.07	0.18
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				

Table 59 HCC activities: Fundraising

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs who in past 12 months had a plan to raise money	0.57	145	0.48	0.65
Proportion of HCCs that in past 12 months actually raised any money	0.30	145	0.23	0.38
Of those that actually raised money, amount raised by HCCs that actually raised any money (USD)	878.84	44	410.93	1,346.75
***Of those that actually raised money*, proportion of HCCs in which self-raised funds were used for…**	0.30	145	0.23	0.38
New infrastructure	0.41	44	0.26	0.56
Security at facility	0.41	44	0.26	0.56
Repairs	0.32	44	0.17	0.46
Transportation	0.18	44	0.06	0.30
Administrative support	0.16	44	0.05	0.27
Buying supplies	0.11	44	0.02	0.21
Environmental sanitation	0.07	44	-0.01	0.15
Food provision	0.05	44	-0.02	0.11
Other	0.14	44	0.03	0.24
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				

Table 60 HCC performance

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCC respondents that…				
Believe discussions held in HCC contribute to improvement of people's health	0.99	145	0.97	1.01
Believe they need additional support to perform HCC duties effectively	0.97	144	0.94	1.00
Face challenges that affect delivery of responsibilities	0.86	143	0.80	0.92
***Of those that face challenges that affect their delivery of responsibilities*, proportion that identify the following as the main challenge…**				
Financial resources	0.81	109	0.73	0.88
Community willingness to participate	0.13	109	0.06	0.19
Knowledge of roles/responsibilities	0.04	109	0.00	0.07
Other*	0.03	109	-0.00	0.06
**Other includes: Responsiveness of DHE; Responsiveness of health facility staff*				

Table 61 Training of HCC members

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs in which current members have received training to help with their job.	0.81	145	0.74	0.87
***Of those who have received training*, proportion of HCCs that have received training by…**				
District Health Team	0.73	117	0.64	0.81
Other Ministry of Health staff	0.51	117	0.42	0.60
Health staff at health facility	0.24	117	0.16	0.32
Other NGO	0.21	117	0.14	0.29
Save the Children	0.13	117	0.07	0.19
Community Working Group on Health	0.09	117	0.04	0.15
Crown Agents	0.04	117	0.01	0.08
CORDAID	0.03	117	-0.00	0.05
Other	0.08	117	0.03	0.13
Do not know	0.09	117	0.03	0.14
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
***Of those who have received training*, proportion of HCCs in which the training received was on…**				
Monitoring and tracking budgets	0.67	116	0.59	0.76
Functions of a health centre committee	0.65	117	0.56	0.74
Preparing and analysing budgets	0.51	117	0.42	0.60

Organizing and mobilizing communities for health	0.47	117	0.38	0.56
Mobilizing financial resources	0.39	117	0.30	0.48
Communication skills	0.29	117	0.21	0.37
Training received, Developing health development plans	0.29	117	0.21	0.37
Holding meetings	0.25	117	0.17	0.33
Implementing and monitoring health plans	0.25	117	0.17	0.33
How to work with health workers	0.24	117	0.16	0.32
Patients' rights and entitlements	0.24	117	0.16	0.32
Advocating and negotiating health issues	0.22	117	0.15	0.30
Writing or presenting reports	0.16	117	0.09	0.23
How to work with different stakeholders	0.12	117	0.06	0.18
Other health issues	0.03	116	-0.00	0.06
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
***Of those who have received training*, proportion that believes they need further training.**	0.97	117	0.93	1.00
***Of those who believe that they need further training,* proportion that believes further training should be on…**				
Functions of a health centre committee	0.46	113	0.37	0.55
Mobilizing financial resources	0.42	113	0.32	0.51
Monitoring and tracking budgets	0.39	113	0.30	0.48
Preparing and analysing budgets	0.35	113	0.26	0.43
Communication skills	0.34	113	0.25	0.42
Organizing and mobilizing communities for health	0.31	113	0.22	0.40
Developing health development plans	0.28	113	0.20	0.37
Holding meetings	0.26	113	0.17	0.34
Writing or presenting reports	0.25	113	0.17	0.33
Advocating and negotiating health issues	0.21	113	0.14	0.29
Implementing and monitoring health plans	0.20	113	0.13	0.28
How to work with health workers	0.21	113	0.14	0.29
Patients' rights and entitlements	0.14	113	0.08	0.21
How to work with different stakeholders	0.10	113	0.04	0.15
Other	0.01	113	-0.01	0.03
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				

Table 62 Knowledge of ANC patients on HCC

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who know of…				

HCC in their community	0.22	1,415	0.19	0.25
Of those who know of HCC in their community…				
Proportion of users who know any HCC members in their community	0.80	311	0.75	0.85
Proportion of users who know of any HCC activities in their community.	0.73	312	0.68	0.78
***Of those who know of any HCC activities in their community*, proportion that acknowledge the following activities:**				
Bring community health priorities	0.73	227	0.66	0.79
Promote quality on health services	0.53	227	0.45	0.61
Monitor quality care	0.46	227	0.37	0.56
Organize community actions for health	0.40	227	0.31	0.49
Promote transparency	0.30	227	0.22	0.38
Organise community inputs to health services	0.22	227	0.16	0.29
Advocate for essential resources	0.17	227	0.12	0.23
Access to district level funds	0.10	227	0.06	0.15
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of users who feel that HCC provides a valuable service in their community	0.93	279	0.90	0.96

Table 63 Knowledge of ANC patients (results disaggregated by HCC quality)

	Low quality HCC			High quality HCC			
Proportion of users who …	Low N	Low Mean	Low SD	High N	High Mean	High SD	Difference in Means
know of HCC in their community	528	0.2	0.4	865	0.2	0.4	0.0
would complain if unhappy about the facility or its staff	528	0.6	0.5	865	0.6	0.5	0.0
admit to knowing patient rights at HF	528	0.4	0.5	865	0.4	0.5	0.0

The HCC Quality Index is a quality score that can range from 0 to 6, depending on the answers to the following questions:
- Does the committee keep minutes of the committee meetings? Score 1 if answer is yes.
- Are the meetings between the HCC members and the community recorded? Score 1 if answer is yes.
- How many times in the past 12 months did the HCC members meet? Score 1 if HCC met a number of times over the median.
- How many times in the past 12 months did the HCC meet with community members? Score 1 if HCC met a number of times over the median.
- Does this HCC have a copy of the HCC handbook? Score 1 if answer is yes.
- Did the health centre committee actually raise some money? Score 1 if answer is yes.

In the disaggregation an HCC considered to be of high quality if the quality score ranges from 3 to 6, and low quality otherwise (quality score ranges from 0 to 2).

Table 64 Knowledge of ANC patients (results disaggregated by poverty index)

	Poorer			Richer			
Proportion of users who …	Low N	Low Mean	Low SD	High N	High Mean	High SD	Difference in Means

know of HCC in their community	701	0.2	0.4	714	0.2	0.4	0.0*
would complain if unhappy about the facility or its staff	701	0.5	0.5	714	0.6	0.5	-0.1***
admit to knowing patient rights at HF	701	0.3	0.5	714	0.4	0.5	-0.1***
The wealth score is a continuous variable generated based on the responses to a large number of questions related to the household's dwelling conditions (source of water, roof, wall, and floor materials, source of energy etc.). In the disaggregation a household is considered to be of richer if the wealth score is above the median wealth score.							

Table 65 Knowledge of carers of under-fives on HCC

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who know of…				
HCC in their community	0.27	1,513	0.24	0.30
Of those who now of HCC in their community, proportion that knows any HCC members in their community	0.80	409	0.75	0.84
Of those who know of HCC in their community…				
Proportion of users who know of any HCC activities in their community.	0.72	410	0.67	0.77
***Of those who know of any HCC activities in their community*, proportion that acknowledge the following activities:**				
Bring community health priorities	0.73	295	0.67	0.79
Promote quality on health services	0.60	295	0.52	0.67
Monitor quality care	0.41	295	0.33	0.49
Organize community actions for health	0.39	295	0.33	0.45
Promote transparency	0.24	295	0.18	0.30
Organise community inputs to health services	0.23	295	0.17	0.29
Advocate for essential resources	0.20	295	0.14	0.25
Access to district level funds	0.13	295	0.07	0.18
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of users who feel that HCC provides a valuable service in their community	0.94	366	0.91	0.97

Table 66 Knowledge of carers of under-fives (results disaggregated by HCC quality)

	Low quality HCC			High quality HCC			
Proportion of users who …	Low N	Low Mean	Low SD	High N	High Mean	High SD	Difference in Means
know of HCC in their community	576	0.2	0.4	917	0.3	0.5	0.0
would complain if unhappy about the facility or its staff	576	0.6	0.5	918	0.6	0.5	0.0
admit to knowing patient rights at HF	576	0.5	0.5	918	0.4	0.5	0.0

The HCC Quality Index is a quality score that can range from 0 to 6, depending on the answers to the following questions:
- Does the committee keep minutes of the committee meetings? Score 1 if answer is yes.
- Are the meetings between the HCC members and the community recorded? Score 1 if answer is yes.
- How many times in the past 12 months did the HCC members meet? Score 1 if HCC met a number of times over the median.
- How many times in the past 12 months did the HCC meet with community members? Score 1 if HCC met a number of times over the median.
- Does this HCC have a copy of the HCC handbook? Score 1 if answer is yes.
- Did the health centre committee actually raise some money? Score 1 if answer is yes.

In the disaggregation an HCC considered to be of high quality if the quality score ranges from 3 to 6, and low quality otherwise (quality score ranges from 0 to 2).

Table 67 Knowledge of carers of under-fives (results disaggregated by poverty index)

	Poorer			Richer			
Proportion of users who …	Low N	Low Mean	Low SD	High N	High Mean	High SD	Difference in Means
know of HCC in their community	750	0.3	0.4	763	0.3	0.4	0.0
would complain if unhappy about the facility or its staff	750	0.6	0.5	764	0.6	0.5	0.0
admit to knowing patient rights at HF	750	0.4	0.5	764	0.5	0.5	0.0*

The wealth score is a continuous variable generated based on the responses to a large number of questions related to the household's dwelling conditions (source of water, roof, wall, and floor materials, source of energy etc.). In the disaggregation a household is considered to be of richer if the wealth score is above the median wealth score.

U.3 Knowledge of rights and entitlements

Table 68 Knowledge of ANC patients: Free health services

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users that were aware…				
Of the Patients' Charter	0.06	1,413	0.04	0.08
Of free health services for women and children	0.71	1,414	0.67	0.75
***Of those who were aware of free health services for women and children,* proportion of users that identified the following as the main source of information on free health services…**				
Facility staff	0.54	981	0.50	0.58
Friend/relatives	0.21	981	0.18	0.24
General knowledge	0.07	981	0.05	0.09
Community health worker	0.05	981	0.03	0.07
Other*	0.12	998	0.10	0.15

Percentages do not sum up to 100 because respondents were allowed to give multiple responses

**Other includes: Mass media; Leaflets and newsletters; Community leader; Literacy facilitators; Centre committee; NGO; School staff.*

Table 69 Knowledge of ANC patients: Rights at health facility

	Sample Mean	N	Lower 95% CI	Upper 95% CI

Proportion of users that admit to knowing patient rights at the health facility	0.39	1,415	0.35	0.42
Of those that admit to knowing patient rights…				
Proportion of users that identified the following rights:				
Health care and treatment rights	0.26	550	0.20	0.31
Healthy environment rights	0.23	550	0.17	0.28
Confidentiality rights	0.23	550	0.18	0.28
Privacy rights	0.20	550	0.15	0.24
Redress of grievances rights	0.13	550	0.10	0.16
Choice of care rights	0.11	550	0.08	0.14
Adequate information and consent rights	0.11	550	0.08	0.14
Participation and representation rights	0.09	550	0.06	0.13
Education rights	0.09	550	0.03	0.14
Safety rights	0.07	550	0.03	0.11
Other rights	0.93	550	0.91	0.96
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
***Of those that identified other rights,* proportion that identified the following rights…**				
Free service	0.28	18	-0.05	0.60
Timely service	0.61	18	0.23	1.00
Fair treatment at facility	0.11	18	-0.15	0.37
Proportion of users that identified:				
Less than 2 rights	0.35	550	0.29	0.41
Less than 5 rights	0.89	550	0.86	0.92
More than 5 rights	0.11	550	0.08	0.14
Proportion of users that identified the following as the main source of information for patient rights…				
Facility staff	0.39	549	0.34	0.44
General knowledge	0.33	549	0.27	0.38
Friend/relatives	0.07	549	0.04	0.09
Community health worker	0.06	549	0.04	0.09
Mass media	0.04	549	0.02	0.06
Other*	0.12	550	0.09	0.15
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Health literacy facilitators; HCC; NGO; Churches; School staff; Community leader; Leaflets and newsletters.*				
Proportion of users that received training on patient rights and entitlements, past 12 months	0.21	549	0.16	0.26

***Of those who received training on patient rights and entitlements,* proportion that received training in…**				
By Health staff at health facility	0.66	116	0.54	0.77
By Community Working Group on Health	0.24	116	0.14	0.34
By Other Ministry of Health staff	0.17	116	0.09	0.25
By Other NGO	0.15	116	0.08	0.21
By District Health Team	0.07	116	0.01	0.13
By Save the Children	0.03	116	-0.00	0.06
By Other	0.13	116	0.00	0.26
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				

Table 70 Knowledge of carers of under-fives: Free health services

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users that were aware…				
Of the Patients' Charter	0.07	1,509	0.05	0.08
Of free health services for women and children	0.77	1,510	0.74	0.81
***Of those who were aware of free health services for women and children,* proportion of users that identified the following as the main source of information on free health services…**				
Facility staff	0.65	1,158	0.61	0.68
Friend/relatives	0.12	1,158	0.10	0.15
General knowledge	0.08	1,158	0.06	0.10
Other*	0.15	1,170	0.12	0.17
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Literacy facilitators; Centre committee; NGO; Churches; Community health worker; School staff; Community leader; Mass media; Leaflets and newsletters.*				

Table 71 Knowledge of carers of under-fives: Rights at health facility

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users that admit to knowing patient rights at the health facility	0.44	1,514	0.40	0.47
Of those that admit to knowing patient rights…				
Proportion of users that identified the following rights:				
Health care and treatment rights	0.28	665	0.24	0.33
Confidentiality rights	0.26	665	0.22	0.31
Healthy environment rights	0.25	665	0.20	0.30
Privacy rights	0.18	665	0.14	0.22
Redress of grievances rights	0.17	665	0.13	0.21
Choice of care rights	0.14	665	0.11	0.18

Adequate information and consent rights	0.10	665	0.07	0.12
Participation and representation rights	0.09	665	0.06	0.12
Safety rights	0.08	665	0.05	0.10
Education rights	0.04	664	0.02	0.06
Other rights	0.90	665	0.88	0.93
***Of those that identified other rights,* proportion that identified the following rights…**				
Free service	0.21	24	0.03	0.38
Timely service	0.71	24	0.50	0.92
Fair treatment at facility	0.08	24	-0.05	0.21
Proportion of users that identified:				
Less than 2 rights	0.34	665	0.28	0.39
Less than 5 rights	0.90	665	0.87	0.93
More than 5 rights	0.10	665	0.07	0.13
Proportion of users that identified the following as the main source of information for patient rights…				
Facility staff	0.38	653	0.33	0.42
General knowledge	0.33	653	0.29	0.37
Community health worker	0.06	653	0.04	0.08
Friend/relatives	0.05	653	0.03	0.07
Mass media	0.04	653	0.03	0.06
Other*	0.13	665	0.10	0.16
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Health literacy facilitators; HCC; NGO; School staff; Community leader; Leaflets and newsletters.*				
Proportion of users that received training on patient rights and entitlements, past 12 months	0.21	664	0.17	0.25
***Of those who received training on patient rights and entitlements,* proportion that received training in…**				
By Health staff at health facility	0.62	142	0.53	0.71
By Community Working Group on Health	0.27	142	0.18	0.36
By Other Ministry of Health staff	0.14	142	0.08	0.20
By Other NGO	0.12	142	0.06	0.18
By District Health Team	0.07	142	0.02	0.12
By Other*	0.13	142	0.07	0.20
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Save the Children; CORDAID; Crown Agents.*				

U.4 Decision making regarding community and health facility resources

Table 72 Health facility's operational plan

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities with an operational plan (reported by health facility)…				
For current year, existent and seen	0.70	145	0.62	0.77
For current year, existent but not seen	0.21	145	0.15	0.28
For current year, non-existent	0.09	145	0.04	0.14
***Of those facilities that have had an operational plan at some point*, proportion of facilities in which the following were involved in setting the operational plan**				
HF staff	0.90	143	0.84	0.95
HF head/in-charge	0.85	143	0.79	0.91
HCC	0.79	143	0.72	0.86
Community health workers	0.24	143	0.17	0.32
Community	0.22	143	0.15	0.29
Ward Health committee	0.19	143	0.12	0.26
MoH/DHE	0.13	143	0.08	0.19
School	0.11	143	0.06	0.16
Church leader	0.09	143	0.04	0.14
NGO	0.03	143	0.00	0.06
Other	0.03	143	0.00	0.06
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
Proportion of health facilities with an operational plan (reported by HCC members)…	0.91	142	0.86	0.96
Of those that own an operational/annual plan, proportion that keep a physical copy of their operational/annual plan	0.77	126	0.70	0.84
Of those that own an operational/annual plan, proportion of HCCs involved in the development of the health facility's operational/annual plan	0.98	129	0.95	1.00
Of those HCCs involved in the development of the heath facility's operational/annual plan, proportion of HCCs that consulted community while developing the health facility's operational/annual plan	0.92	126	0.87	0.97

Table 73 Visits at health facility

	Sample Mean	N	Lower 95% CI	Upper 95% CI

Number of visits in the past 3 months from…				
HCC representative	7.08	146	5.44	8.71
Rural District Council representative	0.56	143	0.39	0.73
DHE member	3.76	147	3.20	4.31
Of those who received visits from a DHE member, number of visits from complete DHE team	1.67	135	1.23	2.11

Table 74 Health facility's funding (reported by health facility)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities that received any money from HSF, RBF or HTF in past 12 months	0.99	146	0.97	1.01
Of those that received money…				
Amount of funding received from HSF, HTF or RBF (USD)				
In Q1 2013	1,957.44	126	1,704.87	2,210.02
In Q2 2013	1,630.30	114	1,408.19	1,852.41
In Q3 2013	1,938.57	115	1,700.99	2,176.14
In Q4 2013	2,189.41	118	1,955.19	2,423.62
Funding used for…				
Buying Supplies	0.92	144	0.87	0.96
Repairs	0.78	144	0.71	0.85
New infrastructure	0.66	144	0.58	0.74
Transportation	0.55	144	0.47	0.63
Environmental sanitation	0.45	144	0.37	0.54
Food provision	0.41	144	0.32	0.49
Security	0.27	144	0.20	0.35
Administrative Support	0.23	144	0.16	0.30
Sensitization / mobilizing community	0.10	144	0.05	0.15
Janitorial services	0.08	144	0.04	0.13
Support outreach teams	0.08	144	0.03	0.12
Training for community health workers	0.04	144	0.01	0.08
Other*	0.15	144	0.09	0.20
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Verification of health facility MNCH results; Training/Awareness on RBF financing; Training/Awareness on RBF activities; Training/Awareness on RBF design*				
Proportion of health facilities in which the following are involved in deciding the use of funds…				
HF staff	0.85	144	0.80	0.91
HF head/in-charge	0.83	144	0.77	0.89
HCC	0.81	144	0.75	0.88
MoH/ DHE team	0.23	144	0.16	0.30
Ward health committees	0.21	144	0.14	0.28

Community Health Workers	0.18	144	0.12	0.24
Community members	0.17	144	0.11	0.23
School head	0.07	144	0.03	0.11
Church leader	0.07	144	0.03	0.11
NGO staff	0.03	144	0.00	0.07
Other	0.03	144	0.00	0.07
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				

Table 75 Health facility's funding (reported by HCC members)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities that received any money in the past 12 months from…				
RBF	0.03	141	0.00	0.06
HSF	0.03	141	0.00	0.06
HTF	0.94	141	0.90	0.98
None of them	0.01	141	-0.01	0.02
Do not know	0.01	145	-0.01	0.03
Of those that received money…				
Amount of funding received from HSF, HTF or RBF (USD)…				
In Q1 2013	2,527.30	91	2,285.45	2,769.15
In Q2 2013	2,144.61	67	1,954.83	2,334.39
In Q3 2013	2,582.66	73	1,987.46	3,177.86
In Q4 2013	2,487.78	87	2,223.70	2,751.86
Funding used for…				
Buying new supplies	0.91	140	0.87	0.96
Repairs at the facility	0.72	140	0.65	0.80
New infrastructure	0.64	140	0.56	0.72
Transportation	0.35	140	0.27	0.43
Food provision	0.33	140	0.25	0.41
Security at the facility	0.32	140	0.24	0.40
Environmental sanitation	0.31	140	0.24	0.39
Administrative support	0.29	140	0.21	0.36
Janitorial services	0.13	140	0.07	0.18
Sensitization / mobilizing community	0.08	140	0.03	0.12
Training for community health workers	0.07	140	0.03	0.11
Support to outreach teams	0.05	139	0.01	0.09
Verification of health facility MNCH	0.04	140	0.00	0.07
Other	0.07	139	0.03	0.12
Proportion of HCCs that were involved in determining how funds from RBF, HTF and HSF were used	0.96	140	0.92	0.99

Proportion of HCCs that feel expenditure by health facility was…				
Fully in line with priorities	0.83	138	0.76	0.89
Partly in line with priorities	0.15	138	0.09	0.21
Not at all in line with priorities	0.02	138	-0.00	0.05

Table 76 Health facility's banking situation

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities with a bank account	0.83	147	0.77	0.89
Proportion of health facilities with a CBZ bank account	0.46	147	0.38	0.54
Proportion of health facilities with another type of bank account	0.31	147	0.23	0.38
Proportion of health facilities with a metropolitan bank account	0.06	147	0.02	0.10
Of those with a bank account, proportion of facilities that had problems accessing their bank account in the past 12 months	0.19	122	0.12	0.26
Of those that had problems accessing their bank account, proportion of facilities that can currently access their bank account	0.70	23	0.49	0.90
Of those with a bank account, proportion of facilities that keep record of transactions to and from bank account, seen	0.75	119	0.67	0.83
Of those with a bank account, proportion of facilities that keep record of transactions to and from bank account, not seen	0.20	119	0.13	0.27
Of those with a bank account, proportion of facilities that do not keep record of transactions to and from bank account	0.05	119	0.01	0.09
Of those with a bank account, current metropolitan bank balance (USD)	1,167.57	69	922.01	1,413.12

Table 77 HCC's banking situation

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs signatory to health facility's bank accounts	0.88	140	0.82	0.93
Proportion of HCCs with separate bank accounts	0.25	145	0.18	0.32
Of those with a separate bank account, proportion of HCCs that had trouble accessing their bank accounts	0.43	35	0.26	0.60

U.5 Complaints mechanism at health facilities

Table 78 Complaint mechanisms reported by health facilities

	Sample Mean	N	Lower 95% CI	Upper 95% CI

Of those health facilities in which some type of health committee is set up…				
Proportion of health facilities in which a formal mechanism for HCC to receive complaints exits	0.52	146	0.44	0.60
***Of those for which a formal mechanism exists,* number of times HCC informed health facilities of complaints, in the past 12 months**	3.85	74	2.59	5.11
***Of those for which a formal mechanism exists,* proportion of health facilities in which the main reason for complaints was…**				
Attention/treatment received at facility	0.30	67	0.19	0.41
Inadequacy of facility's equipment	0.16	67	0.07	0.26
Inadequacy of staff availability	0.15	67	0.06	0.24
Inadequacy of facility's infrastructure	0.10	67	0.03	0.18
Staff attitude	0.10	67	0.03	0.18
Other	0.18	67	0.08	0.27
Proportion of health facilities in which changes occurred due to complaints, past 12 months	0.67	123	0.59	0.76
***Of those for which changes occurred,* number of times in which changes occurred, in the past 12 months**	2.92	74	0.58	5.26
***Of those for which changes occurred,* proportion of health facilities in which the main change was…**				
Attention/treatment received at facility	0.25	88	0.16	0.34
Inadequacy of facility's infrastructure	0.25	88	0.16	0.34
Inadequacy of facility's equipment	0.11	88	0.05	0.18
Inadequacy of staff availability	0.11	88	0.05	0.18
Staff attitude	0.09	88	0.03	0.15
Other	0.18	88	0.10	0.26

Table 79 Complaint mechanisms reported by HCC members

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCCs that obtain information on patient opinion on quality care and overall	0.92	144	0.88	0.97
***Of those that obtain information on patient opinion on quality care and overall,* proportion of HCCs that obtain it through the following means…**				
Regular feedback meetings	0.77	133	0.69	0.84
Client surveys	0.36	133	0.28	0.44
Complaint/Suggestion box	0.26	133	0.19	0.34
Other	0.17	133	0.10	0.23

Proportion of HCCs that keep a record of complaints about health facility from community in past 12 months	0.51	145	0.43	0.59
Of those that keep a record of complaints, proportion of HCCs that can produce a record of complaints about health facility from community in past 12 months, seen	0.27	74	0.17	0.37
Of those that keep a record of complaints, number of complaints recorded past 12 months	4.25	20	1.78	6.72
Of those that keep a record of complaints, number of complaints raised that were addressed and signed off by DHE	2.10	20	0.75	3.45
Proportion of HCCs with a mechanism to inform the health facility staff about patient opinion or complaints, apart from regular HCC meetings	0.57	145	0.49	0.65
Of those with a mechanism to inform health facility staff about patient opinion, number of times the HCC informed health facility staff about patient opinion or complaints, past 12 months	5.55	80	2.26	8.84
Of those with a mechanism to inform health facility staff about patient opinion, proportion of facilities in which any changes occurred as a result of patient opinion any member of HCC shared with health facility staff, past 12 months	0.87	142	0.81	0.92

Table 80 Complaints from ANC patients: Hypothetical

	Sample Mean	N	Lower 95% CI	Upper 95% CI
If unhappy about the facility or its staff, proportion of users who…				
Who WOULD complain	0.59	1,415	0.55	0.62
Who WOULD NOT complain	0.41	1,415	0.38	0.45
***Of those who would not complain,* proportion of users who won't complain because…**				
They don't know where to report	0.33	570	0.29	0.37
They are afraid to report	0.28	570	0.23	0.33
There is nowhere to report	0.17	570	0.13	0.21
Nothing will happen if they report	0.11	570	0.08	0.14
They prefer to discuss the matter with the person who treated them	0.06	570	0.04	0.08
Other	0.05	570	0.03	0.07
***Of those who would complain*, proportion of users who will most likely complain to…**				

Nurse in charge	0.39	672	0.34	0.43
Community Leader	0.15	672	0.11	0.18
Other health facility staff	0.13	672	0.10	0.15
Suggestion/complaint box	0.08	672	0.05	0.10
Police	0.07	672	0.05	0.10
HCC member	0.05	672	0.03	0.07
District Health Executive team	0.04	672	0.03	0.06
Other	0.09	672	0.06	0.12

Table 81 Complaints from ANC patients: Actual

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who have been unhappy or unsatisfied with the facility or its staff, in the past 12 months.	0.08	1,415	0.05	0.10
***Of those who have been unhappy or unsatisfied,* they have been unhappy with…**				
Staff attitude	0.66	107	0.56	0.77
Waiting period on a visit	0.58	107	0.44	0.72
Availability of staff	0.22	107	0.13	0.32
Availability of medicines	0.16	107	0.07	0.24
Opening hours	0.16	107	0.08	0.24
Staff competency	0.14	107	0.08	0.20
Other*	0.11	107	0.05	0.17
Percentages do not sum up to 100 because respondents were allowed to give multiple responses				
**Other includes: Privacy and confidentiality; Poor infrastructure or facilities; Payment for services/cost*				
***Of those who have been unhappy or unsatisfied,* proportion of users who reported anything they were not happy with, in the past 12 months**	0.07	107	0.02	0.13
***Of those unhappy users who reported anything in the past 12 months,* proportion of users who complaint to…**				
Community Leader	0.38	8	-0.06	0.81
HCC member	0.25	8	-0.14	0.64
Nurse in charge	0.13	8	-0.17	0.42
Other health facility staff	0.13	8	-0.17	0.42
Suggestion/complaint box	0.13	8	-0.17	0.42
***Of those unhappy users who reported anything in the past 12 months*, proportion of users whose complaints, to their knowledge…**				
Were actioned on	0.86	7	0.51	1.21
Were NOT actioned on	0.14	7	-0.21	0.49

***Of those unhappy users who did not report anything in the past 12 months*, proportion of users who did not report because…**				
Don't know where to report	0.30	98	0.20	0.39
Are afraid to report	0.26	98	0.17	0.34
There is nowhere to report	0.22	98	0.15	0.30
Nothing will happen if I report	0.12	98	0.06	0.18
Other	0.10	98	0.05	0.16

Table 82 Opinion of ANC patients on HCC's complaint mechanism

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Of those who know of HCC in their community, proportion of users who feel they can easily complain to HCC if unsatisfied with HF or HF staff	0.86	283	0.81	0.91
Of those who know of HCC in their community, proportion of users who feel that HCC always acts on their complaints	0.88	272	0.83	0.92

Table 83 Complaints from carers of under-fives: Hypothetical

	Sample Mean	N	Lower 95% CI	Upper 95% CI
If unhappy about the facility or its staff, proportion of users who…				
Who WOULD complain	0.59	1,514	0.56	0.62
Who WOULD NOT complain	0.41	1,514	0.38	0.44
***Of those who would not complain,* proportion of users who won't complain because…**				
They don't know where to report	0.33	597	0.28	0.38
They are afraid to report	0.30	597	0.25	0.34
There is nowhere to report	0.21	597	0.16	0.26
Nothing will happen if they report	0.08	597	0.06	0.11
They prefer to discuss the matter with someone that treated them	0.04	597	0.03	0.06
Other	0.04	597	0.02	0.05
***Of those who would complain*, proportion of users who will most likely complain to…**				
Nurse in charge	0.38	741	0.33	0.42
Community Leader	0.15	741	0.12	0.18
Other health facility staff	0.14	741	0.11	0.16
Suggestion/complaint box	0.08	741	0.05	0.11
HCC member	0.06	741	0.04	0.08
District Health Executive team	0.05	741	0.04	0.07
Police	0.05	741	0.03	0.07
Other	0.10	741	0.07	0.12

Table 84 Complaints from carers of under-fives: Actual

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who have been unhappy or unsatisfied with the facility or its staff, in the past 12 months.	0.12	1,514	0.09	0.15
***Of those who have been unhappy or unsatisfied,* they have been unhappy with…**				
Staff attitude	0.60	182	0.51	0.69
Waiting period on a visit	0.47	182	0.38	0.55
Availability of medicines	0.24	182	0.16	0.32
Staff competency	0.18	182	0.12	0.25
Availability of staff	0.16	182	0.09	0.24
Opening hours	0.16	182	0.08	0.23
Poor infrastructure or facilities	0.04	182	-0.00	0.09
Other*	0.09	182	0.04	0.13
**Other includes: Privacy and confidentiality; Payment for services/cost.*				
***Of those who have been unhappy or unsatisfied,* proportion of users who reported anything they were not happy with, in the past 12 months**	0.13	182	0.06	0.20
***Of those unhappy users who reported anything in the past 12 months,* proportion of users who complaint to…**				
Community Leader	0.43	23	0.22	0.65
Other health facility staff	0.35	23	0.12	0.57
Nurse in charge	0.22	23	-0.04	0.47
***Of those unhappy users who reported anything in the past 12 months*, proportion of users whose complaints, to their knowledge…**				
Were actioned on	0.65	20	0.38	0.92
Were NOT actioned on	0.35	20	0.08	0.62
***Of those unhappy users who did not report anything in the past 12 months*, proportion of users who did not report because…**				
Don't know where to report	0.32	157	0.24	0.40
Are afraid to report	0.28	157	0.20	0.36
There is nowhere to report	0.20	157	0.14	0.26
Nothing will happen if I report	0.11	157	0.05	0.18
Other	0.09	157	0.04	0.14

Table 85 Opinion of carers of under-fives on HCC's complaint mechanism

	Sample Mean	N	Lower 95% CI	Upper 95% CI

Of those who know of HCC in their community, proportion of users who feel they can easily complain to HCC if unsatisfied with HF or HF staff	0.83	368	0.78	0.89
Of those who know of HCC in their community, proportion of users who feel that HCC always acts on their complaints	0.90	345	0.86	0.93

U.6 Technical quality of health facilities

Table 86 Facility's management

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of health facilities headed by…				
Primary Care Nurse	0.51	147	0.43	0.59
State Registered Nurse	0.37	147	0.29	0.45
Nurse Midwife	0.05	147	0.01	0.08
State Certified Nurse	0.04	147	0.01	0.07
State Certified Maternity Nurse	0.02	147	-0.00	0.04
Other	0.01	147	-0.01	0.03

Table 87 ANC treatment: Registry

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users…				
With an ANC card	1.00	1,400	0.99	1.00
For which reported length of pregnancy matches card	26.50	1,387	25.90	27.10

Table 88 ANC treatment: Cost

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who…				
Paid for anything at visit today	0.04	1,415	0.02	0.06
Of those who did not pay for anything today, proportion that paid for any previous visits for current pregnancy	0.03	1,360	0.01	0.04
Amount of money (USD)…				
Paid for registration today	3.00	50	0.47	5.53
Paid for medical tests today	1.96	25	0.23	3.69
Paid for medicines today	1.30	44	-0.61	3.20
Paid for else other than consultation, blood tests and meds today	1.00	1	.	.
Spent at health facility, excluding transportation, today	4.67	55	0.76	8.58
Spent during previous visits by those who did not pay today	3.88	40	1.65	6.10

Table 89 Under-fives treatment: Cost

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who…				
Paid for anything at visit today	0.02	1,514	0.00	0.03
Of those who did not pay for anything today, proportion that paid for any previous visits for current pregnancy	0.01	1,490	0.00	0.01
Amount of money…				
Paid for registration today	1.00	20	1.00	1.00
Paid for medicines today	3.67	3	-41.51	48.84
Spent at health facility, excluding transportation, today	1.55	20	0.29	2.81
Spent during previous visits by those who did not pay today	2.64	11	0.15	5.12

Table 90 Main challenges for health workers (reported by HCC members)

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of HCC members that identify the following as the main challenge for health workers…				
Poor working conditions	0.77	145	0.70	0.84
Inadequate staffing	0.71	145	0.64	0.79
Lack of supplies	0.52	145	0.43	0.60
Lack of equipment	0.50	145	0.41	0.58

U.7 Perceived quality of care

Table 91 ANC patients' perceived quality of care

	N	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree
Overall satisfaction					
Proportion of users who…					
Are very satisfied with the quality of care received during the visit at this facility	1,414	0.01	0.01	0.06	0.92
Satisfaction with health workers					
Proportion of users who…					
Completely trust the health workers in this facility	1,400	0.01	0.02	0.13	0.84
Believe that health workers in this facility are extremely thorough and careful	1,413	0.01	0.01	0.10	0.88
Trust in the skills and abilities of the health workers of this facility	1,406	0.01	0.01	0.11	0.87
Completely trust the health worker's decisions about medical treatments in this	1,411	0.00	0.01	0.10	0.88
Believe that health workers in this facility are very friendly and approachable	1,408	0.01	0.02	0.11	0.86

Believe that health workers in this facility are easy to make contact with	1,400	0.01	0.02	0.11	0.86
Believe that health workers in this facility care about their health just as much or more than they do	1,396	0.01	0.02	0.14	0.84
Believe that health workers did a good job of explaining how to take care of their unborn baby	1,413	0.02	0.01	0.10	0.86
Believe that health worker spent a sufficient amount of time with them	1,414	0.01	0.01	0.10	0.88
Believe that health workers in this facility are often absent	1,353	0.91	0.03	0.03	0.03
Believe that health workers in this facility act differently toward rich people than toward poor people	1,308	0.88	0.04	0.03	0.05
Satisfaction with the facility and costs					
Proportion of users who…					
Believe that it is convenient to travel from their house to the health facility	1,412	0.12	0.06	0.11	0.71
Believe that the amount of time spent waiting to be seen by a health provider was reasonable	1,413	0.06	0.05	0.11	0.78
Believe that it is easy to get medicine that health workers prescribe	1,388	0.03	0.04	0.14	0.79
Believe that they had enough privacy during visit	1,413	0.00	0.01	0.07	0.92
Believe that the health facility is clean	1,407	0.01	0.02	0.14	0.83
Of those who paid health facility fees today, proportion who believes that the total fees were reasonable	41	0.12	0.02	0.02	0.83

Table 92 Carers of under-fives' perceived quality of care

	N	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree
Overall satisfaction					
Proportion of users who…					
Are very satisfied with the quality of care received during the visit at this facility	1,511	0.01	0.01	0.07	0.90
Satisfaction with health workers					
Proportion of users who…					
Completely trust the health workers in this facility	1,507	0.01	0.02	0.13	0.84
Believe that health workers in this facility are extremely thorough and careful	1,508	0.01	0.02	0.11	0.86
Trust in the skills and abilities of the health workers of this facility	1,504	0.01	0.01	0.11	0.87
Completely trust the health worker's decisions about medical treatments in this	1,507	0.01	0.01	0.10	0.89
Believe that health workers in this facility are very friendly and approachable	1,508	0.00	0.01	0.08	0.83

Believe that health workers in this facility are easy to make contact with	1,498	0.01	0.01	0.09	0.83
Believe that health workers in this facility care about their health just as much or more than they do	1,495	0.01	0.01	0.12	0.79
Believe that health workers did a good job of explaining how to take care of their unborn baby	1,506	0.01	0.01	0.06	0.87
Believe that health worker spent a sufficient amount of time with them	1,509	0.01	0.01	0.07	0.86
Believe that health workers in this facility are often absent	1,448	0.86	0.02	0.03	0.02
Believe that health workers in this facility act differently toward rich people than toward poor people	1,409	0.81	0.03	0.03	0.06
Satisfaction with the facility and costs					
Proportion of users who…					
Believe that it is convenient to travel from their house to the health facility	1,510	0.09	0.05	0.09	0.69
Believe that the amount of time spent waiting to be seen by a health provider was reasonable	1,511	0.04	0.04	0.08	0.74
Believe that it is easy to get medicine that health workers prescribe	1,484	0.03	0.04	0.12	0.73
Believe that they had enough privacy during visit	1,508	0.02	0.02	0.06	0.84
Believe that the health facility is clean	1,507	0.01	0.01	0.12	0.77
Of those who paid health facility fees today, proportion who believes that the total fees were reasonable	18	-0.25	-0.22	-0.06	0.08

U.8 MNCH service utilisation

Table 93 Catchment Population

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Population under health facility's catchment…				
Total population	7,877.35	144	6,848.38	8,906.32
Male population	3,797.84	45	3,154.23	4,441.46
Female population	4,340.17	46	3,398.24	5,282.10
Female 15-49 population	1,757.74	124	1,559.64	1,955.84
U5 population	1,217.13	119	1,064.86	1,369.39
U1 population	248.05	128	212.44	283.65
Where sample size <147 facilities, the catchment population or sub population was not available.				

Table 94 Decision on delivery

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who…				

Have decided where they will deliver their baby	0.76	1,406	0.73	0.79
Of those who have decided where they will deliver their baby, proportion that will use this health facility for the delivery of their baby	0.68	1,062	0.64	0.72
Of those who have decided where they will deliver their baby, proportion that will use another health facility for the delivery of their baby	0.31	1,062	0.27	0.36

Table 95 Planning for cost of future delivery

	Sample Mean	N	Lower 95% CI	Upper 95% CI
Proportion of users who…				
Have set aside any money for delivery	0.28	1,414	0.25	0.31
Of those who have set aside any money for delivery, proportion that have enough money for delivery	0.44	394	0.39	0.50
Of those who have set aside any money for delivery, proportion that are not sure whether they have enough money for delivery	0.28	394	0.23	0.33
Of those who have set aside any money for delivery, proportion that do not have enough money for delivery	0.27	394	0.22	0.32
Amount of money (USD)…				
Set aside by those who have set aside some	56.39	281	39.51	73.27
Perceived to be required for delivery	202.15	1,160	75.34	328.95

Annex V Quantitative results from HMIS data – Utilisation of Health Facilities

Figure 9 Average number of new out patients per facility per month

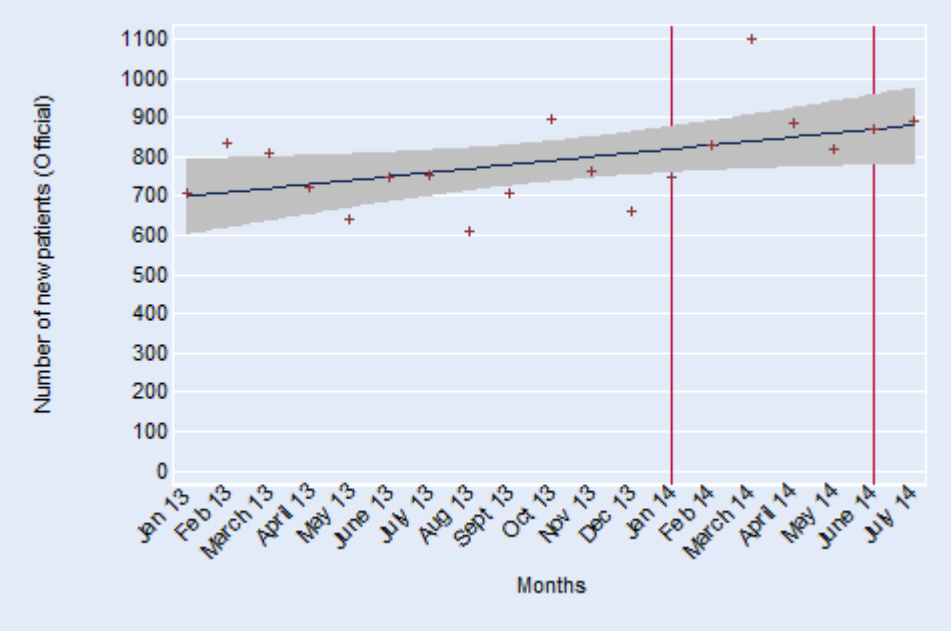
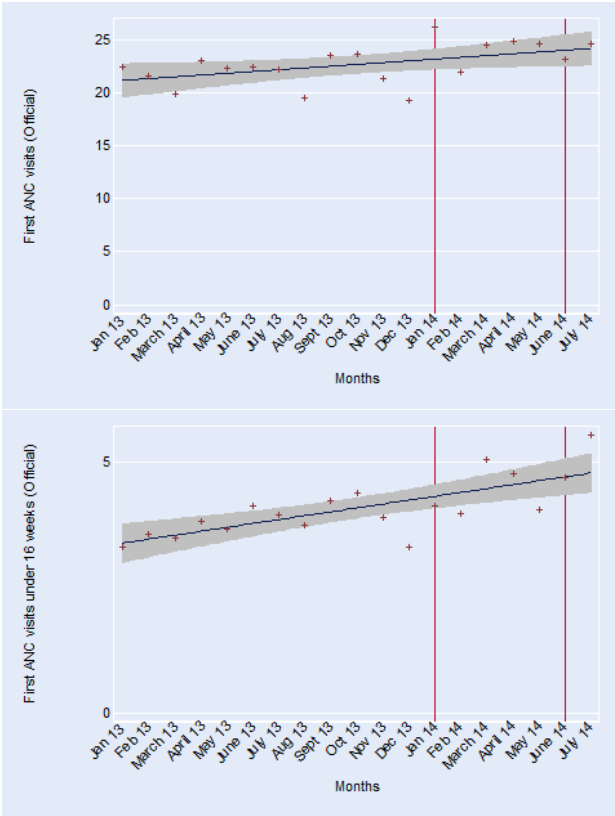


Figure 10 Average Number of ANC first visits per facility per month (total and by weeks pregnant)



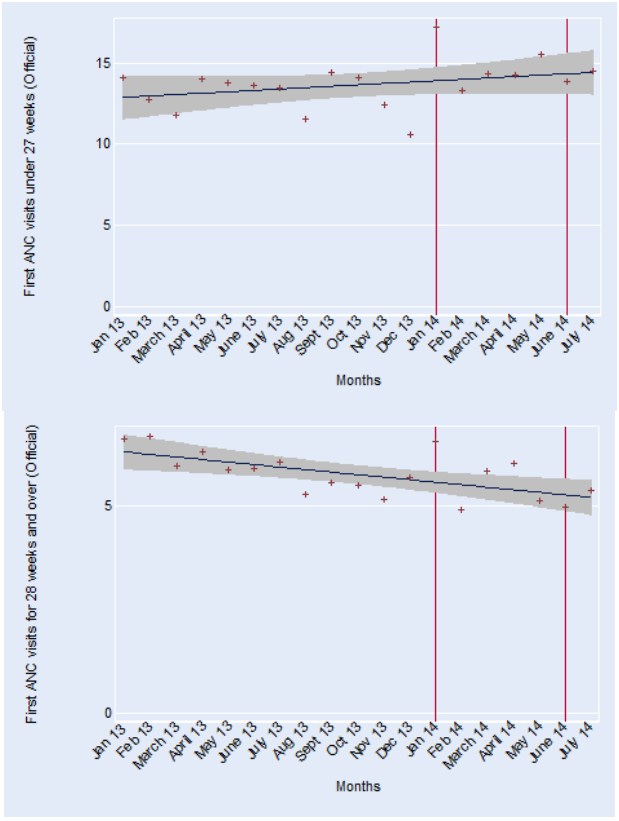


Figure 11 Average number of ANC second, third, fourth+ visits per facility per month

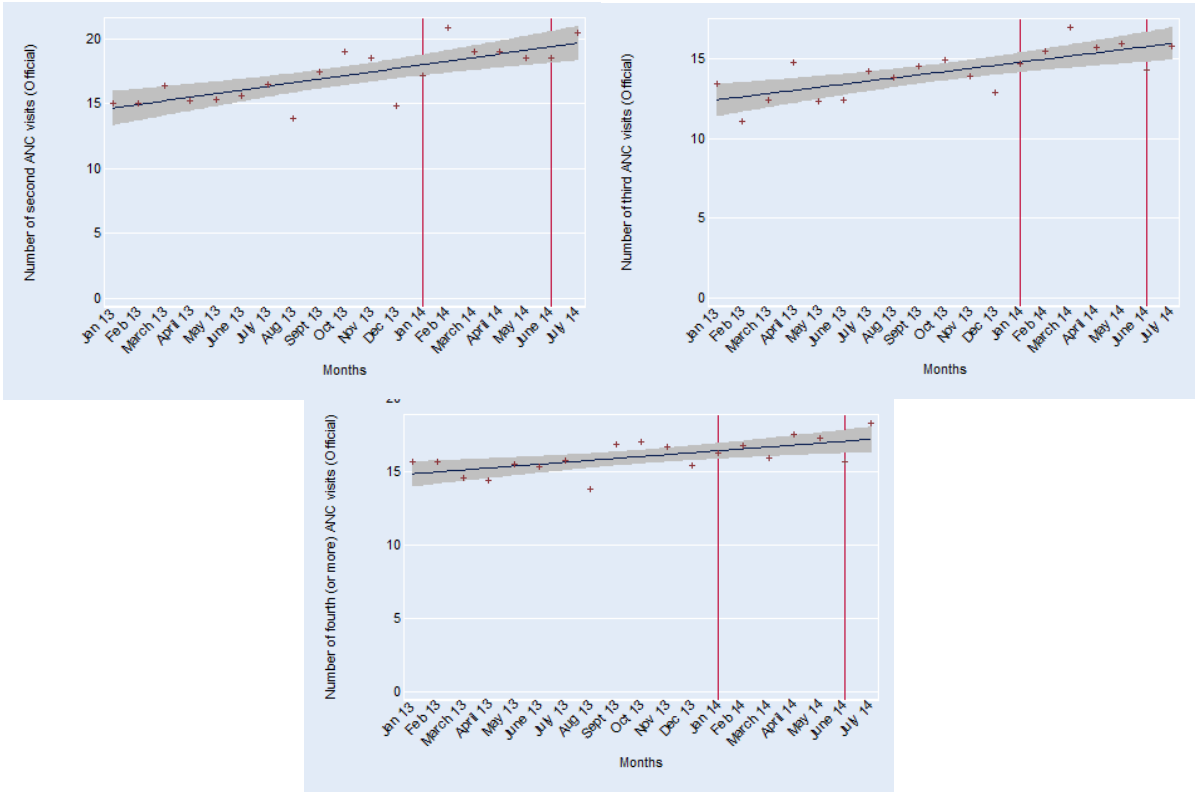


Figure 12 Average number of PNC visits per month

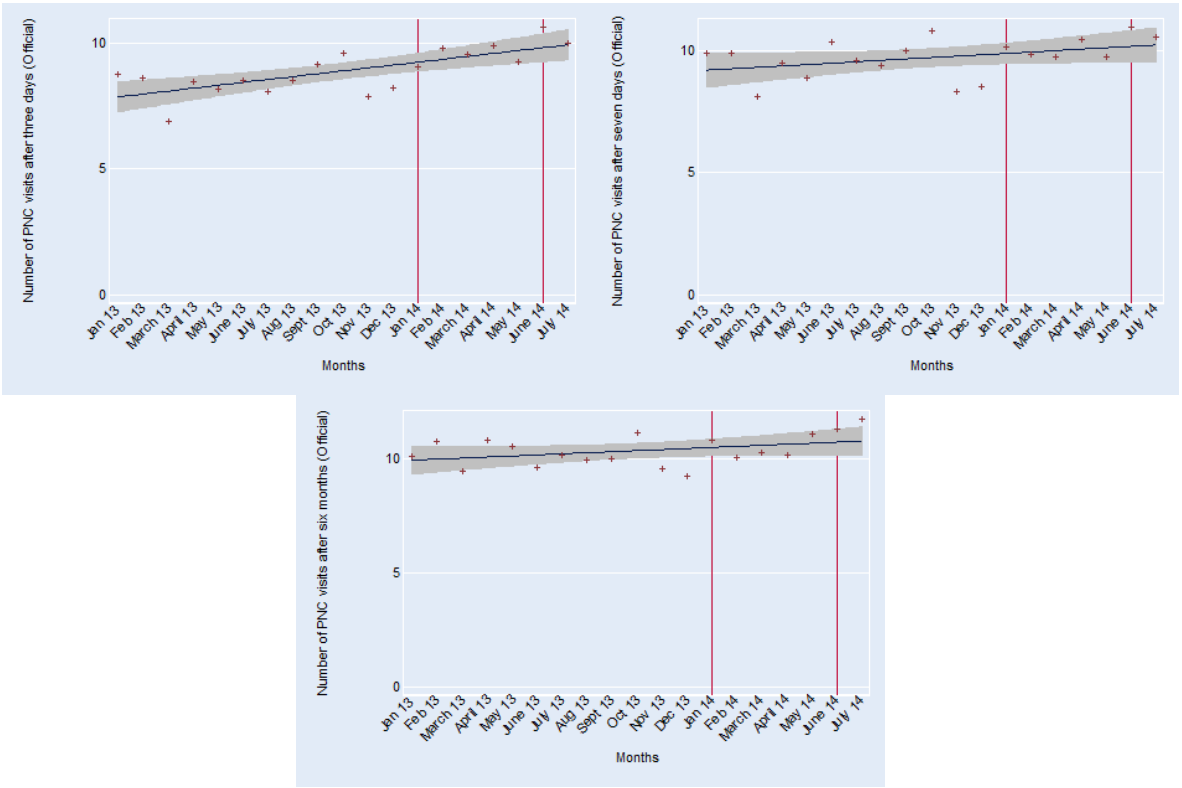
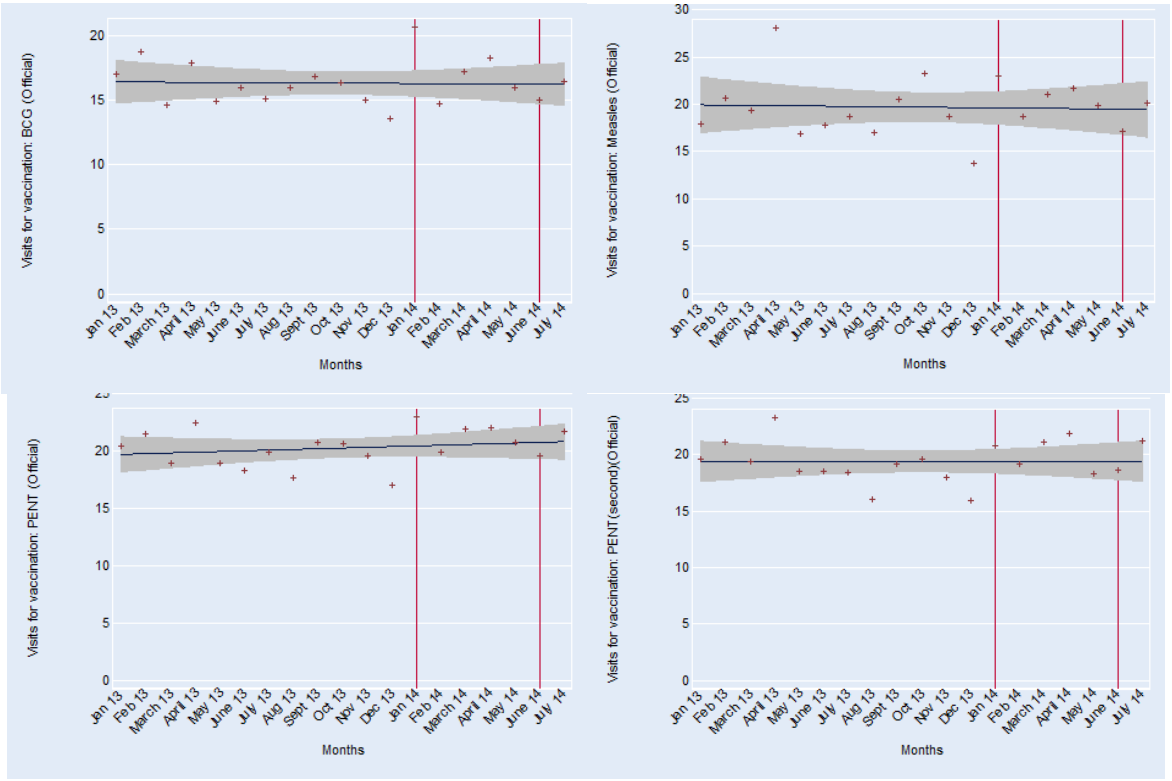
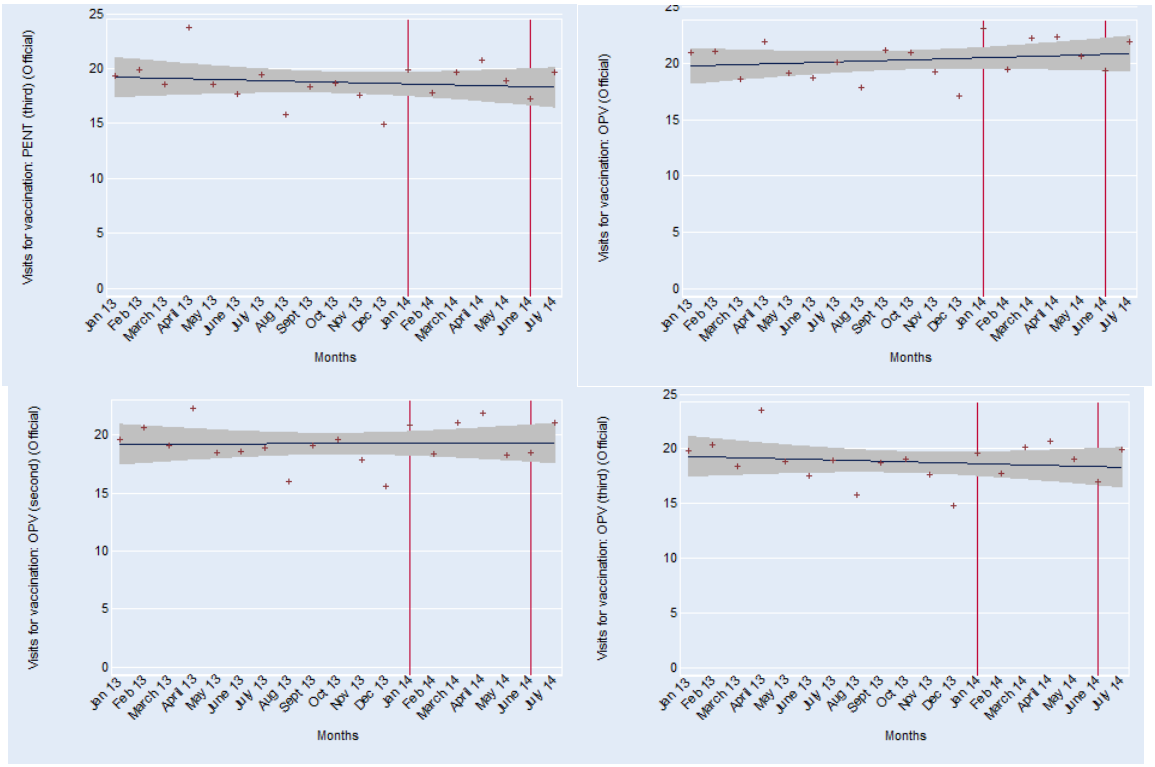


Figure 13 Average number of vaccinations per facility (by vaccination type)




Visits for vaccination: PENT (third) (Official)
Visits for vaccination: OPV (Official)
Visits for vaccination: OPV (second) (Official)
Visits for vaccination: OPV (third) (Official)
Months
Jan 13
Feb 13
March 13
April 13
May 13
June 13
July 13
Aug 13
Sept 13
Oct 13
Nov 13
Dec 13
Jan 14
Feb 14
March 14
April 14
May 14
June 14
July 14

Annex W HMIS verification

Health Management Information Systems are a critical component of well-functioning health care systems, and a key tool for obtaining relevant information on the extent to which a specific population makes use of the health services offered to them. For this evaluation, we intend to use Zimbabwe's official HMIS database to estimate the impact of the programme on the utilisation of different MNCH services of interest such as antenatal care, postnatal care, or vaccination services (see for example Section 5.7). In this baseline report, we present the baseline estimates of utilisation.

The purpose of this section is therefore to briefly investigate the robustness, reliability, and quality of the official HMIS data provided by Zimbabwe's MoHCC. By comparing the official database with the data available in the registers at the facilities, we aim to identify potential discrepancies between both data sources, so as to assess the robustness and reliability of the official MoHCC HMIS dataset.

W.1 Zimbabwe's HMIS data collection process

In Zimbabwe, the official MoHCC HMIS dataset is created on a monthly basis by following the below process.

- Health facilities are responsible for keeping daily records detailing all patients that come to the health facility for treatment. Patient records are recorded into different registers, depending on the type of treatment received at the facility (e.g. ANC register, PNC register, etc.).

- Health facilities are then in charge of manually tallying the daily registers on a monthly basis. The counts are hand-written into the monthly report form (called T5), and these are then sent to the District Health Information Officer, who enters them electronically.

- From the district, provincial and national levels, all HMIS data collected is then computerised.

W.2 HMIS data verification method

To assess the quality of the official HMIS data and to provide an alternative way to measure the utilisation of MNCH services, our teams also collected HMIS data through what we call "HMIS Data Verification Survey".

- First, registers at health facilities were reviewed and our teams again manually counted the number of monthly cases for ANC, PNC and new outpatients.

- Second, data written on the T5 forms stored at health facilities was manually copied again for vaccinations, ANC, PNC and new outpatients[43].

The existence of this two alternative data collection processes enables us to compare the following three data sources:

[43] Vaccinations are not recorded in a register but instead a tally sheet in kept which is input directly into the T5

- HMIS data from the official MOHCC HMIS dataset [DATABASE]
- HMIS data from our tally of health facility registers [REGISTERS]
- HMIS data from what is written (and has been copied) on the T5 forms at facilities [T5]

To assess the quality of the official HMIS data, this section will compare information on monthly records for eighteen different[44] MNCH services from the three aforementioned data sources: i) "Database"; "Registers"; and "T5". The data collected covers 147 Zimbabwean health facilities from the six months of January 2014 to June 2014.

W.3 HMIS data verification results

First of all, Table 96 illustrates the average proportion of monthly missing values present in each one of the HMIS datasets for the services of interest. As it can be seen, the levels of missing information are not significantly concerning, and rather similar across the three data sources for all MNCH services. The only exception can be found in the average number of monthly new patients admitted to the health facility, for which the proportion of missing data in the official source (4%) doubles the one in the T5 forms (2%), and increases up to 7% in the case of the registers.

Table 96: Average proportion of missing values per MNCH service

Health Service	Database	Registers	T5 forms
First ANC under 16 weeks	0.03	0.01	0.02
First ANC under 27 weeks	0.02	0.01	0.02
First ANC for 28 weeks and over	0.03	0.01	0.02
Second ANC	0.02	0.01	0.02
Third ANC	0.02	0.01	0.02
Fourth (or more) ANC	0.03	0.01	0.02
PNC after three days	0.02	0.02	0.02
PNC after seven days	0.02	0.02	0.02
PNC after six months	0.02	0.02	0.02
New patients	0.04	0.07	0.02
Vaccination BCG	0.01	.	0.02
Vaccination OPV	0.01	.	0.02
Vaccination OPV(second)	0.01	.	0.02
Vaccination OPV (third)	0.01	.	0.02
Vaccination PENT	0.01	.	0.02
Vaccination PENT(second)	0.01	.	0.02
Vaccination PENT (third)	0.01	.	0.02
Vaccination Measles	0.02	.	0.02

[44] First antenatal care visit for children under 16 weeks; first antenatal care visit for children under 27 weeks; first antenatal care visit for children aged 28 weeks or over; second antenatal care visit; third antenatal care visit; fourth (or more) antenatal care visit; postnatal care visit after three days of birth; postnatal care visit after seven days of birth; postnatal care visit after 6 months of birth; vaccination for BCG; first vaccination for OPV; second vaccination for OPV; third vaccination for OPV; first vaccination for PENT; second vaccination for PENT; third vaccination for PENT; and vaccination for measles.

Although missing information does not seem to constitute a key problem in general terms, Table 96 demonstrates that the average number of monthly cases registered for the MNCH services of interest considerably varies across the three data sources. In particular, Table 97 shows that for all services, the average number of monthly cases in the registers is lower than the one offered by the T5 forms, and even lower than the one reported by the official dataset. This is further confirmed by Table 98, which demonstrates that in general, only 80% of the numbers showed in the registers and T5 forms lie within the range of +/- 2 cases reported by the official dataset.

Table 97: Average number of monthly cases per MNCH service

Health Service	Database	Registers	T5 forms
First ANC under 16 weeks	4.44	3.72	4.15
First ANC under 27 weeks	14.72	13.27	13.31
First ANC for 28 weeks and over	5.55	4.98	5.00
Second ANC	18.85	15.67	17.10
Third ANC	15.56	11.58	14.16
Fourth (or more) ANC	16.61	11.69	15.07
PNC after three days	9.70	8.33	8.62
PNC after seven days	10.13	9.30	9.44
PNC after six months	10.60	8.00	10.26
New patients	876.65	639.83	666.45
Vaccination BCG	17.00	.	15.45
Vaccination OPV	21.20	.	19.30
Vaccination OPV(second)	19.86	.	18.16
Vaccination OPV (third)	19.04	.	17.31
Vaccination PENT	21.20	.	19.29
Vaccination PENT(second)	19.97	.	18.25
Vaccination PENT (third)	19.05	.	17.52
Vaccination Measles	20.22	.	18.98

Table 98: Proportions of monthly registers and T5 cases within the “+/- 2 cases” of database

Health Service	Registers within the “+/- 2 cases” of database	T5 within the “+/- 2 cases” of database
First ANC under 16 weeks	0.9	0.9
First ANC under 27 weeks	0.8	0.8
First ANC for 28 weeks and over	0.9	0.9
Second ANC	0.8	0.8
Third ANC	0.8	0.8
Fourth (or more) ANC	0.8	0.8
PNC after three days	0.8	0.8
PNC after seven days	0.8	0.8
PNC after six months	0.8	0.8
New patients	0.7	0.7
Vaccination BCG	.	0.8

Vaccination OPV	.	0.8
Vaccination OPV(second)	.	0.8
Vaccination OPV (third)	.	0.8
Vaccination PENT	.	0.8
Vaccination PENT(second)	.	0.8
Vaccination PENT (third)	.	0.8
Vaccination Measles	.	0.8

Results in Table 99 are also consistent with the ones in previous tables. Absolute differences in the average number of monthly cases are largest between the database and registers data, followed by differences between T5 forms and official data, and between registers data and T5 forms in the last place. There is also a great amount of variation across MNCH services: while the number of new patients admitted to the health facility keeps appearing as the most inconsistent variable across data sources, there are others (number of first antenatal care visits under 16 weeks, for example) for which absolute differences are considerably lower.

Table 99: Average of absolute differences by month per facility

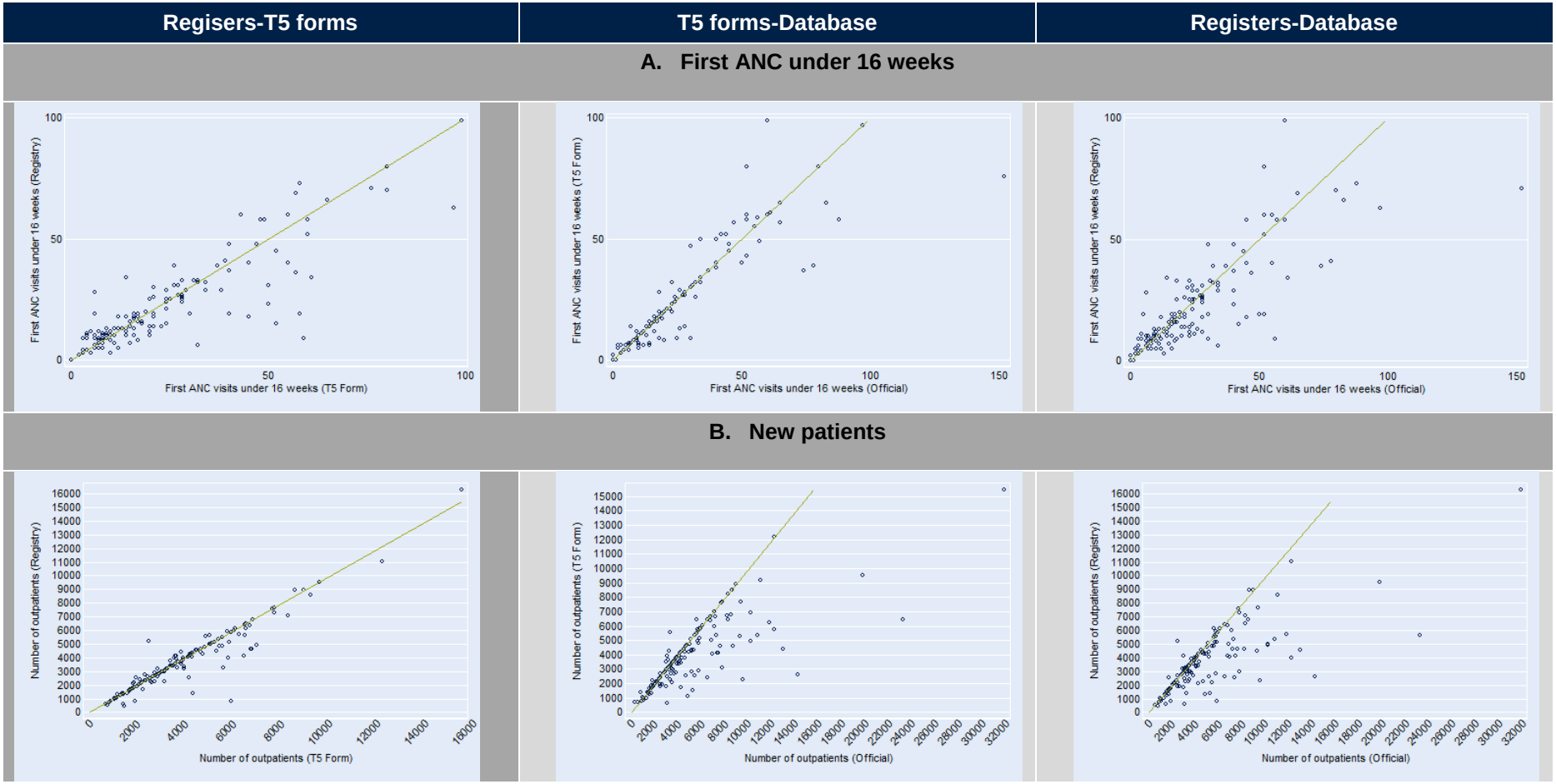
Health Service	Registers-T5	T5-Database	Registers-Database
First ANC under 16 weeks	1.4	3.2	3.1
First ANC under 27 weeks	2.2	6.5	6.6
First ANC for 28 weeks and over	1.7	3.8	3.8
Second ANC	5.2	8.6	9.0
Third ANC	5.2	7.7	8.5
Fourth (or more) ANC	6.5	9.7	10.2
PNC after three days	2.6	5.0	5.6
PNC after seven days	3.0	4.9	5.6
PNC after six months	4.2	6.2	6.8
New patients	53.6	369.3	374.3
Vaccination BCG	.	8.8	.
Vaccination OPV	.	9.0	.
Vaccination OPV(second)	.	8.3	.
Vaccination OPV (third)	.	8.2	.
Vaccination PENT	.	8.6	.
Vaccination PENT(second)	.	8.1	.
Vaccination PENT (third)	.	8.0	.
Vaccination Measles	.	10.8	.
This table gives the mean of the absolute differences for each pair of observations in month x, averaged across months and across facilities			

Figure 14 completes the results by visually depicting the existing differences across datasets in the total number of cases over the six months (January 2014-June 2014) of two of the MNCH variables of interest[45]: first antenatal care visit for children under 16 weeks, and number of new patients admitted to the facility. As it could be expected, observations lie closer to the 45 degree line in the case of graphs illustrating differences between register and T5 form data in both cases. However, the number of differing observations gets larger

[45] Graphs on the other MNCH services are available from authors under request.

when comparing T5 form and official information, and even greater when plotting register against official data. A closer inspection of the graphs illustrating new patients’ records also reveals the potential existence of “problematic” health facilities for which the official reported values are tremendously larger than the ones recorded in the corresponding facility’s register and T5 forms.

Figure 14: Scatterplots of the total number of cases for each facility



W.4 HMIS data verification conclusion

This preliminary verification process has revealed the existence of considerable discrepancies between our three available sources of HMIS data. We have discussed these results with the MOHCC. MOHCC have themselves sometimes found discrepancies between the registers and T5 forms but not between the T5 forms and the database so it is possible that this reflects some difficulties in fieldwork. Given that our ability to measure impact at endline will be highly dependent on the reliability of our data sources, we will mitigate the risk that the official HMIS database is not accurate by again conducting the same HMIS verification survey, which will provide us with an alternative measure of the utilisation of MNCH services in the facilities of interest.