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Strengthening Community Participation in Health Final Evaluation

Volume II: Technical Compendium

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Preface

This report constitutes Volume II of the final 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). This is the technical companion to Volume I of our final report. OPM also produced a baseline report at the start of programme implementation which is available separately.

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.

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List of abbreviations

ANC	Antenatal care
CDC	Centers for Disease Control and Prevention
CM	Community Monitor
CWGH	Community Working Group on Health
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
DMO	District Medical Officer
DNO	District Nursing Officer
EPI	Expanded Programme on Immunisation
EU	European Union
FGD	Focus group discussion
HCC	Health Centre Committee
HLF	Health Literacy Facilitator
HMIS	Health management information system
HTF	Health Transition Fund
ISP	Integrated Support Programme
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MoHCC	Ministry of Health and Child Care
MOU	Memorandum of understanding
NGO	Non-governmental organisation
NIHFA	National Integrated Health Facility Assessment
OPD	Outpatients per month
OPM	Oxford Policy Management
PICES	Poverty, Income, Consumption, Expenditure Survey

PEC	Provincial Engagement Coordinator
PNC	Postnatal care
RBF	Results-based financing
SCPH	Strengthening Community Participation in Health programme
ToC	Theory of change
UNICEF	UN Children's Fund
USAID	US Agency for International Development
U5s	Children under the age of five
VHWs	Village health workers
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey

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1 Introduction

1.1 Objectives of this report

This report is the technical and methodological companion to Volume I of OPMs final evaluation of the 'Strengthening Community Participation in Health' programme. Volume I is a descriptive report, which presents the findings of the evaluation. Volume II is intended to provide further supporting technical information about the evaluation approach and methodology. In this report we also present the full set of results tables, figures and graphs that the evaluation produced. The target audience for this report is those interested in the details of the evaluation methods, for those interested in the findings of the evaluation and discussion of the results please refer to Volume I.

1.2 Structure of this report

The report is organised into 4 sections and 12 annexes.

Section **2** presents the methodology for our evaluation in detail. This section begins with our evaluation questions and the overall evaluation design. Then we outline the quantitative and qualitative methods in turn, including the key objectives, sampling approach, data collection and analysis.

Section **3** presents the results tables from the quantitative component of our evaluation. This section is divided into the balance tables and regression results.

Section **4** presents additional figures and graphs from the quantitative component of the evaluation, including graphs of the MoHCC Quality of Care Checklist data, HMIS data on facility utilisation and the results of our verification of the HMIS data.

Annex **A** contains the original Terms of Reference for the evaluation

Annex **B** contains the departures of our evaluation from the Terms of Reference

Annex **C** presents the evaluation team and team structure

Annex **D** contains our overall evaluation matrix, including all evaluation questions and sub-questions that the evaluation aims to address, together with the data sources used to answer each one.

Annex **E** contains the SCPH Theory of Change and OPMs comments on the Theory of Change

Annex **F** contains the logframe for SCPH and the findings of OPMs verification of the outcome and impact indicators reported.

Annex **G** presents the sample size calculations for the quantitative health facility survey

Annex **H** describes the ethical considerations for this evaluation

Annex **I** contains the VFM framework template used for the VFM analysis in this evaluation

Annex **J** contains a template for the non-participant observation carried out at each of the 6 health facilities visited for the qualitative research

Annex **K** contains the question guides that were used during the qualitative fieldwork, for both our key informant interviews and focus group discussions.

Annex **L** contains a list of the respondents that we interviewed for our assessment of the national advocacy strategy conducted under SCPH

2 Methodology

2.1 Key evaluation questions

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 overarching purpose of this evaluation was to generate lessons to shape future decisions made in health policy and programming in Zimbabwe.

We use the DAC criteria to structure the evaluation questions because, as a result of discussions with DFID during the inception period and our reading of the ToRs, these were considered a suitable fit to the priority questions of DFID and represent an internationally recognised framework.

Table 1 DAC Criteria and key evaluation questions

DAC Criteria and key evaluation questions	
DAC Criteria	**Key evaluation questions**
Impact	What was the causal effect and contribution of the programme on the expected outputs, outcomes and impact along its theory of change?
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?
Effectiveness	What worked well and what worked less well and why? What were the major factors influencing the achievement or non-achievement of the objectives?
Efficiency	Was it good VfM? How could VfM have been improved?
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?

An evaluation matrix showing all the evaluation sub-questions and data sources is in Annex D.

2.2 Overall evaluation design

The overall evaluation takes a **theory-based approach** and uses **mixed methods**. 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 quantitative research uses a quasi-experimental method to address whether the intervention worked, and the qualitative research looks at how and why the intervention worked, or did not work.

The evaluation comprises a baseline and an endline. The baseline was intended to measure the situation on the ground before the programme starts while the endline measured the impact of the programme after it has been operational for two years. The dates of key activities are summarised in the table below:

Table 2 Timeline of the evaluation

Timeline of the evaluation	
Date	**Activity**
Feb 2014 – Jun 2014	Development of ToC and evaluation design
Jul 2014 – Aug 2014	Quantitative and qualitative baseline data collection
Sep 2014 – Feb 2015	Baseline report
Jul 2016 – Dec 2016	Quantitative and qualitative endline data collection
Sep 2016 – Feb 2017	Endline (final) evaluation report
Source: OPM	

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

- The use of the programme's ToC diagram during our inception phase, in consultation with SC and CWGH. This is shown in Annex E.
- The articulation of the assumptions behind the ToC diagram at baseline and the testing of the assumptions at baseline to assess the strengths and weaknesses of the programme design and the likely effectiveness of the programme. This is discussed in the baseline report Section 6;
- A refinement of the ToC diagram and assumptions at endline 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. This is shown in Volume 1 Section 5 and 18.

The evaluation is mixed methods in that it employs both quantitative and qualitative research methods within a common overall framework to answer the evaluation questions. A breakdown of how these different methods and sources of evidence are integrated to answer our evaluation questions is presented in the evaluation matrix in Annex D.

The quantitative research uses a quasi-experimental method to address whether, and to what extent, the intervention worked. The qualitative research explores how and why the programme achieved or did not achieve its key results, by examining and explaining the processes that have influenced the observed changes, and seeking to identify any significant influencing factors (for example, assumptions and contextual factors) that have played a role in determining the causal chain for this intervention. We used these research methods sequentially; conducting the quantitative fieldwork first (in July and August 2016) and the qualitative fieldwork in November and December 2016. This was so that the lines of inquiry explored in the qualitative research could be developed to respond to emerging hypotheses from the quantitative analysis.

2.1 Quantitative component

This section outlines the design and methodology of the quantitative part of the evaluation, which uses a health facility survey and secondary data.

2.1.1 Objective

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 (see Volume 1 Section 5). These indicator areas are: the quality and functionality of HCCs (output); knowledge of patient rights and entitlements, and healthy MNCH practices (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.

2.1.2 Identifying the comparison group

As described in more detail below, **the evaluation uses both primary data from a health facility survey we conducted and a range of secondary data**. The primary data cover a sample of the health facilities that were supported by the intervention and their matched comparison facilities. For secondary data sources, information is available for the full set of all intervention facilities. Part of our analysis of secondary data draws on this full list of intervention facilities, and for some analysis we again consider the same sample that is covered by the primary data collection, in order to allow information from the health facility survey to be incorporated into the analysis. For both types of data we have used matching to identify comparison health facilities. The intervention is rolled out in 21 districts, but does not cover all the health facilities in each district of operation. We have selected comparison health facilities from the remaining health facilities in these districts that are not covered by SCPH.

The evaluation used a matching design to identify comparison facilities that had similar characteristics to the intervention facilities. We then could compare intervention and comparison facilities to measure the impact of the programme. 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 intervention and comparison groups will on average be the same before the intervention begins. The facilities where SCPH was implemented were not selected randomly, and therefore they may not on average share the same characteristics as the facilities that were not chosen. Matching attempts to mimic randomisation by identifying a set of health facilities (and the communities they serve) that did not receive the intervention, but which are comparable with respect to their observed characteristics to the set of health facilities (and the communities they serve) where SCPH was implemented.

We used **propensity score nearest neighbour matching** to identify one comparison health facility for each intervention facility in our sample. The matching was based on the characteristics of the facilities as derived from available 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 propensity scores were then matched one-to-one using the nearest neighbour method.

In the baseline report, we presented the results of a comparison of intervention and comparison groups to determine whether there were any significant differences between them. **The results showed that the two groups were well matched, meaning that they had similar characteristics before SCPH started.**

At endline, we have conducted two further kinds of test to reconfirm this assumption. First, we repeated the balance tests performed on the HCCs and facility head nurses surveys, using the baseline data. The reason for repeating these tests was because there were some minor changes to the facilities where SCPH was working since the baseline analysis was done. Therefore we needed to check that the two groups were still well balanced under the new, slightly different, assignment of the intervention. We also conducted a new set of balance tests on the samples of ANC and U5 facility users that were interviewed at endline. This was because we did not interview the same facility users at endline as we did at baseline, and therefore needed to check the balance again in the endline sample. In order to do this we assessed the groups only against characteristics that could not have plausibly been affected in any way by the fact that one group had been exposed to SCPH. This implied comparing the groups in terms of their 'persistent' characteristics, such as age, religion and household size. The results from the two new kinds of balance test are presented in Section 3.2Balance tests. In addition to checking for significant differences between intervention and comparison groups in all variables individually, we also computed F-tests for joint significance of the whole set of variables tested. The F test provides a measure of whether the set of variables are collectively associated with being exposed to the intervention.

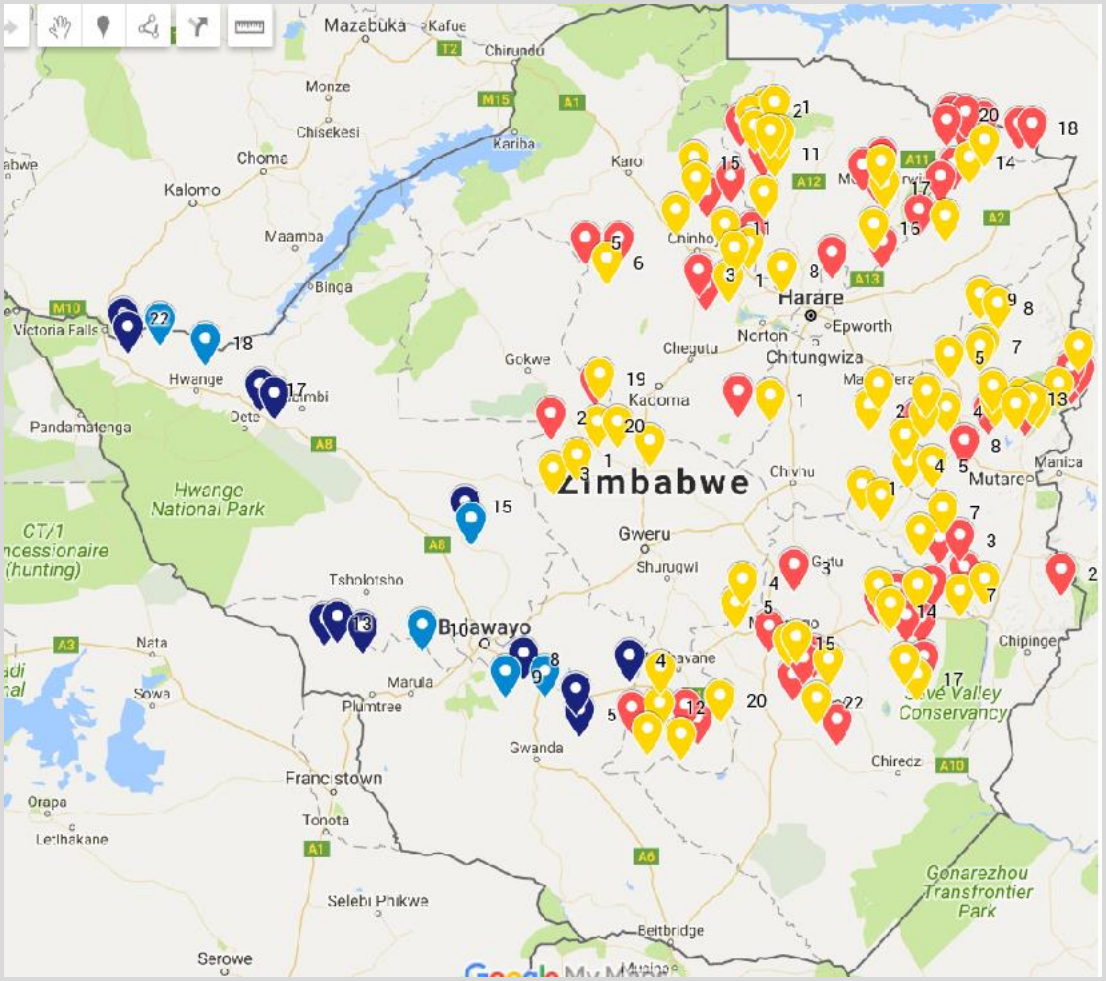
In the balance tests that were re-done on the baseline HCC and Head Nurse data we found some small differences between the intervention and comparison groups in the HCC data. The intervention group HCCs were found to be more likely to report meeting with the community to get their feedback, more likely to have a copy of the Patients Charter and more likely to have received training in their roles. This may reflect the fact that implementation of SCPH started in some districts before the baseline data collection was carried out. However the groups were balanced along almost all other variables tested, and the joint significance test is only weakly significant.

For the balance tests performed on the endline data for the ANC and U5 samples, we found significant differences in both groups in the language of respondents, with a relatively higher proportion of the intervention group found to be Ndebele-speaking than in the comparison group. This meant that when language is included in a joint-significance test, the set of characteristics of ANC and U5 patients emerges as being 'jointly' associated with the intervention. However when language is removed from the specification the groups are again balanced. The reason for the difference in the groups in the main language spoken by respondents is that in spite of the matching conducted at the facility level (which was performed in respect of characteristics related to the quality of health facilities and services provided), the intervention and comparison samples drawn were differentially distributed across provinces in Zimbabwe. A relatively higher proportion of the intervention facilities were drawn from Matabeleland. This is shown in Figure 1 below, which illustrates the

distribution of our quantitative health facility sample across Zimbabwe. From this figure we observe that within the provinces of Zimbabwe that are majority-Ndebele speaking, there is a higher proportion of intervention facilities than comparison facilities. However since the samples are well balanced across the majority of other dimensions tested, we are not concerned about the implications of this for the overall comparability of the intervention and comparison groups.

Figure 1 Distribution of the health facility survey across Zimbabwe

Distribution of the health facility quantitative sample across Zimbabwe



Key:

	Majority Shona-speaking area – comparison facilities
	Majority-Shona speaking area – intervention facilities
	Majority-Ndebele speaking area – comparison facilities
	Majority-Ndebele speaking area – intervention facilities

Source: OPM

The comparability of the two groups means that we can assess the impact of SCPH by comparing outcomes at endline, and be confident that any differences we observe are

due to the influence of SCPH. In this report the results presented are derived from comparing the average outcome in the intervention group with the average outcome in the comparison group. In the results section below, we also show some graphs of our main outcome variables that illustrate the average outcome at baseline as well as at endline. These graphs are intended for illustrative purposes, to show how outcomes have evolved over time on average, however the baseline data is not used for our main impact estimates.

There is one key difference between intervention and comparison facilities is that the intervention facilities have a larger catchment populations than the comparison facilities. This arose due to the way that SCPH selected its facilities to work in and deliberately sought to work in facilities with large catchment areas. In order to ensure that our results were not biased by the difference in catchment populations, we account for it in two ways in our additional analysis that is presented in Volume 2. Firstly we controls for catchment population size in our regressions using the facility head nurse and HCC surveys. Secondly we estimate difference in difference estimates so that any differences in outcomes at baseline are taken into account when comparing differences at endline.

2.1.3 Quantitative data sources

Primary data

The core of the quantitative primary data collection is a health facility survey. At baseline we visited 147 health facilities out of an intended sample of 150. At endline we revisited the same facilities, but were able to reach all 150 facilities in the sample.

This survey consisted of the following instruments:

1. ANC patient exit interview
2. Carers of U5 patient exit interview
3. Nurse in charge interview
4. Health centre committee interview
5. HMIS Data Verification Survey.
6. Village Health Worker survey (Comparison health facilities, at endline only)
7. Community Monitors Survey (Intervention health facilities, at endline only)
8. Health Literacy Facilitators Survey (Intervention health facilities, at endline only)

In addition, during the endline we interviewed one representative from the District Health Executive in each district where the intervention was implemented (21 in total).

Secondary data

The secondary data sources used for the quantitative component 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 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** depends on the quantity and the quality of services offered. Facilities received an amount based on their quality score, and amount based on the quantity of patients. The total amount of RBF disbursement is a measure that combines quality and quality. Note, the first RBF disbursement was made in January 2015, and therefore the quality of care composite score is available from Q3 2014.

- To understand how the programme was implemented, and the timeline of implementation, we reviewed **programme monitoring reports.** These included: Status of Intervention reports, Save the Children quarterly and monthly progress reports to DFID, and progress reports to the EC.

All primary and secondary data sources used for the quantitative component of the evaluation are summarised in Table 3 below.

Table 3 Quantitative primary and secondary data sources

Quantitative primary and secondary data sources				
Data source	Primary or secondary data	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
Official HMIS	Secondary	Yes	To check the consistency and quality of the Utilisation Survey	To check the consistency and quality of the Utilisation Survey
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 health facility resources, and complaint mechanisms at the health facilities	To measure the impact of the programme on the quality and functionality of HCCs, decision-making regarding health facility resources, and complaint mechanisms at the health facilities
Health Facility Survey – Utilisation Survey	Primary	-	To measure baseline levels of utilisation of MNCH services	To measure the impact of the programme on the utilisation of health facilities
Health Facility Survey – Village Health Worker, Health Literacy Facilitator and Community Monitor Survey	Primary	-	Not used	To assess what volunteers trained under the programme have done in their roles compared with what VHWs in non-intervention areas do.
Survey of District Health Executive (DHE) members	Primary	-	Not used	To understand impacts of the programme on decisions taken at the district level, as well as the attitudes and perceptions of DHE staff around decision making, community feedback and challenges affecting service delivery. The district level survey is also a key source of evidence to assess whether there are likely to have been any spillovers as a result of the programme within districts, whereby non-intervention facilities

				have been influenced in some way by the roll-out of SCPH to other facilities in the district.
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
Save the Children/ CWGH programme implementation and monitoring data – (Status of Intervention reports, quarterly and monthly progress reports, list of volunteer numbers and coverage and milestone reports to DFID)	Secondary	-	Not used	To assess the effectiveness of the programme in terms of what support was provided by the intervention and when. Milestone reports are used for the measurement of VFM.
***Data from the first disbursements made under RBF and data from the quality of care checklist became available starting from quarter 3 2014, and therefore were not available during the production of the baseline report.**				

2.1.4 Fieldwork for the primary data collection

The baseline data collection took place between July and August 2014, and the endline data collection between July and August 2016.

All data collected tools were pre-tested before the field teams were trained, and then again during training when the teams piloted the research protocols before the survey was conducted. Draft tools were also shared with DFID, Save the Children and CWGH for their comments before piloting. 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 consisted 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 travelled between field teams to ensure quality and consistency, as well as carrying out a number of back check interviews to verify the quality of data collected and conduct of our field teams during fieldwork.

The OPM and Jimat team led the training for the entire field team rather than relying on a "training of the trainers" approach. The training topics covered 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 fieldwork manual, which laid out the fieldwork procedures, and described the intended meaning of survey questions. The objectives of the training and fieldwork manual were to ensure that the field teams were fully equipped to carry out the assignment and confident in their roles.

At baseline, 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. At endline the data collection was done electronically using tablets. We used the World Bank's Survey Solutions software to programme the surveys.

The ability to collect data electronically at endline provided opportunities to ensure high quality data. The first benefit was that a set of consistency checks could be built-in to the data collection tool, to immediately notify field teams during an interview if any answers were entered that were inconsistent with an answer previously given. Secondly, teams were instructed to upload newly collected data every day, which meant that the data could be further checked for quality and consistency during the fieldwork. This meant that OPM staff and the independent field monitors could provide rapid feedback to field teams in case of any inconsistencies or concerns around quality.

Once fieldwork was complete, the data was further cleaned and checked using range and logical consistency checks in Stata.

2.1.5 Sampling

Sampling at baseline

We initially drew a sample of 140 facilities and planned on spending 1 field day on average per facility. During this time, the team was expected to conduct:

- One nurse in charge interview
- One HCC member interview
- 10 exit interviews of each type (ANC visits, and mothers with children under 5 years of age)
- One HMIS data verification survey[1].

This system was designed to deliver a final sample of 140 nurse in charge interviews, 140 HCC member interviews, 1400 ANC exit interviews, 1400 U5 exit interviews, 140 HMIS data verification interviews. Each exit interview lasted for around 20 minutes.

We sampled intervention health facilities using systematic random sampling with probabilities proportional to size (PPS), where size is the number of ANC patients. 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 intervention facilities in all of the 21 districts where the programme is operating, and we chose to sample intervention and comparison facilities from the same district in order that our intervention and comparison sample would, on average, be subject to the same district management functions. 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, and planned a fixed number of patient interviews in each facility, 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=(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.

With PPS sampling at the facility level, and constant within facility sample across all facilities, the sample is self-weighted and representative of the population of patients. As the sample was PPS, the larger facilities are over-represented in comparison to the smaller facilities. The aim of the sample was to achieve representative sample of patients and not necessarily the representative sample of the facilities.

[1] There was no district level interview, VHW, CM or HLF survey during the baseline data collection.

The initial field plan also included the within facility sampling plan, which was based on systematic sampling of exit interviews using the sampling sheet provided to field teams. The sampling sheet provided a systematic selection of respondents, based on the estimate of the daily volume of patients at the facility and on filling out the leaving patients counts.

However, due to low volumes of exit interviews at the facilities encountered at the beginning of the baseline survey, the interviewers were interviewing all the eligible patients and therefore the within facility sampling was not used in the field.

In order to achieve the target sample sizes, the number of facilities was increased from 140 to 150. The supplemental facilities were selected based on their estimated size – remaining largest facilities in the intervention sample and their matched controls. The field model was also changed in order to allow the field teams to be present at the facility for more than 1 day. Some of the commonly present field approaches of the field teams were to split the team into single members and work on the exit interviews of 3 facilities simultaneously in order to maximise the yield of the especially ANC exit patients. All of the available patients present while teams were at the facility were interviewed. Additionally, in the later stages of the fieldwork, some high volume facilities, were re-visited in order to boost the number of exit interviews.

The changes in methodology yielded the required sample sizes. The post-fieldwork analysis also revealed that 147 facilities have been actually visited during the baseline fieldwork period out of supplied 150.

Analysis of baseline sample data

We conducted an analysis of the baseline data sampled based on the submitted and entered sampling forms, and on the exit interview datasets. Number of interviews per day, number of interviewers present at each facility per day and total number of days worked at the facility indicators were created to facilitate the understanding of the sampling approach used.

The analysis of the baseline data revealed that the field model that was used in the facilities varied a great deal. Some facilities were completed within a single day, and in some at least one interviewer was present for up to 5 days. Despite this flexible field model, some facilities yielded very low volumes of exit interviews.

As the equal number of exit interviews per facility could not have been observed due to objectively too low volumes of patients in many of the selected facilities, the final sample is not self-weighted anymore. In order to assess the representativeness of the baseline sample, accurate and up-to-date estimates of the volumes of service deliveries would need to exist for all of the intervention facilities. A tentative assessment indicates that the sample is biased towards patients using larger facilities as their numbers in the final sample have been given a double boost – from the PPS sampling of facilities where larger facilities had a greater probability of being selected and from the field model, where additional exit interviews were conducted in larger facilities in order to compensate for low turn-out in smaller facilities. However, this tentative assessment may be flawed as the basis for the PPS sampling approach was based on what is now believed not-accurate estimates of the volumes.

Sampling approach and fieldwork model at endline

For the end-line survey we used the same sample of facilities visited at baseline in order to have a panel of health facilities. Due to severely low volumes in the majority of the sampled facilities, it was decided that the end-line survey field model will not include any within facility sampling. Therefore, all available exiting patients need to be interviewed until the expected number of exit interviews for a facility is reached.

The main adjustment to the sampling methodology for the end-line was to adopt a systematic approach towards achieving high enough volumes of exit interviews. The approach was modified such that interviews in each facility would be conducted over 2 days. We expected that the equal number of interviews in each facility could not be achieved due to differences in volumes and high proportion of facilities with very low volume of patients, in particular ANC patients. Therefore, more patients would need to be interviewed in higher volume facilities to achieve our target sample size. In order to achieve a systematic oversampling in larger facilities the target sample of exit interviews was increased:

- from 10 to 20 for ANC patients and
- from 10 to 12 for under-5 patients in each facility.

The target sample was identified as the number of exit interviews to be achieved in the two-day presence at the facility. We anticipated that in most facilities the upper targets would not be reached. The target sample sizes of the number of exit interviews in each facility were estimated based on the sample sizes achieved during the baseline, to yield the required number of exit interviews overall, in the presence of some variation across facilities.

The proposed sample design does not yield a fully representative sample of patients. Ideally, an equal number of patients would have been sampled in each facility in order to compensate for the selection of facilities using the PPS methods in the first stage. However it was not possible to do this due to the variation in patient volumes across facilities. The proposed sampling design at endline is an improvement on the approach used at baseline to make up the full sample number, as it was designed to deliver the required number of exit interviews in a systematic manner and under current and known constraints.

The proposed sampling design thus required that the field teams be present at each facility for 2 full days. The 2 field day requirement for each facility resulted in a field model that was beyond the confines of the existing budget. To address this, the fieldwork plan was designed such that 4 facilities would be covered by 1 field team in 3 days. This meant that the team would split up and on some days, so that different members could be present in more than one facility. On at least one of the working days at the facility at least two members were present. The model assumes the following field arrangements:

Table 4 Endline fieldwork implementation

Fieldwork implementation				
	Day 1	Day 2	Day 3	Day 4
Member 1	Facility 1	Facility 1	Facility 3	Facility 3
Member 2	Facility 1	Facility 2	Facility 2	Facility 3
Member 3	Facility 1	Facility 2	Facility 2	Facility 3

2.1.6 Sampling weights

As is usual practice when using a 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.

2.1.7 Attrition

We revisited the same health facilities at baseline and endline. At the facility level there was no issue of attrition from the sample. In fact, the fieldwork reached the full sample of 150 facilities at endline compared with 147 at baseline.

Our survey did not re-interview the same patients at the baseline and endline, so the problem of attrition does not apply. However, we did not manage to achieve the full intended sample of ANC patients at the endline period. We interviewed 1175 out of a target of 1400. This is discussed further in Volume 1, Section 2.6.

2.1.8 Indicators

Altogether, the primary and secondary data sources provided data on a large number of indicators. Our approach to data analysis was to identify within these sources they key outcome indicators, related to the ToC, on which impact would be assessed. The remaining data was used to provide descriptive and supporting information, to provide evidence on the context and background for our main results as well as to provide explanatory information to help us interpret them. The selection of key outcome indicators was done before the analysis took place. As far as possible we aimed to limit the number of main outcome indicators that our evaluation would use to assess impact, in order to mitigate the problem of multiple hypothesis testing.

2.1.9 Data analysis and estimation strategies

After cleaning the data thoroughly and performing balance tests, the data analysis for the survey data consisted of the following:

Descriptive analysis for all indicators

We compared the average outcome at endline between the intervention and comparison groups, for all indicators in our surveys.

For the CM, HLF, VHW and District-level surveys the descriptive analysis was a bit different because these surveys did not include both intervention and comparison observations. For the District level survey we simply computed the average outcome across the whole sample. For the CM and HLF surveys, where we collected the same indicators in the VHW survey we compared outcomes with the VHWs. For example, we can compare the average number of CMs in intervention areas who report needing more training to conduct their roles that the corresponding average of VHWs in comparison areas. For outcomes that were not comparable, we simply present the mean in the sample.

Impact estimation for the ANC and U5 indicators

Since our survey did not collect a panel of ANC and U5 patients, we did not have the ability to perform a differences in differences estimation to assess programme impact. Therefore we analysed the ANC and U5 data using regressions estimated on the endline data only. Given the high levels of balance observed in the persistent characteristics of the people in our sample between the intervention and comparison groups, and the success of the matching at the health facility level, we are confident that the comparison of the two groups at endline provides an unbiased estimate of the impact of SCPH.

Using data from endline we ran three regression specifications, as follows:

$$Y_{ij} = \alpha + \beta_1 T_j + \varepsilon_{ij}$$

$$Y_{ij} = \alpha + \beta_1 T_j + \gamma_1 X_i + \varepsilon_{ij}$$

$$Y_{ij} = \alpha + \beta_1 T_j + \gamma_1 X_i + \gamma_2 District_j + \varepsilon_{ij}$$

Where:

- Y_{ij} is the outcome for individual i in the catchment area of facility j
- T_j is equal to 1 if facility j is covered by the SCPH intervention
- X_i is a vector of covariates for individual i[2]
- $District_j$ refers to a fixed effect for the district of facility j.

Standard errors are clustered at the health facility level.

β_1 gives the estimate of the impact of SCPH on Y_{ij} from patients comparing intervention and comparison facilities at endline.

Impact estimation for the HCC, health facility and head nurse indicators

[2] The covariates that we used for the regressions were as follows: respondent's first language is Shona, age, years of education, religion, time taken to reach the clinic, household size, education level of household head, household uses improved water source, household uses improved toilet facility, number of assets owned, household flooring material, household roofing material and household wall material, household has a bank account.

Using data from endline we ran two regression specifications, as follows:

$$Y_j = \alpha + \beta_1 T_j + \varepsilon_j$$

$$Y_j = \alpha + \beta_1 T_j + \gamma_1 Catchment\_pop_{0j} + \gamma_2 Catchment\_pop_{0j}^2 + \gamma_3 District_j + \varepsilon_j$$

Where:

- Y_j is the outcome for facility j
- T_j is equal to 1 if facility j is covered by the SCPH intervention
- $Catchment\_pop_{0j}$ is the catchment population of facility j during the baseline period
- $District_j$ refers to a fixed effect for the district of facility j.

β_1 gives the estimate of the impact of SCPH on Y_j from comparing intervention and comparison facilities at endline.

Using data from baseline and endline, we ran two regression specifications, as follows:

$$Y_{j1} = \alpha + \beta_1 T_j + \pi Y_{j0} + \varepsilon_j$$

$$Y_{j1} = \alpha + \beta_1 T_j + \pi Y_{j0} + \gamma_1 Catchment\_pop_{0j} + \gamma_2 Catchment\_pop_{0j}^2 + \gamma_2 District_j + \varepsilon_j$$

Where:

- Y_{j1} is the outcome for facility j during the endline period
- Y_{j0} is the outcome for facility j during the baseline
- T_j is equal to 1 if facility j is covered by the SCPH intervention
- $Catchment\_pop_{0j}$ is the catchment population of facility j during the baseline period
- $District_j$ refers to a fixed effect for the district of facility j.

β_1 gives the ANCOVA difference in differences estimate of the impact of SCPH on Y_{ij} .

For the regressions using MoHCC quality of care checklist we were able to use to a larger sample of all intervention facilities matched to controls.

For the regressions measuring the utilisation of health facilities, at both baseline and endline we had six observations (six months) per facility. In order to remove random variation by month we first took the average of these six observations (six months) for each facility to obtain one observation per facility at both baseline and endline.

Disaggregations

We conducted some further analysis on a limited set of outcomes[3] to test for evidence of heterogeneous impacts on various population subgroups in the ANC and U5 data.[4] We estimated the following regression separately on each subgroup of interest:

$$Y_j = \alpha + \beta_1 T_j + \varepsilon_j$$

The subgroups that were tested were as follows:

- Poverty status of the respondent's household.
- Whether or not the respondent belongs to an Apostolic religion
- Whether the respondent is over or under 30.

Poverty status was determined by generating a continuous variable, for each respondent, based on 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.). This was done using a Principal Component Analysis technique. Respondents with a final score below the median value of the index were assigned to the lower wealth category, with the remainder assigned to the higher wealth category.

The findings from this exercise did not reveal any meaningfully different results between the subgroups tested.

We did not conduct disaggregated analysis on data collected at the facility level, including the HMIS data, due to limited sample sizes at this level.

2.2 Qualitative component

2.2.1 Objectives

The main objective of the qualitative component at the endline is to provide deeper contextual understanding and explanations for the findings from the quantitative surveys. Beyond looking for evidence on impact and seeking explanations for the results observed in the quantitative analysis, this component also explores questions around the relevance of the programme's design, its efficiency and the sustainability of its results.

The research was divided into national-level interviews and research at the sub-national level. At the national level, our interviews were designed to address questions relating to the relevance, efficiency and sustainability of the programme. We also conducted interviews at this level to learn about the effectiveness and results of the national advocacy strategy component of SCPH. A list of the respondents we spoke to is provided in Annex L.

At the sub-national level, the main objective was to understand programme impact at the community level, in terms of what has worked well or less well for the programme in these

[3] The outcomes tested were the proportion of facility users who are: aware of the HCC, aware of the Patients Charter, aware of free MNCH services, aware of any patient rights, received training on rights and entitlements, received training on health responsibilities, would complain if ever unsatisfied with health services, actually complained about anything in the past 12 months, were ever unhappy with anything at the health facility in the past 12 months. We also tested the average 'score' capturing awareness of health responsibilities and satisfaction with the health facility.

[4] We do not conduct disaggregated analysis for facility level outcomes, since sample sizes are limited.

places and the reasons why. We adopted a case-based approach, focusing on six health facilities together with their surrounding communities. The aim was to develop a story around each of these facilities and catchment areas to learn about what happened in each place during the intervention period and why. In addition to carrying out interviews in the health facilities and communities, we also interviewed health officials at the district and province level, and programme implementers at the province level, to ensure that our research included the perspectives of a range of stakeholders at all levels at which the SCPH programme operates.

In each of these six cases, the research aimed to understand:

- The functions, roles and responsibilities of HCC's, what they do and how, and with what challenges and constraints;
- The support they have received in terms of quantity, regularity and duration, including support provided by the programme.
- The community's perceptions of local health services including in terms of its accessibility and quality, and the different sources from which they seek care. This includes their awareness and perceptions of the feedback mechanisms available to them, the roles of HCCs and other community members engaged in health and the importance and social connectedness with these different actors, and;
- The nature and quality of engagement between facilities and HCCs, and between facilities and community members. This included the extent to which each group participates and engages in decision making for the facility, and any constraints faced. Data collection methods

The qualitative evaluation draws on two principle qualitative methods namely: interviews and focus group discussions (FGDs). Key informant interviews were carried out in Harare, in the two districts of Rushinga and Bulilimamangwe (Bulilima), in selected facilities within these districts and in the communities within the catchment areas of each facility. For the FGD's the team used a number of participatory tools, including community and social mapping and proportional piling. The evaluation undertook a total of 46 semi-structured interviews and 18 FGDs in Rushinga and Bulilima, and 8 interviews at the national level. The interview guides are presented in Annex K.

Additionally the team undertook 6 non-participant observations within the facilities to look for evidence of programme influence (e.g. availability of complaints box, statistics, etc.) and carried out a transect walk within the vicinity of the health facilities. The facility observation checklist template that teams used to do this is presented in Annex J.

2.2.2 Sampling

The sampling for endline qualitative evaluation followed a similar logic to that of the baseline: The research team visited the two districts of Bulilima and Rushinga and carried out interviews at provincial, district, health facility and community level. Within each district we visited three sites, consisting of a health facility and the communities in the surrounding catchment area.

There were also some changes to the sampling approach since baseline. Rather than visiting the same sites within these two districts again, the selection was made in response to emerging findings from the quantitative analysis, which was undertaken before the qualitative fieldwork began. In particular, the sampling approach used the following logic:

- The idea was to try and ensure that the qualitative sample included both some facilities where HCCs were found to be working well and others where they were working less well. The rationale behind this was so to provide an opportunity to compare and contrast the conditions in these areas in order to better understand the circumstances in which HCCs may perform better, and, the circumstances in which SCPH has had greater or lesser impact.

- The measure that we chose in order to select the qualitative sample was the change since the baseline survey in the proportion of facility users from the quantitative survey who were aware of the HCC. The quantitative survey data at the facility level shows much variation on this outcome. Although not representative at facility level, this data provides some indication of raising the visibility of the HCC. Including these facilities in our sample for the qualitative research provided us with an opportunity to compare intervention areas where the awareness has significantly increased to those in which there hasn't been any change (or negative change) and to unpick the underlying reasons for this.

- In Rushinga, the SCPH was implemented in all health facilities in the district. As the qualitative evaluation does not rely on a counterfactual based design, we judged the value of an additional case within the same district with variation in outcomes of interest to be of greater interest than visiting a comparison facility in a neighbouring district.

- Within the catchment of each health facility, in addition to speaking to some health facility users near to the facility, the teams also visited one village and spoke to both community members there. The ability to conduct interviews at the community level was a very important contribution of the qualitative research to the overall evaluation design, since the quantitative survey only targeted facility users. With the support of the Village Health Workers, the team carried out focus group discussions with users of the facilities and the community leaders and supplemented this with interviews with some non-users as well other key informants.

The team interviewed the same type of stakeholders at provincial, district, facility and community level as the baseline. At the provincial, district and facility level the teams interviewed individuals with relevant knowledge and involvement in health services in Zimbabwe, namely: HCC chairs/ heads; facility heads; DHE members, (District Medical Officers (DMOs); District Nursing Officers (DNOs); Provincial Medical Directors; and Provincial Engagement Coordinators. At community level, respondents included:

- Facility users

- Facility non-users or infrequent users, where these could be identified

- Members of HCCs and/or village health workers; and

- Opinion leaders (including religious and traditional leaders, local business persons etc.).

These categories of respondents were selected in order to address the key research questions that we were aiming to answer in each research site.

Overall the evaluation team conducted 18 focus group discussions and 46 interviews. The numbers across each district and facility are summarised in Table 5 below.

Table 5 Number of interviews and FGDs

Number of qualitative interviews and FGDs				
	Rushinga		Bulilima	
Level	Interviews	Focus Group Discussion	Interviews	Focus Group discussions
Provincial level	1	N/A	1	N/A
District level	2	N/A	3	N/A
Facility level	12	3 (with HCC members)	11 (Including project volunteers and HCC chairs)	3 (with HCC members)
Community level	8	6 (facility users and opinion leaders)	8	6 (facility users and opinion leaders)
Total	23	9	23	9

2.2.3 Brief profile of research locations

2.2.3.1 Rushinga district

Rushinga is one of the eight districts in Mashonaland Central province. SCPH was implemented in all 10 rural health facilities in Rushinga, where it is funded by the EU. Rushinga is also one of the districts selected for a continuation of the SCPH programme beyond July 2016 (when the programme ended elsewhere). It is scheduled to continue in Rushinga until March 2017.

2.2.3.2 Bulilima district

Bulilima is one of the 6 districts in Matabeleland South. The district shares its border with Botswana and is close to the Kalahari Desert – making it arid and prone to drought. SCPH was funded by DFID and implemented by the Community Working Group on Health (CWGH). Unlike Rushinga, the programme did not receive additional funding to continue beyond July 2016.

The six cases selected for the qualitative research are centred on the following facilities, within Rushinga and Bulilima.

Facility 1

Facility 1 is a Rural District Council run clinic with 3 nurses, serving a catchment population of 6734 (in 2016). There is a Mothers Waiting Shelter at the clinic, and one staff home where the Environmental Health Technician (EHT) lives. The catchment area covered by the clinic consists of 3 wards. The furthest ward in the catchment area is about 12 km from the clinic, and road networks in that area are poor, though the roads nearer the facility are in good condition. The clinic is close to a nearby growth point and District Hospital.

The main livelihoods in the catchment area are irrigation schemes and agriculture, and livelihoods had been badly affected by poor rains during the qualitative research teams' visit. Members of the Marange Apostolic sect are found in this area, whose members religious beliefs do not normally permit visiting health facilities or taking pills to treat illness.

Facility 2

Facility 2 is about 20km from Facility 1. The clinic has a Mothers Waiting Shelter within the grounds, but no water source. The closest source of water is a borehole a short distance from the facility, although the water table is low. The catchment area served by the clinic is extremely large, covering five wards. Some communities on the periphery of the catchment area live very near the Zimbabwe border, and within these households it is common to spend months at a time during the year farming on the fertile lands in the border areas.

Facility 3

Facility 3 is very near the Zimbabwe border, in a remote area with extremely poor network connection. There is a Mothers Waiting Home and staff houses for 3 members of staff onsite, including the head nurse. Water for the facility is pumped in from a borehole off-site, and electricity is provided through solar power.

The catchment area consists of a single ward, in which the main livelihoods are farming. Communities living in the far end of the catchment area have access to relatively fertile land, and also earn livelihoods through gold panning and fishing around the river. Incomes are reasonably high compared to other catchment areas in this region due to the fertile soils, but households are vulnerable to poor rains. Migration across the border for farming is also common. Educational outcomes and literacy rates in the area are low and there is currently no secondary school in the area.

Facility 4

Facility 4 is an RDC run clinic serving a population of 8199 in the catchment area in 2016. The clinic appeared to be a low-volume facility, with three nurses. The consultation room was well-maintained. However, the store rooms and bathroom in the premise were in a state of disrepair. The clinic was electrified, but the delivery room did not have any power. The clinic had an improvised room to function as a mothers' waiting home.

There are some communities in the catchment area living 10-15 km away from the clinic, who find it hard to reach this clinic. There are plans to construct a second clinic so that people living very far from the clinic may have access to health services. The site for this has already been identified and the foundation has been dug.

The primary source of income is from farming crops and vegetables. Others earn money from cutting down trees and selling firewood or clearing land for farming. Over the last two years this has changed because of droughts and boreholes running dry.

Facility 5

Facility 5 is a government run clinic, and is situated in an extremely arid region in the district. The facility was staffed with 1 Registered General Nurse (currently at midwifery school), 1 Primary Care Nurse, 1 EHT and 1 General Hand. The clinic had no borehole or water at the facility and relied on the community has to bring water to the facility. The clinic had electricity, and very limited phone connectivity. There was an ANC and PNC ward and four newly built toilets in the facility.

The largest religious group in the community is Zion. Most community members utilise the facility's services, with the exception of the Johanne Marange Apostolic Church who do not use the hospital. There is one village in the catchment area that has built its own clinic, and other villages in the catchment area that were further away from the facility and found it hard to reach the facility, were hoping to do the same in the future.

Facility 6

Facility 5 was founded by the mission of the Seventh-Day Adventist Church. This facility has not received the intervention and was studied as a comparison site for the qualitative study. There is one head nurse and two PCNs that have been loaned to the clinic up to replace two PCNs who were attending a training programme at the time of the study.

The presence of commercial farming and resettlement plots meant that the homes were scattered across the catchment area with communities approximately 25km from the facility. Despite this, this was a high volume at the facility as people came from outside the catchment area to be treated. Support from the missionary, food to people in need and basic supplies for mothers at the waiting shelter, and cotton-wool and other basic medical supplies to people also encouraged utilisation. The clinic had electricity and water. There was a mothers waiting shelter, with a kitchen for the mothers as well.

2.2.4 Training and fieldwork

Training

The qualitative evaluation was carried out by 3 international staff and a team of 6 local researchers. The local researchers were trained for one week before starting fieldwork. The training included an introduction to the programme, the aims of the evaluation, the evaluation questions as well as the methods and tools that were used to obtain the answers. The training also covered logistics of the fieldwork and the protocols for data collection. During the training week we also piloted our approach and tools and to incorporated lessons learned into the final version of the research guide provided to the researchers. Table 6 Training schedule below provides an overview of the training week.

Table 6 Training schedule

Day	Aims of the day
Monday	Introducing the programme and evaluation Objective: to learn about the programme, what it aims to achieve and how, the purpose of evaluation and the key evaluation questions
Tuesday	An introduction to qualitative research: methods and principles, discussion of field approach and conduct
Wednesday	The interview questions and data collection tools, practice and role play
Thursday	Day off (National level interviews and fieldwork preparation)
Friday	Piloting of tools and approach in Shamva district
Saturday	Lessons learned/ update of research guide and questions / logistics

Fieldwork

Following the training, the fieldwork was carried out by two teams concurrently in the two district of Rushinga and Bulilima during the period 27th November to 6th December 2016.

The fieldwork was organised into 3 days at each site, with one day at the start to make introductions at the district and province level and carry out some interviews there. In each site, the teams spent one day working in and around the health facility to carry out interviews and FGDs, and one day working in the surrounding communities. The third day was spent carrying out any further interviews that could not be scheduled in the preceding two days, and writing up notes and discussing the overall findings from that site.

2.2.5 Analysis of data

Given the timeline for the production of the report after the fieldwork, and challenges in using voice recorders during the baseline, the evaluation made use of in-field data capturing and analysis. The teams were provided with protocols and templates to capture key findings, illustrative quotes and observations as well as visual evidence generated through the participatory tools and other photographic evidence.

The teams held daily debriefs to discuss and analyse finding from the day and in light of these, to discuss the key lessons, emerging themes and formulate areas of interest and focus for the next day. To prepare for the de-brief sessions, all researchers were asked to spend some time in the afternoon writing their notes up to highlight the key things they learned. These were then discussed at the de-briefing sessions facilitated by the team leaders. These discussions were captured in template, used to document learnings of the day. On the third day spent in each site, the teams had an additional day to write up their notes and discuss the major findings for each case.

Following the completion of the fieldwork, a two day debriefing session was held with both teams in Harare, where the findings from each of the six cases were discussed and compared with one another. Subsequent to the fieldwork, six country case study notes were written up by the two international lead researchers, and were subsequently analysed in conjunction with evidence gathered from other sources including the quantitative survey and written as part this “mixed-methods” evaluation report.

Our approach to capturing and analysing evidence for the qualitative research was to use consistent data-capturing and note-taking templates, where information was recorded against key themes. Daily team debriefs were them structured along these themes (rather than going through each individual interview or FGDs one by one), in order to facilitate the synthesis of evidence along the main lines of inquiry.

For our research at the community and health facility level, these primary themes were:

- HCC roles and functionality
- Patient satisfaction with services
- Patient awareness of rights and entitlements
- Community engagement with complaints mechanisms
- Responsiveness of decision makers to complaints
- Service quality
- Service utilisation, any recent changes and reasons for use or non-use of services.
- Local context
- What support has been provided by SCPH and views on sustainability

For our research at the national level, in respect of the advocacy strategy, the primary were:

- History and background to the health policy environment.
- Institutional context, key stakeholders and relations within the health policy space, including potential barriers to reform
- Background and current developments in each of the policy or reform areas highlighted by the advocacy strategy
- Reasons for any changes in the health policy space, (particularly around the areas highlighted by the advocacy strategy)
- What activities have been undertaken under the advocacy strategy, and how successful these were perceived to be

The rationale behind the approach toward capturing information along themes was to enable synthesis of all qualitative evidence against the different lines of inquiry that were the focus

of the qualitative study. By bringing together all the evidence in respect of a particular theme (and structuring daily team debriefs along these themes), this approach enabled the strength of evidence and likely contribution of SCPH toward the various results areas under investigation to be assessed, using the evaluative judgement of the research team.

2.2.6 Strategies for ensuring rigour

To ensure the rigor of our work, a number of steps and processes were put in place in order to minimise potential biases and to provide a clear basis for our inferences and analytical conclusions. The steps that were taken included:

- A clear sampling strategy that explained the justification for identification of the facilities visited, and individuals and groups spoken to;
- A comprehensive guide for the researchers that included the data collection tools, protocols and questions;
- One week of training for the research team and pilot testing of the tools and protocol;
- Fieldwork, led by OPM's own staff who were part of the data collection throughout, to ensure that evolving stories and their nuances would be adequately captured and reflected in the final report;
- Systematic collection of all data, through developed templates and guidelines on a daily basis and after each case in field;
- Daily debrief sessions, providing a platform for sharing each researchers' own learnings and conclusions and to member check these by comparison and discussion within the team;
- Triangulation of findings against different sources, both qualitative and quantitative and multiple rounds of analysis and discussions throughout the research process and the analysis phase to reduce the possibility of individual researcher bias (reflexivity), and;
- A comprehensive peer review process including internal and external reviewers during design, implementation, analysis and report production.

3 Results tables

3.1 How to read tables in this section

In this section we present the results from the quantitative analysis of primary and secondary data sources. Section 3.2 contains balance tables that report how similar the intervention and comparison groups in our data sources are in terms of their long term or pre-SCPH characteristics. Section 3.3 contains regression results to estimate the impact of SCPH on a range of key outcome variables.

3.1.1 How to read joint significant test tables

Joint significant test tables present the results of a test on whether a set of characteristics are found to be 'jointly' associated with whether or not a facility or patient was exposed to the SCPH intervention. This kind of test shows whether or not units exposed to the intervention are systematically different from the comparison group in terms of a combination of their long term of persistent characteristics.

- The columns in this table correspond to different data sources tested, or models within each data source (that is, different sets of variables on which joint significance was tested).
- Row 1 presents the F statistic associated with the joint significance test.
- Row 2 presents the p-value associated with that F-statistic, indicating the likelihood of obtaining that F-statistic if the true association between the set of variables and assignment to the intervention was zero.
- Row 3 shows the sample size.

3.1.2 How to read balance tables

Balance tables present the results of individual t-tests on the average values of a set of pre-intervention or long-term characteristics between the intervention and comparison groups. The tables contain the following information:

- Column 1 shows the comparison group mean, Column 2 the intervention group mean, and Column 3 the difference between them. Significance stars on the column reporting the difference shows whether that difference is significantly different from zero.
- The rows in the table contain information corresponding to the different variables tested.
- For each variable, the first row contains the estimated value (of the comparison mean, intervention mean and difference between them respectively). The second row contains the standard deviations of the estimated means in cases where the variable is continuous (we do not present standard deviations for binary outcomes where the means represent proportions) and the standard error associated with the difference. The third row contains sample sizes.

3.1.3 How to read regression results tables

We present one table for each outcome variable. The table has two parts – descriptive information on the left and regression results on the right.

- The first two columns of results contain descriptive information. Column 1 shows the mean outcome in the comparison group at endline, and Column 2 shows the mean in the intervention group.
- In these first two columns, the mean of the outcome is presented in the first row, with the standard deviation of the mean and sample size underneath.
- The remaining columns in the table contain regression results from a range of models tested.
- Each model is described first by whether it corresponds to an 'endline-data only' specification (that is, based on comparing the intervention and comparison groups at endline, or a 'panel dataset' specification (that is, based on a differences in differences model). This information is contained in the second row of the title section of the table.
- Models are also distinguished according to whether covariates or district level fixed effects were used in the specification. This is shown in the final two rows of the table.
- Regression results themselves are presented with the treatment estimate from each model in the first row, together with significance stars to indicate whether the effect is estimated to be significantly different from zero, with the standard error associated with that treatment estimate in the next row, followed by the sample size used to calculate the regression.

3.2 Balance tests

Balance tests on the endline data

Table 7 Joint significance tests of ANC and U5 patients indicators at endline

Joint significance tests of ANC and U5 patients indicators at endline				
	ANC patients indicators		U5 patients indicators	
	Model 1	Model 2	Model 1	Model 2
F statistic	1.442*	1.068	1.57**	1.333
P value	0.071	0.386	0.034	0.123
N	1156	1156	1543	1544

1. Results from a joint significance test of all 'persistent' characteristics of ANC and U5 patients on assignment to the intervention.
2. Model 1 includes the full set of balancing covariates, and Model 2 excludes the language of the respondent. Variables with many missing values were excluded, as were those which were collinear in the regression
3. * = p<0.1, ** = p<0.05, ***=p<0.00

Table 8 ANC patients indicators at endline

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Respondent's socioeconomic information				
Proportion of respondents with Shona as their first language	*Estimate*	96.77	88.22	-8.55**
				SE=1.31
	N	620	552	
Respondent's age	*Estimate*	26.06	26.01	-0.05
		SD=6.33	SD=6.46	SE=.24
	N	618	549	
Literacy				
Proportion of respondents who can read and write	*Estimate*	90.94	92.9	1.96
				SE=1.46
	N	618	549	
Proportion of respondents who can read only	*Estimate*	1.13	0.55	-0.59
				SE=.46
	N	618	549	
Proportion of respondents who can write only	*Estimate*	0.16	0.73	0.57
				SE=.16
	N	618	549	
Proportion of respondents who CANNOT read or write	*Estimate*	7.77	5.83	-1.94
				SE=1.33
	N	618	549	
Respondent's religion				
Apostolic faith	*Estimate*	56.47	59.93	3.45
				SE=2.34
	N	618	549	
Christian – (Pentecostal, Protestant, Roman Catholic)	*Estimate*	38.83	35.88	-2.95
				SE=2.46
	N	618	549	
Traditional	*Estimate*	0.32	0.91	0.59
				SE=.23
	N	618	549	
No religion	*Estimate*	3.56	2.91	-0.65
				SE=.8
	N	618	549	
Other	*Estimate*	0.81	0.36	-0.44
				SE=.41
	N	618	549	
Respondent's education level				
No education	*Estimate*	1.78	0.91	-0.87
				SE=.54
	N	618	549	

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Pre-school	*Estimate*	0	0	0
				SE=.
	N	622	553	
Primary education	*Estimate*	33.82	31.15	-2.67
				SE=2.29
	N	618	549	
Secondary education	*Estimate*	63.11	67.21	4.11
				SE=2.4
	N	618	549	
Tertiary education	*Estimate*	1.29	0.73	-0.57
				SE=.43
	N	618	549	
Travel to health facility				
Proportion of respondents reporting that the facility is the nearest one to their home	*Estimate*	94.33	94.67	0.34
				SE=1.13
	N	618	545	
Time take to travel to health facility (minutes)	*Estimate*	77.01	80.22	3.21
		SD=60.5	SD=66.87	SE=3.55
	N	611	537	
Proportion of respondents who walked to the health facility	*Estimate*	79.94	81.65	1.72
				SE=3.14
	N	618	545	
Household size	*Estimate*	4.71	4.68	-0.03
		SD=2.17	SD=2.1	SE=.11
	N	618	545	
Education level of the household head				
No education	*Estimate*	2.1	2.39	0.28
				SE=.65
	N	618	545	
Preschool level education	*Estimate*	0	0	0
				SE=.
	N	622	553	
Primary level education	*Estimate*	16.67	16.15	-0.52
				SE=1.63
	N	618	545	
Secondary level education	*Estimate*	70.06	69.36	-0.71
				SE=1.88
	N	618	545	
Tertiary level education	*Estimate*	3.56	2.2	-1.36
				SE=.85
	N	618	545	
Adult education or literacy classes	*Estimate*	0.16	0.55	0.39

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
				SE=.16
	N	618	545	
Other	*Estimate*	0	0	0
				SE=.
	N	622	553	
Unknown	*Estimate*	7.44	9.36	1.91
				SE=1
	N	618	545	
Proportion of households whose source of drinking water is…				
Piped into dwelling	*Estimate*	3.56	0.92	**-2.642***
				SE=1.37
	N	618	545	
Piped into yard/plot	*Estimate*	4.37	3.67	-0.7
				SE=.99
	N	618	545	
Public tap/ standpipe	*Estimate*	5.02	3.12	-1.9
				SE=1.22
	N	618	545	
Tube well or borehole	*Estimate*	46.76	51.01	4.25
				SE=3.67
	N	618	545	
Protected well	*Estimate*	20.06	18.9	-1.17
				SE=2.64
	N	618	545	
Unprotected well	*Estimate*	9.22	7.89	-1.33
				SE=1.69
	N	618	545	
Protected spring	*Estimate*	2.27	2.39	0.12
				SE=1.01
	N	618	545	
Unprotected spring	*Estimate*	1.78	1.83	0.05
				SE=.59
	N	618	545	
Rainwater	*Estimate*	0.16	0	-0.16
				SE=.16
	N	618	545	
Tanker truck	*Estimate*	0	0	0
				SE=.
	N	618	545	
Cart with a small tank	*Estimate*	0	0	0
				SE=.
	N	618	545	

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Surface water	*Estimate*	6.63	10.28	3.64
				SE=1.75
	N	618	545	
Bottled water	*Estimate*	0	0	0
				SE=.
	N	618	545	
Other source	*Estimate*	0.16	0	-0.16
				SE=.16
	N	618	545	
Proportion of households whose toilet facility is…				
Piped to sewer system	*Estimate*	3.07	2.2	-0.87
				SE=1.25
	N	618	545	
Flush to septic tank	*Estimate*	1.13	2.2	1.07
				SE=.56
	N	618	545	
Flush to pit latrine	*Estimate*	0.32	0.18	-0.14
				SE=.22
	N	618	545	
Pit latrine with a slab	*Estimate*	42.39	45.87	3.48
				SE=2.78
	N	618	545	
Pit latrine without slab	*Estimate*	11.33	9.54	-1.79
				SE=1.94
	N	618	545	
Other	*Estimate*	0	0	0
				SE=.
	N	618	545	
Proportion of households whose source of electricity is…				
Electricity is connected	*Estimate*	11.17	7.34	-3.83
				SE=2.27
	N	618	545	
Battery or generator	*Estimate*	41.1	42.39	1.28
				SE=3.16
	N	618	545	
Solar panel	*Estimate*	68.77	66.97	-1.8
				SE=2.78
	N	618	545	
Proportion of households that have…				
Radio	*Estimate*	68.28	65.14	-3.15
				SE=2.31
	N	618	545	

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
TV	*Estimate*	27.83	23.85	-3.98
				SE=2.59
	N	618	545	
Mobile phone	*Estimate*	89.64	88.81	-0.84
				SE=1.45
	N	618	545	
Non-mobile phone	*Estimate*	0.97	1.1	0.13
				SE=.37
	N	618	545	
Fridge	*Estimate*	5.02	5.69	0.67
				SE=1.18
	N	618	545	
Computer	*Estimate*	2.91	3.3	0.39
				SE=.79
	N	618	545	
Proportion of households in which a household member owns a…				
Bicycle	*Estimate*	39	43.3	4.31
				SE=2.13
	N	618	545	
Motorcycle or motor scooter	*Estimate*	3.24	4.04	0.8
				SE=.82
	N	618	545	
Animal drawn cart	*Estimate*	32.69	34.68	1.99
				SE=2.84
	N	618	545	
Car or truck	*Estimate*	10.19	7.71	-2.49
				SE=1.5
	N	618	545	
Tractor	*Estimate*	1.13	0.37	-0.77
				SE=.46
	N	618	545	
Wheelbarrow	*Estimate*	45.47	46.79	1.32
				SE=2.92
	N	618	545	
Proportion of households whose source of energy for cooking is…				
Electricity	*Estimate*	4.37	3.12	-1.25
				SE=1.26
	N	618	545	
Paraffin or kerosene	*Estimate*	0.49	2.02	**1.533****
				SE=.27
	N	618	545	
Wood	*Estimate*	93.85	93.39	-0.46

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
				SE=1.35
	N	618	545	
Proportion of households where cooking happens…				
In the house	*Estimate*	8.25	8.61	0.36
				SE=1.58
	N	618	546	
In a separate building	*Estimate*	82.36	80.59	-1.78
				SE=2.62
	N	618	546	
Outdoors	*Estimate*	9.22	10.62	1.4
				SE=1.52
	N	618	546	
Proportion of households where flooring material is…				
Earth or sand	*Estimate*	24.6	26.01	1.41
				SE=2.7
	N	618	546	
Dung	*Estimate*	6.15	9.34	3.19
				SE=1.92
	N	618	546	
Cement	*Estimate*	68.45	63.55	-4.89
				SE=2.59
	N	618	546	
Other material	*Estimate*	0	0.18	0.18
				SE=.
	N	618	546	
Proportion of households where roofing material is…				
Thatch	*Estimate*	29.13	36.45	**7.321***
				SE=2.45
	N	618	546	
Metal	*Estimate*	34.79	31.14	-3.65
				SE=2.67
	N	618	546	
Asbestos	*Estimate*	35.11	30.4	-4.71
				SE=3
	N	618	546	
Proportion of households where exterior wall material is…				
Mud	*Estimate*	12.62	12.82	0.2
				SE=1.93
	N	618	546	
Cement	*Estimate*	41.91	37.55	-4.36
				SE=2.75
	N	618	546	

ANC Patient's Indicators at endline				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Brick	*Estimate*	43.04	47.25	4.21
				SE=2.45
	N	618	546	
Other material	*Estimate*	0.16	0	-0.16
				SE=.16
	N	618	546	
Number of rooms in dwelling used for sleeping	*Estimate*	2.22	2.22	0
				SE=.06
	N	618	546	
Livestock				
Proportion of households that own any livestock	*Estimate*	81.88	83.85	1.98
				SE=2.44
	N	618	545	
Banking				
Proportion of households with at least 1 member that has a bank account	*Estimate*	20.87	20.92	0.04
				SE=1.89
	N	618	545	
Proportion of households with at least 1 member that owns a mobile save account	*Estimate*	14.4	14.13	-0.27
				SE=2.2
	N	618	545	

Table 9 U5 patients indicators

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Respondent's socioeconomic information				
Proportion of respondents with Shona as their first language		92.24	80.98	-11.265**
				SE=2.51
		851	715	
Respondent's age	*Estimate*	28.45	27.92	-0.53
		SD=8.16	SD=8.22	SE=.29
	N	846	710	
Literacy				
Proportion of respondents who can read and write	*Estimate*	90.58	92.98	2.4
				SE=1.44
	N	849	712	
Proportion of respondents who can read only	*Estimate*	0.59	0.42	-0.17
				SE=.26

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
	N	849	712	
Proportion of respondents who can write only	*Estimate*	0.82	0.7	-0.12
				SE=.3
	N	849	712	
Proportion of respondents who CANNOT read or write	*Estimate*	8.01	5.9	-2.11
				SE=1.29
	N	849	712	
Respondent's religion				
Apostolic faith	*Estimate*	50.18	52.95	2.77
				SE=2.49
	N	849	712	
Christian – (Pentecostal, Protestant, Roman Catholic)	*Estimate*	44.76	42.28	-2.48
				SE=2.77
	N	849	712	
Traditional	*Estimate*	0.47	0.42	-0.05
				SE=.29
	N	849	712	
No religion	*Estimate*	4.12	3.79	-0.33
				SE=.84
	N	849	712	
Other	*Estimate*	0.47	0.56	0.09
				SE=.23
	N	849	712	
Respondent's education level				
No education	*Estimate*	3.42	1.26	**-2.152****
				SE=.78
	N	849	712	
Pre-school	*Estimate*	0	0	0
				SE=.
	N	858	720	
Primary education	*Estimate*	31.92	33.85	1.93
				SE=2.13
	N	849	712	
Secondary education	*Estimate*	63.02	63.34	0.33
				SE=2.2
	N	849	712	
Tertiary education	*Estimate*	1.65	1.54	-0.1
				SE=.41
	N	849	712	
Travel to health facility				
Proportion of respondents reporting that the facility is the nearest one to their home	*Estimate*	94.09	96.62	**2.53****
				SE=.94

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
	N	847	710	
Time take to travel to health facility (minutes)	*Estimate*	72.66	76.69	4.03
		SD=57.21	SD=56.58	SE=2.62
	N	836	703	
Proportion of respondents who walked to the health facility	*Estimate*	83.94	89.72	**5.775****
				SE=2.27
	N	847	710	
Household size	*Estimate*	5.46	5.21	**-.251****
				SE=.1
	N	846	708	
Education level of the household head				
No education	*Estimate*	2.13	2.97	0.84
				SE=.53
	N	846	708	
Preschool level education	*Estimate*	0.12	0	-0.12
				SE=.12
	N	846	708	
Primary level education	*Estimate*	19.03	24.15	**5.122****
				SE=1.57
	N	846	708	
Secondary level education	*Estimate*	65.37	64.27	-1.1
				SE=1.98
	N	846	708	
Tertiary level education	*Estimate*	4.49	4.1	-0.4
				SE=.98
	N	846	708	
Adult education or literacy classes	*Estimate*	0.24	0.28	0.05
				SE=.17
	N	846	708	
Other	*Estimate*	0.12	0	-0.12
				SE=.12
	N	846	708	
Unknown	*Estimate*	8.51	4.24	**-4.273*****
				SE=1.13
	N	846	708	
Proportion of households whose source of drinking water is…				
Piped into dwelling	*Estimate*	2.84	0.85	**-1.989***
				SE=1.08
	N	846	708	
Piped into yard/plot	*Estimate*	2.84	3.53	0.69
				SE=.69
	N	846	708	

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Public tap/ standpipe	*Estimate*	2.72	2.12	-0.6
				SE=.77
	N	846	708	
Tube well or borehole	*Estimate*	48.7	51.41	2.71
				SE=3.27
	N	846	708	
Protected well	*Estimate*	22.22	21.05	-1.18
				SE=2.6
	N	846	708	
Unprotected well	*Estimate*	9.57	8.76	-0.82
				SE=1.35
	N	846	708	
Protected spring	*Estimate*	1.18	1.84	0.65
				SE=.42
	N	846	708	
Unprotected spring	*Estimate*	1.54	1.55	0.02
				SE=.43
	N	846	708	
Rainwater	*Estimate*	0	0	0
				SE=.
	N	846	708	
Tanker truck	*Estimate*	0.12	0	-0.12
				SE=.12
	N	846	708	
Cart with a small tank	*Estimate*	0	0	0
				SE=.
	N	846	708	
Surface water	*Estimate*	8.16	8.76	0.6
				SE=1.47
	N	846	708	
Bottled water	*Estimate*	0	0	0
				SE=.
	N	846	708	
Other source	*Estimate*	0.12	0.14	0.02
				SE=.12
	N	846	708	
Proportion of households whose toilet facility is…				
Piped to sewer system	*Estimate*	2.48	0.85	-1.63
				SE=1.06
	N	846	708	
Flush to septic tank	*Estimate*	1.89	0.99	-0.9
				SE=.48

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
	N	846	708	
Flush to pit latrine	*Estimate*	0.24	0	-0.24
				SE=.24
	N	846	708	
Pit latrine with a slab	*Estimate*	44.8	47.46	2.66
				SE=2.77
	N	846	708	
Pit latrine without slab	*Estimate*	11.35	10.31	-1.04
				SE=1.85
	N	846	708	
Other	*Estimate*	0.12	0.14	0.02
				SE=.12
	N	846	708	
Proportion of households whose source of electricity is…				
Electricity is connected	*Estimate*	8.39	5.79	-2.6
				SE=1.7
	N	846	708	
Battery or generator	*Estimate*	43.74	43.22	-0.51
				SE=2.48
	N	846	708	
Solar panel	*Estimate*	68.68	67.09	-1.59
				SE=2.01
	N	846	708	
Proportion of households that have…				
Radio	*Estimate*	64.78	62.01	-2.77
				SE=1.87
	N	846	708	
TV	*Estimate*	25.89	20.48	**-5.406****
				SE=1.82
	N	846	708	
Mobile phone	*Estimate*	87.23	89.27	2.03
				SE=1.33
	N	846	708	
Non-mobile phone	*Estimate*	1.77	0.71	**-1.067***
				SE=.45
	N	846	708	
Fridge	*Estimate*	6.15	3.81	-2.33
				SE=1.18
	N	846	708	
Computer	*Estimate*	4.26	3.53	-0.72
				SE=.85
	N	846	708	

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Proportion of households in which a household member owns a…				
Bicycle	*Estimate*	41.61	36.3	**-5.308***
				SE=2.31
	N	846	708	
Motorcycle or motor scooter	*Estimate*	3.07	2.4	-0.67
				SE=.64
	N	846	708	
Animal drawn cart	*Estimate*	29.67	31.5	1.83
				SE=2.3
	N	846	708	
Car or truck	*Estimate*	8.63	5.93	**-2.697***
				SE=.97
	N	846	708	
Tractor	*Estimate*	0.59	0.14	-0.45
				SE=.31
	N	846	708	
Wheelbarrow	*Estimate*	48.58	50.42	1.84
				SE=2.23
	N	846	708	
Proportion of households whose source of energy for cooking is…				
Electricity	*Estimate*	3.43	2.54	-0.89
				SE=.81
	N	846	708	
Paraffin or kerosene	*Estimate*	0.12	0.56	0.45
				SE=.12
	N	846	708	
Wood	*Estimate*	95.51	95.9	0.4
				SE=.87
	N	846	708	
Proportion of households where cooking happens…				
In the house	*Estimate*	8.04	8.76	0.72
				SE=1.34
	N	846	708	
In a separate building	*Estimate*	83.45	83.19	-0.26
				SE=2.13
	N	846	708	
Outdoors	*Estimate*	8.16	7.77	-0.39
				SE=1.23
	N	846	708	
Proportion of households where flooring material is…				
Earth or sand	*Estimate*	23.17	26.41	3.24

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
				SE=2.58
	N	846	708	
Dung	*Estimate*	5.56	5.79	0.24
				SE=1.03
	N	846	708	
Cement	*Estimate*	69.86	66.81	-3.05
				SE=2.45
	N	846	708	
Proportion of households where roofing material is…				
Household doesn't have a roof	*Estimate*	0	0	0
				SE=.
	N	846	708	
Thatch	*Estimate*	30.5	34.75	4.25
				SE=2.37
	N	846	708	
Metal	*Estimate*	31.68	30.79	-0.89
				SE=2.18
	N	846	708	
Asbestos	*Estimate*	35.46	31.92	-3.54
				SE=2.69
	N	846	708	
Proportion of households where exterior wall material is…				
Mud	*Estimate*	12.29	14.27	1.97
				SE=1.75
	N	846	708	
Cement	*Estimate*	45.63	38.98	**-6.643***
				SE=2.57
	N	846	708	
Brick	*Estimate*	39.6	43.93	4.33
				SE=2.27
	N	846	708	
Other material	*Estimate*	0.83	0.14	-0.69
				SE=.51
	N	846	708	
Number of rooms in dwelling used for sleeping	*Estimate*	2.3	2.25	-0.05
				SE=.05
	N	846	708	
Livestock				
Proportion of households that own any livestock	*Estimate*	83.57	83.76	0.19
				SE=1.78
	N	846	708	
Banking				

U5 Carer's Indicators				
		Comparison mean at endline	Intervention mean at endline	Difference in means
Proportion of households with at least 1 member that has a bank account	*Estimate*	21.51	19.92	-1.6
				SE=1.67
	N	846	708	
Proportion of households with at least 1 member that owns a mobile save account	*Estimate*	15.13	11.86	-3.27
				SE=2.27
	N	846	708	

Balance tests on the baseline data

Table 10 Joint significance tests of HCC and facility Head Nurse data

Joint significance tests of HCC and facility Head Nurse		
	HCC indicators	Facility Head Nurse indicators
F statistic	1.599	0.552
P value	0.072*	0.863
N	129	119

1. Results from a joint significance test of covariates in the HCC and facility Head Nurse data. Variables with many missing values were excluded, as were those which were collinear in the regression
2. * = p<0.1, ** = p<0.05, ***=p<0.00

Table 11 HCC respondents' indicators at baseline

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
Proportion of HCC respondents who are…				
Chairperson	*Estimate*	60.76	69.7	8.94
				SE=5.51
	N	79	66	
Vice Chairperson	*Estimate*	15.19	13.64	-1.55
				SE=4.05
	N	79	66	
Treasurer	*Estimate*	18.99	15.15	-3.84
				SE=4.43
	N	79	66	
Vice Secretary	*Estimate*	1.27	1.52	0.25
				SE=1.26
	N	79	66	
Other leadership	*Estimate*	3.8	0	-3.797*
				SE=2.16
	N	79	66	
Proportion of male HCC respondents	*Estimate*	78.21	77.27	-0.93
				SE=4.69
	N	79	66	
Proportion of facilities that				
Have an operational/annual plan	*Estimate*	92.21	89.23	-2.98
				SE=3.07
	N	79	66	

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
Proportion of HCC members that identify their HCC as…				
HCCs	*Estimate*	84.81	87.88	3.07
				SE=4.05
	N	79	66	
Sub Health committees	*Estimate*	0	1.52	1.52
				SE=.
	N	79	66	
Ward Health Committees	*Estimate*	13.92	9.09	-4.83
				SE=3.91
	N	79	66	
Other	*Estimate*	1.27	1.52	0.25
				SE=1.26
	N	79	66	
Age in years of HCC	*Estimate*	8.51	4	**-4.514*** **
		SD=8.57	SD=3.62	SE=1.41
	N	37	30	
Number of HCC members…				
Total	*Estimate*	8.74	8.6	-0.14
		SD=3.15	SD=2.96	SE=.36
	N	78	65	
Male	*Estimate*	4.76	4.71	-0.05
		SD=2.06	SD=2.08	SE=.23
	N	79	66	
Female	*Estimate*	4	3.92	-0.08
		SD=2.3	SD=1.97	SE=.26
	N	79	66	
Proportion of HCCs with representation of…				
Nurse in Charge	*Estimate*	96.2	95.45	-0.75
				SE=2.16
	N	79	66	
Ordinary community members	*Estimate*	91.14	93.94	2.8
				SE=3.21
	N	79	66	
Political leader (e.g. councillor)	*Estimate*	74.68	75.76	1.07
				SE=4.91
	N	79	66	
Traditional community leader	*Estimate*	68.35	65.15	-3.2
				SE=5.25
	N	79	66	
Community Health Worker	*Estimate*	63.29	68.18	4.89
				SE=5.44
	N	79	66	
Church representative	*Estimate*	55.7	45.45	-10.24
				SE=5.61
	N	79	66	
Other Health Facility staff	*Estimate*	44.3	54.55	10.24
				SE=5.61
	N	79	66	
Government Extension workers	*Estimate*	48.1	42.42	-5.68
				SE=5.64
	N	79	66	
School headmaster/Health Master	*Estimate*	34.18	48.48	**14.308***
				SE=5.35

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
	N	79	66	
Youth Organisation	*Estimate*	36.71	28.79	-7.92
				SE=5.44
	N	79	66	
NGO/CSO	*Estimate*	15.19	21.21	6.02
				SE=4.05
	N	79	66	
Proportion of HCCs with a…				
Chairperson	*Estimate*	92.41	92.42	0.02
				SE=2.99
	N	79	66	
Vice chair	*Estimate*	79.75	80.3	0.56
				SE=4.54
	N	79	66	
Treasurer	*Estimate*	92.41	92.42	0.02
				SE=2.99
	N	79	66	
Secretary	*Estimate*	91.03	92.42	1.4
				SE=3.25
	N	79	66	
HCC meetings				
Proportion of HCCs that have met to discuss health issues at least once in past 12 months	*Estimate*	1	1	0
				SE=.
	N	79	66	
Proportion of HCCs that record minutes of meetings in the past 12 months	*Estimate*	97.37	100	2.63
				SE=1.84
	N	77	66	
HCC interaction with their local community				
Proportion of HCCs that have met with the community to get feedback in the past 12 months	*Estimate*	81.01	90.91	**9.896***
				SE=4.43
	N	79	66	
Proportion of HCCs that recorded their meetings with the community	*Estimate*	71.43	70	-1.43
				SE=5.71
	N	64	60	
HCC interaction with the DHE				
Proportion of HCCs that participate in district level meetings with the District Health Executive	*Estimate*	53.16	63.64	10.47
				SE=5.63
	N	79	66	
Proportion of HCCs that never kept up to date on health developments by DHE	*Estimate*	3.85	3.08	-0.77
				SE=2.19
	N	78	65	
Proportion of HCCs that rarely kept up to date on health developments by DHE	*Estimate*	3.85	13.85	**10.0****
				SE=2.19
	N	78	65	
Proportion of HCCs that sometimes kept up to date on health developments by DHE	*Estimate*	21.79	18.46	-3.33
				SE=4.69
	N	78	65	
Proportion of HCCs that often kept up to date on health developments by DHE	*Estimate*	21.79	21.54	-0.26
				SE=4.69
	N	78	65	
Proportion of HCCs that always kept up to date on health developments by DHE	*Estimate*	48.72	43.08	-5.64
				SE=5.68
	N	78	65	

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
HCC Handbook				
Proportion of HCCs with a copy of HCC handbook	*Estimate*	29.49	34.85	5.36
				SE=5.18
	N	79	66	
Patient's Charter				
Proportion of HCCs with copy of Patient's charter	*Estimate*	20.25	37.88	**17.626****
				SE=4.54
	N	79	66	
Display MNCH Statistics				
Proportion of HCCs that display MNCH statistics, including current month	*Estimate*	11.54	12.31	0.77
				SE=3.63
	N	78	65	
Proportion of HCCs that display MNCH statistics, but not for this month	*Estimate*	19.23	26.15	6.92
				SE=4.48
	N	78	65	
Proportion of HCC that DO NOT record and display MNCH statistics	*Estimate*	69.23	61.54	-7.69
				SE=5.24
	N	78	65	
HCC reports on MNCH				
Proportion of HCCs that submit written reports on MNCH access	*Estimate*	32.91	37.88	4.97
				SE=5.31
	N	79	66	
HCC monitoring				
Proportion of HCCs that monitor health facilities	*Estimate*	96.2	96.92	0.72
				SE=2.16
	N	79	66	
Proportion of health facilities that record HCC monitoring visits	*Estimate*	32.89	28.57	-4.32
				SE=5.41
	N	76	63	
Fund raising				
Proportion of HCCs who in past 12 months had a plan to raise money	*Estimate*	59.49	53.03	-6.46
				SE=5.54
	N	79	66	
Proportion of HCCs that actually raised any money in past 12 months	*Estimate*	34.18	25.76	-8.42
				SE=5.35
	N	79	66	
Proportion of HCCs that implemented their own initiatives in the community to improve health.	*Estimate*	65.38	66.67	1.28
				SE=5.41
	N	79	66	
Proportion of HCCs in which the following make the decision on finances…				
Chairperson	*Estimate*	100	96.97	-3.03
				SE=.
	N	79	66	
Vice Chairperson	*Estimate*	55.7	42.42	-13.27
				SE=5.61
	N	79	66	
Treasurer	*Estimate*	82.28	83.33	1.05
				SE=4.31
	N	79	66	
Secretary	*Estimate*	78.48	78.79	0.31

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
				SE=4.64
	N	79	66	
Health Workers	*Estimate*	51.9	51.52	-0.38
				SE=5.64
	N	79	66	
Proportion of HCCs that report instances where decisions are sometimes made by one person	*Estimate*	2.53	3.03	0.5
				SE=1.77
	N	79	66	
Proportion of HCC respondents that…				
Believe discussions held in HCC contribute to improvement of people's health	*Estimate*	98.73	98.48	-0.25
				SE=1.26
	N	79	66	
Believe they need additional support to perform HCC duties effectively	*Estimate*	97.47	95.38	-2.08
				SE=1.77
	N	79	66	
Face challenges that affect delivery of responsibilities	*Estimate*	82.05	90.77	8.72
				SE=4.36
	N	79	66	
Proportion of HCCs in which current members have received training to help with their job.	*Estimate*	73.42	89.39	**15.976****
				SE=4.99
	N	79	66	
***Of those who have received training*, proportion of HCCs that have received training by…**				
District Health Team	*Estimate*	79.31	66.1	-13.21
				SE=5.34
	N	58	59	
Other Ministry of Health staff	*Estimate*	53.45	49.15	-4.3
				SE=6.58
	N	58	59	
Health staff at health facility	*Estimate*	29.31	18.64	-10.67
				SE=6
	N	58	59	
Other NGO	*Estimate*	15.52	27.12	11.6
				SE=4.77
	N	58	59	
Save the Children	*Estimate*	6.9	18.64	**11.748***
				SE=3.34
	N	58	59	
Community Working Group on Health	*Estimate*	8.62	10.17	1.55
				SE=3.7
	N	58	59	
Crown agents	*Estimate*	1.72	6.78	5.06
				SE=1.72
	N	58	59	
CORDAID	*Estimate*	1.72	3.39	1.67
				SE=1.72
	N	58	59	
Other	*Estimate*	8.62	6.78	-1.84
				SE=3.7
	N	58	59	
Do not know	*Estimate*	8.62	8.47	-0.15
				SE=3.7
	N	58	59	
***Of those who have received training,* proportion of HCCs in which the training received was on…**				
Monitoring and tracking budgets	*Estimate*	67.24	67.24	0
				SE=6.19

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
	N	58	59	
Functions of a health centre committee	*Estimate*	67.24	62.71	-4.53
				SE=6.19
	N	58	59	
Preparing and analysing budgets	*Estimate*	53.45	49.15	-4.3
				SE=6.58
	N	58	59	
Organizing and mobilizing communities for health	*Estimate*	41.38	52.54	11.16
				SE=6.49
	N	58	59	
Mobilizing financial resources	*Estimate*	37.93	40.68	2.75
				SE=6.4
	N	58	59	
Communication skills	*Estimate*	25.86	32.2	6.34
				SE=5.77
	N	58	59	
Developing health development plans	*Estimate*	29.31	28.81	-0.5
				SE=6
	N	58	59	
Holding meetings	*Estimate*	25.86	23.73	-2.13
				SE=5.77
	N	58	59	
Implementing and monitoring health plans	*Estimate*	24.14	25.42	1.29
				SE=5.64
	N	58	59	
How to work with health workers	*Estimate*	20.69	27.12	6.43
				SE=5.34
	N	58	59	
Patients' rights and entitlements	*Estimate*	18.97	28.81	9.85
				SE=5.17
	N	58	59	
Advocating and negotiating health issues	*Estimate*	22.41	22.03	-0.38
				SE=5.5
	N	58	59	
Writing or presenting reports	*Estimate*	13.79	18.64	4.85
				SE=4.55
	N	58	59	
How to work with different stakeholders	*Estimate*	8.62	15.25	6.63
				SE=3.7
	N	58	59	
Other health issues	*Estimate*	0	5.17	**5.172***
				SE=.
	N	58	59	
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	*Estimate*	98.59	96.55	-2.04
				SE=1.4
	N	71	58	
Proportion of health facilities that received any money in the past 12 months from…				
RBF	*Estimate*	2.6	3.13	0.53
				SE=1.82
	N	77	64	
HSF	*Estimate*	2.6	3.13	0.53
				SE=1.82
	N	77	64	

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
HTF	*Estimate*	94.81	92.19	-2.62
				SE=2.54
	N	77	64	
None of them	*Estimate*	0	1.56	1.56
				SE=.
	N	77	64	
Of those that received money…				
Amount of funding received from HSF, HTF or RBF (USD)…				
Q1 2013	*Estimate*	2419.37	2671.21	251.84
		SD=1022.64	SD=1309.85	SE=141.81
	N	52	39	
Q2 2013	*Estimate*	2050.12	2293.62	243.49
		SD=742.35	SD=808.78	SE=115.94
	N	41	26	
Q3 2013	*Estimate*	2628.04	2495.52	-132.52
		SD=3083.23	SD=859.48	SE=445.03
	N	48	25	
Q4 2013	*Estimate*	2410.96	2607.53	196.57
		SD=1340	SD=1051.52	SE=184.06
	N	53	34	
Proportion of HCCs that were involved in determining how funds from RBF, HTF and HSF were used	*Estimate*	97.4	93.65	-3.75
				SE=1.82
	N	77	63	
Proportion of HCCs that feel expenditure by health facility was				
Fully in line with priorities	*Estimate*	84	80.95	-3.05
				SE=4.25
	N	75	63	
Partly in line with priorities	*Estimate*	14.67	15.87	1.21
				SE=4.1
	N	75	63	
Not at all in line with priorities	*Estimate*	1.33	3.17	1.84
				SE=1.33
	N	75	63	
Banking				
Proportion of HCCs signatory to health facility's bank accounts	*Estimate*	89.61	85.71	-3.9
				SE=3.49
	N	77	63	
Proportion of HCCs with separate bank accounts	*Estimate*	22.78	27.27	4.49
				SE=4.74
	N	79	66	
Proportion of HCCs that obtain information on patient opinion on quality care and overall	*Estimate*	89.74	95.45	5.71
				SE=3.45
	N	79	66	
Proportion of HCCs that keep a record of complaints about health facility from community in past 12 months	*Estimate*	49.37	53.03	3.66
				SE=5.64
	N	79	66	
Proportion of HCCs with a mechanism to inform the health facility staff about patient opinion or complaints, apart from regular HCC meetings	*Estimate*	55.7	59.09	3.39
				SE=5.61
	N	79	66	
Proportion of HCCs that report that health facility staff are…				
Not at all responsive to complaints	*Estimate*	1.28	3.17	1.89
				SE=1.28

HCC respondents indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
	N	78	63	
Rarely responsive to complaints	*Estimate*	3.85	7.94	4.09
				SE=2.19
	N	78	63	
Often responsive to complaints	*Estimate*	30.77	30.16	-0.61
				SE=5.24
	N	78	63	
Very responsive to complaints	*Estimate*	64.1	58.73	-5.37
				SE=5.45
	N	78	63	
Proportion of HCCs that report that the DHE is…				
Not at all responsive to suggestions	*Estimate*	5.19	1.56	-3.63
				SE=2.54
	N	77	64	
Rarely responsive to suggestions	*Estimate*	18.18	10.94	-7.24
				SE=4.41
	N	77	64	
Often responsive to suggestions	*Estimate*	38.96	43.75	4.79
				SE=5.58
	N	77	64	
Very responsive to suggestions	*Estimate*	37.66	43.75	6.09
				SE=5.54
	N	77	64	

Table 12 Facility Head Nurse Indicators at baseline

Facility head nurse indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
Population under health facility's catchment…				
Total catchment population	*Estimate*	7638.65	8175.72	537.07
		SD=7621.45	SD=3876.33	SE=852.1
	N	80	66	
Male catchment population	*Estimate*	3676.37	3980.06	303.69
		SD=2340.63	SD=1788.6	SE=450.45
	N	80	66	
Female catchment population	*Estimate*	4170.03	4630.41	460.38
		SD=3778.47	SD=1652.88	SE=701.65
	N	80	66	
Female 15-49 catchment population	*Estimate*	1608.18	1958.09	**349.911***
		SD=1106.98	SD=1092.45	SE=131.37
	N	80	66	
Under 5 catchment population	*Estimate*	1055.3	1418.64	**363.338****
		SD=710.91	SD=936.18	SE=87.51
	N	80	66	
Under 1 catchment population	*Estimate*	223.88	281.17	57.29
		SD=162.06	SD=245.61	SE=18.84
	N	80	66	
Proportion of health facilities headed by…				
Primary Care Nurse	*Estimate*	48.75	53.73	4.98
				SE=5.61
	N	80	67	
State Registered Nurse	*Estimate*	36.25	37.31	1.06
				SE=5.39
	N	80	67	

Facility head nurse indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
Nurse Midwife	*Estimate*	6.25	2.99	-3.26
				SE=2.72
	N	80	67	
State Certified Nurse	*Estimate*	3.75	4.48	0.73
				SE=2.13
	N	80	67	
State Certified Maternity Nurse	*Estimate*	3.75	0	**-3.75***
				SE=2.13
	N	80	67	
Other	*Estimate*	1.25	1.49	0.24
				SE=1.25
	N	80	67	
Number of visits to community health workers for supervision purposes, past 3 months	*Estimate*	3.96	3.64	-0.33
		SD=3.86	SD=3.54	SE=.43
	N	80	67	
Proportion of health facilities in which the following committees are set up…				
HCC	*Estimate*	60	58.21	-1.79
				SE=5.5
	N	80	67	
Sub-health committee	*Estimate*	1.25	0	-1.25
				SE=1.25
	N	80	67	
Ward health committee	*Estimate*	12.5	7.46	-5.04
				SE=3.71
	N	80	67	
HCC and sub-health committee	*Estimate*	3.75	1.49	-2.26
				SE=2.13
	N	80	67	
HCC and Ward health committee	*Estimate*	21.25	28.36	7.11
				SE=4.59
	N	80	67	
Sub-health and ward health committee	*Estimate*	0	0	0
				SE=.
	N	80	67	
HCC, sub, and ward committee	*Estimate*	1.25	2.99	1.74
				SE=1.25
	N	80	67	
No committee	*Estimate*	0	1.49	1.49
				SE=.
	N	80	67	
Number of HCC meetings in the past 12 months	*Estimate*	8.9	9.84	0.94
		SD=4.92	SD=6.22	SE=.58
	N	80	66	
Proportion of facilities in which HCC implemented a new initiative in the past 12 months	*Estimate*	85.9	80.95	-4.95
				SE=3.95
	N	80	66	
Proportion of facilities in which HCC conducted other roles apart from "new initiatives" in the past 12 months.	*Estimate*	67	51	
		79.75	64.62	**-15.131****
	N			SE=4.54
	Estimate	80	66	
Proportion of health facilities with an operational plan…				
For current year, existent and seen	*Estimate*	71.25	67.69	-3.56

Facility head nurse indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
				SE=5.08
	N	80	65	
For current year, existent but not seen	*Estimate*	22.5	20	-2.5
				SE=4.68
	N	80	65	
For current year, non-existent	*Estimate*	6.25	12.31	6.06
				SE=2.72
	N	80	65	
Number of visits in the past 3 months from…				
HCC representative	*Estimate*	7.65	6.4	-1.24
		SD=12.1	SD=6.73	SE=1.36
	N	80	67	
Rural District Council representative	*Estimate*	0.5	0.63	0.13
		SD=.85	SD=1.24	SE=.1
	N	80	67	
DHE member	*Estimate*	3.66	3.87	0.2
		SD=3.25	SD=3.62	SE=.36
	N	80	67	
Banking				
Proportion of health facilities with a bank account	*Estimate*	86.25	79.1	-7.15
				SE=3.86
	N	80	67	
Proportion of health facilities with a CBZ bank account	*Estimate*	50	41.79	-8.21
				SE=5.61
	N	80	67	
Proportion of health facilities with another type of bank account	*Estimate*	30	31.34	1.34
				SE=5.14
	N	80	67	
Proportion of health facilities with a metropolitan bank account	*Estimate*	6.25	5.97	-0.28
				SE=2.72
	N	80	67	
Proportion of health facilities that received any money from HSF, RBF or HTF in past 12 months	*Estimate*	98.75	98.48	-0.27
				SE=1.25
	N	80	67	
Amount of funding received from HSF, HTF or RBF (USD)…				
Q1 2013	*Estimate*	1992.15	1916.76	-75.39
		SD=1249.08	SD=1620.43	SE=151.47
	N	79	65	
Q2 2013	*Estimate*	1806.86	1396.08	**-410.78***
		SD=1089.43	SD=1289.21	SE=135.13
	N	79	65	
Q3 2013	*Estimate*	2320.41	1459.39	**-861.014*****
		SD=1144.12	SD=1292.62	SE=143.01
	N	79	65	
Q4 2013	*Estimate*	2171.96	2212.33	40.38
		SD=950.83	SD=1621.72	SE=116.16
	N	79	65	
Proportion of health facilities that used funding for…				
Buying Supplies	*Estimate*	96.2	84.62	**-11.587****
				SE=2.16
	N	79	65	
Repairs	*Estimate*	79.75	75.38	-4.36

Facility head nurse indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
				SE=4.54
	N	79	65	
New infrastructure	*Estimate*	62.03	69.23	7.21
				SE=5.48
	N	79	65	
Transportation	*Estimate*	59.49	49.23	-10.26
				SE=5.54
	N	79	65	
Environmental sanitation	*Estimate*	41.77	49.23	7.46
				SE=5.57
	N	79	65	
Food provision	*Estimate*	37.97	43.08	5.1
				SE=5.48
	N	79	65	
Security	*Estimate*	26.58	27.69	1.11
				SE=4.99
	N	79	65	
Admin Support	*Estimate*	29.11	15.38	**-13.729****
				SE=5.13
	N	79	65	
Sensitization / mobilizing community	*Estimate*	12.66	6.15	-6.5
				SE=3.75
	N	79	65	
Janitorial services	*Estimate*	6.33	10.77	4.44
				SE=2.75
	N	79	65	
Support outreach teams	*Estimate*	8.86	6.15	-2.71
				SE=3.21
	N	79	65	
Training for community health workers	*Estimate*	3.8	4.62	0.82
				SE=2.16
	N	79	65	
Proportion of health facilities in which the following are involved in deciding the use of funds…				
Facility staff	*Estimate*	87.34	83.08	-4.26
				SE=3.75
	N	79	65	
Facility head nurse	*Estimate*	82.28	84.62	2.34
				SE=4.31
	N	79	65	
HCC	*Estimate*	78.48	84.62	6.13
				SE=4.64
	N	79	65	
MoH/ DHE team	*Estimate*	25.32	20	-5.32
				SE=4.91
	N	79	65	
Ward health	*Estimate*	18.99	23.08	4.09
				SE=4.43
	N	79	65	
Community Health Workers	*Estimate*	15.19	21.54	6.35
				SE=4.05
	N	79	65	
Community members	*Estimate*	17.72	15.38	-2.34
				SE=4.31
	N	79	65	
School head	*Estimate*	6.33	7.69	1.36

Facility head nurse indicators				
		Comparison mean at baseline	Intervention mean at baseline	Difference in means
				SE=2.75
	N	79	65	
Church leader	*Estimate*	7.59	6.15	-1.44
				SE=2.99
	N	79	65	
NGO staff	*Estimate*	3.8	3.08	-0.72
				SE=2.16
	N	79	65	
Other	*Estimate*	2.53	4.62	2.08
				SE=1.77
	N	79	65	
Proportion of health facilities owned by…				
Council/local government	*Estimate*	55.7	59.09	3.39
				SE=5.61
	N	79	66	
National Government	*Estimate*	36.71	39.39	2.69
				SE=5.44
	N	79	66	
Mission/faith based organisation	*Estimate*	6.33	1.52	-4.81
				SE=2.75
	N	79	66	
NGO	*Estimate*	1.27	0	-1.27
				SE=1.26
	N	79	66	
Proportion of health facilities in which a formal mechanism for HCC to receive complaints exits	*Estimate*	45	60.61	**15.606***
				SE=5.58
	N	80	66	

3.3 Regression results

3.3.1 HCC performance

HCC engagement with the community

Table 13 Proportion of HCCs that met with the community at least once in the past 12 months

Proportion of HCCs that met with the community at least once in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that met with the community at least once in the past 12 months		76.25	95.65	19.402***	23.786***	17.190***	21.556***
	SE			(5.372)	(5.262)	(5.274)	(5.335)
	N	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 14 Among HCCs that met with the community, the number of meetings held in the past 12 months

Among HCCs that meet with the community, the number of meetings held in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among HCCs that meet with the community, the number of meetings held in the past 12 months		4.88	5.44	0.556	0.003	0.014	-0.243
	SE	SD=3.93	SD=3.93	(0.718)	(0.723)	(0.731)	(0.824)
	N	61	66	120	115	103	101

	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

HCC engagement with heath facilities

Table 15 Proportion of HCCs that made visits to the health facility for monitoring

Proportion of HCCs that made visits to the health facility for monitoring							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that made visits to the health facility for monitoring		95	98.55	3.551	5.092	3.403	4.824
	SE			(2.839)	(3.576)	(2.849)	(3.526)
	N	80	69	149	143	144	141
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 16 Among HCCs that made visits to the health facility for monitoring, number of monitoring visits in the past 12 months

Among HCCs that make visits to the health facility for monitoring, the average number of monitoring visits in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among HCCs that make visits to the health facility for monitoring,		23.2	29.25	6.055	4.93	7.057	5.763
	SE	SD=20.57	SD=43.22	(6.568)	(5.659)	(8.391)	(6.085)

the average number of monitoring visits in the past 12 months	*N*	76	68	116	110	99	97
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 17 Proportion of HCCs that held any meetings in the past 12 months

Proportion of HCs that held any meetings in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that held any meetings in the past 12 months		100	100	0	0	0	0
	SE			(.)	(.)	(.)	(.)
	N	80	69	149	143	143	140
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 18 Among HCCs that hold internal meetings, the average number of meetings held in the past 12 months

Among HCCs that hold internal meetings, the average number of meetings held in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among HCCs that hold internal meetings, the average number of		9.28	10.31	1.033	1.042	0.722	1.115
	SE	SD=5.94	SD=4.4	(0.879)	(0.878)	(0.890)	(0.990)
	N	80	69	139	133	129	126

meetings held in the past 12 months							
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

HCC initiatives

Table 19 Proportion of HCCs that actually raised some money in the past 12 months

Proportion of HCCs that actually raised some money in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that actually raised some money in the past 12 months		33.75	43.48	9.728	15.406*	1.073	0.392
	SE			(8.000)	(8.080)	(15.870)	(21.410)
	N	80	69	149	143	44	43
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 20 Among HCCs that raised any money, average amount of money raised in the past 12 months

Among HCCs that raised any money, average amount of money raised in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among HCCs that raised any money, average amount of		783.21	617.43	-165.776	-13.771	-128.729	29.053
	SE	SD=815.1	SD=598.2	(202.326)	(209.737)	(215.890)	(234.348)

money raised in the past 12 months	*N*	783.21	617.43	51	50	49	49
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 21 Proportion of HCCs that implemented any new initiatives in the past 12 months (HCC perspective)

Proportion of HCCs that implemented any new initiatives in the past 12 months (HCC perspective)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that implemented any new initiatives in the past 12 months (HCC perspective)		78.75	81.16	2.409	8.284	1.948	7.507
	SE			(6.586)	(6.816)	(6.724)	(6.867)
	N	80	69	149	143	144	141
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 22 Proportion of facilities in which the HCC implemented a new initiative in the past 12 months (facility Head Nurse perspective)

Proportion of facilities in which the HCC implemented a new initiative in the past 12 months (facility Head Nurse perspective)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of facilities in which the HCC implemented a new		87.65	88.24	0.581	-6.755	1.599	-5.891
	SE			(5.368)	(5.986)	(5.657)	(6.153)

initiative in the past 12 months (facility Head Nurse perspective)	*N*	81	68	149	143	140	137
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

HCC engagement with the DHE

Table 23 Proportion of HCCs that participate in meetings with the DHE

Proportion of HCCs that participate in meetings with the DHE							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that participate in meetings with the DHE		71.25	91.3	20.054***	18.963***	18.511***	17.028***
	SE			(6.113)	(6.188)	(6.067)	(5.952)
	N	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 24 Among HCCs that do meet with the DHE, the average number of meetings attended in the past 12 months

Among HCCs that do meet with the DHE, the average number of meetings attended in the past 12 months							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4

Among HCCs that do meet with the DHE, the average number of meetings attended in the past 12 months		1.81	3.59	1.775***	1.657***	1.797***	2.101***
	SE	SD=1.75	SD=1.86	(0.342)	(0.342)	(0.312)	(0.353)
	N	57	63	111	106	65	65
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 25 Proportion of HCCs that submit written reports on MNCH access to the DHE

Proportion of HCCs that submit written reports on MNCH access to the DHE							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that submit written reports on MNCH access to the DHE		36.25	50.72	14.475*	11.873	12.846	10.063
	SE			(8.096)	(8.656)	(8.197)	(8.713)
	N	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

HCC challenges

Table 26 Proportion of HCCs who believe that further resources are needed to implement their roles

Proportion of HCCs who believe that further resources are needed to implement their roles							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs who believe that further resources are needed to implement their roles		100	98.55	-1.449	-2.923	-1.558	-3.319
	SE			(1.444)	(2.677)	(1.551)	(2.985)
	N	80	69	149	143	144	141
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 27 Proportion of HCCs that face challenges in implementing their roles

Proportion of HCCs that face challenges in implementing their roles							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that face challenges in implementing their roles		96.25	91.3	-4.946	-3.891	-5.852	-4.699
	SE			(4.016)	(4.127)	(3.973)	(4.228)
	N	80	69	149	143	143	140
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Community awareness and perceptions of the HCC

Table 28 Proportion of ANC patients that are aware of the HCC

Proportion of ANC patients that are aware of the HCC

	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients that are aware of the HCC		16.34	21.79	5.452*	5.248	4.014
	SE			(3.265)	(3.276)	(3.184)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 29 Among ANC patients who know the HCC, proportion that are aware of any members

Among ANC patients who know the HCC, proportion that are aware of any members						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among ANC patients who know the HCC, proportion that are aware of any members		77.23	77.31	0.083	2.244	8.448
	SE			(6.386)	(6.542)	(5.349)
	N	101	119	220	217	217
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 30 Among ANC patients that know the HCC, proportion that are aware of any HCC activities

Among ANC patients that know the HCC, proportion that are aware of any HCC activities						
	Model			(1)	(2)	(3)
				Endline-data only specifications		

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among ANC patients that know the HCC, proportion that are aware of any HCC activities		69.31	64.71	-4.601	1.044	12.492*
	SE			(6.663)	(6.499)	(6.976)
	N	101	119	220	217	217
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 31 Among ANC patients that know the HCC, the extent to which they feel the HCC provides a valuable service in their community (score out of 3)

Among ANC patients that know the HCC, the extent to which they feel the HCC provides a valuable service in their community (score out of 3)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among ANC patients that know the HCC, the extent to which they feel the HCC provides a valuable service in their community (score out of 3)		2.27	2.6	0.326***	0.417***	0.467***
	SE	SD=.93	SD=.61	(0.122)	(0.115)	(0.123)
	N	95	105	200	199	199
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 32 Among ANC patients that know the HCC, proportion that have attended a meeting with the HCC

Among ANC patients that know the HCC, proportion that have attended a meeting with the HCC						
	Model			(1)	(2)	(3)

				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among ANC patients that know the HCC, proportion that have attended a meeting with the HCC		17.82	17.65	-0.175	-1.553	-0.576
	SE			(4.967)	(5.475)	(5.973)
	N	101	119	220	217	217
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 33 Proportion of U5 patients that are aware of the HCC

Proportion of U5 patients that are aware of the HCC						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients that are aware of the HCC		26.36	22.43	-3.933	-4.321	-2.486
	SE			(3.095)	(2.995)	(2.787)
	N	846	709	1555	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 34 Among U5 patients who know the HCC, proportion that are aware of any members

Among U5 patients who know the HCC, proportion that are aware of any members						
	Model			(1)	(2)	(3)
				Endline-data only specifications		

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among U5 patients who know the HCC, proportion that are aware of any members		80.72	82.39	1.672	1.592	2.656
	SE			(3.841)	(3.973)	(4.116)
	N	223	159	382	373	373
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 35 Among U5 patients that know the HCC, proportion that are aware of any HCC activities

Among U5 patients that know the HCC, proportion that are aware of any HCC activities						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among U5 patients that know the HCC, proportion that are aware of any HCC activities		71.75	69.18	-2.566	-3.128	-1.003
	SE			(5.543)	(5.697)	(5.593)
	N	223	159	382	373	373
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 36 Among U5 patients that know the HCC, the extent to which they feel the HCC provides a valuable service in their community (score out of 3)

Among U5 patients that know the HCC, the extent to which they feel the HCC provides a valuable service in their community (score out of 3)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among U5 patients that know the HCC, the extent to which they feel the HCC provides a valuable service in their community (score out of 3)		2.37	2.5	0.135	0.102	0.033
	SE	SD=.86	SD=.7	(0.102)	(0.096)	(0.094)
	N	197	142	339	332	332
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 37 Among U5 patients that know the HCC, proportion that have attended a meeting with the HCC

Among U5 patients that know the HCC, proportion that have attended a meeting with the HCC						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among U5 patients that know the HCC, proportion that have attended a meeting with the HCC		19.28	15.19	-4.093	-3.908	-8.932**
	SE			(4.266)	(4.197)	(3.873)
	N	223	158	381	373	373
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

3. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
4. * = p<0.1, ** = p<0.05, ***=p<0.001

HCC administration and record keeping

Table 38 Proportion of HCCs displaying MNCH statistics for the current month

Proportion of HCCs displaying MNCH statistics for the current month							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs displaying MNCH statistics for the current month		15	14.49	-0.507	3.19	1.256	3.751
	SE			(5.842)	(6.581)	(6.011)	(6.765)
	N	80	69	149	143	143	140
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 39 Proportion of HCCs displaying MNCH statistics, but not for the current month

Proportion of HCCs displaying MNCH statistics, but not for the current month							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs displaying MNCH statistics, but not for the current month		12.5	28.99	16.486**	19.155***	15.257**	16.575**
	SE			(6.618)	(7.065)	(6.837)	(7.192)
	N	80	69	149	143	143	140
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 40 Proportion of HCCs that do not display MNCH statistics

Proportion of HCCs that do not display MNCH statistics							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that do not display MNCH statistics		72.5	56.52	-15.978**	-22.345***	-16.638**	-20.764**
	SE			(7.807)	(8.093)	(7.997)	(8.438)
	N	80	69	149	143	143	140
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 41 Proportion of HCCs that keep minutes for internal meetings

Proportion of HCCs that keep minutes for internal meetings							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that keep minutes for internal meetings		96.25	98.55	2.301	3.957*	2.539	5.054*
	SE			(2.574)	(2.266)	(2.751)	(2.855)
	N	80	69	149	143	142	139
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 42 Proportion of HCCs that have a copy of the HCC handbook

Proportion of HCCs that have a copy of the HCC handbook							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that have a copy of the HCC handbook		40.26	78.79	38.528***	27.992***	33.436***	27.461***
	SE			(7.547)	(8.318)	(8.341)	(9.399)
	N	80	69	143	137	121	119
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 43 Proportion of HCCs that have a copy of the Patients Charter

Proportion of HCCs that have a copy of the Patients Charter							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that have a copy of the Patients Charter		44.74	92.65	47.910***	48.538***	52.866***	57.393***
	SE			(6.546)	(7.378)	(6.907)	(8.128)
	N	80	69	144	138	124	122
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

HCC training

Table 44 Proportion of HCCs in which any members have received training

Proportion of HCCs in which any members have received training							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs in which any members have received training		57.14	82.61	25.466***	21.843***	26.187***	23.580***
	SE			(7.279)	(6.474)	(7.495)	(6.173)
	N	79	69	146	140	142	139
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 45 Proportion of HCCs who believe that further training is required

Proportion of HCCs who believe that further training is required							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs who believe that further training is required		96.25	88.41	-7.844*	-6.726	-9.621*	-9.085*
	SE			(4.416)	(4.589)	(5.010)	(5.472)
	N	80	69	149	143	117	115
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.2 Patient knowledge and awareness

Awareness of Patients' rights

Table 46 Proportion of ANC patients aware of the Patients Charter

Proportion of ANC patients aware of the Patients Charter						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients aware of the Patients Charter		1.78	5.86	4.081***	2.836**	3.274**
	SE			(1.367)	(1.207)	(1.292)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 47 Proportion of U5 patients aware of the Patients Charter

Proportion of U5 patients aware of the Patients Charter						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients aware of the Patients Charter		4.49	9.31	4.817**	2.437*	2.592*
	SE			(2.166)	(1.467)	(1.489)
	N	846	709	1555	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).

2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 48 Proportion of ANC patients aware of free services for pregnant women and carers of under 5s

Proportion of ANC patients aware of free services for pregnant women and carers of under 5s						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients aware of free services for pregnant women and carers of under 5s		76.21	82.78	6.570*	7.087*	7.428**
	SE			(3.626)	(3.750)	(3.162)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 49 Proportion of U5 patients aware of free services for pregnant women and carers of under 5s

Proportion of U5 patients aware of free services for pregnant women and carers of under 5s						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients aware of free services for pregnant women and carers of under 5s		83.22	88.43	5.219*	5.698**	6.290***
	SE			(2.750)	(2.682)	(2.360)
	N	846	709	1555	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 50 Proportion of ANC patients aware of any patients' rights

Proportion of ANC patients aware of any patients' rights						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients aware of any patients' rights		49.19	52.38	3.19	3.411	8.158**
	SE			(4.355)	(4.315)	(3.978)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 51 Proportion of U5 patients aware of any patients' rights

Proportion of U5 patients aware of any patients' rights						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients aware of any patients' rights		51.77	55.99	4.221	4.846	7.991***
	SE			(3.599)	(3.405)	(3.058)
	N	846	709	1555	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 52 Among ANC patients aware of any rights, the average number of rights that users are aware of

Among ANC patients aware of any rights, the average number of rights that users are aware of

	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among ANC patients aware of any rights, the average number of rights that users are aware of		1.61	1.82	0.213	0.101	0.153
	SE	SD=.93	SD=1.22	(0.129)	(0.095)	(0.093)
	N	304	286	590	581	581
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 53 Among U5 patients aware of any rights, the average number of rights that users are aware of

Among U5 patients aware of any rights, the average number of rights that users are aware of						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Among U5 patients aware of any rights, the average number of rights that users are aware of		1.76	2.03	0.270*	0.067	0.062
	SE	SD=1	SD=1.46	(0.152)	(0.098)	(0.087)
	N	438	397	835	824	824
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Awareness of health responsibilities

Table 54 Average ANC patients knowledge about health responsibilities (average score out of 6)

Average ANC patients knowledge about health responsibilities (average score out of 6)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Average ANC patients knowledge about health responsibilities (average score out of 6)		4.59	4.62	0.024	-0.027	-0.003
	SE	SD=1.03	SD=1.09	(0.078)	(0.077)	(0.080)
	N	622	553	1175	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001
3. Score derived by awarding 1 point for each of the following answers: recommend check-ups for pregnant women, recommend at least 4 check-ups for pregnant women, aware of supplements for pregnant women, recommend 6 months exclusive breastfeeding, recommend salt, sugar or syrup solution to treat diarrhoea OR recommend health facility to treat diarrhoea. Extra point if they knew what supplements for pregnant women are. Max score is 6

Table 55 Average U5 patients knowledge about health responsibilities (average score out of 6)

Average U5 patients knowledge about health responsibilities (average score out of 6)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Average U5 patients knowledge about health responsibilities (average score out of 6)		4.69	4.74	0.049	0.043	0.078*
	SE	SD=.99	SD=1.04	(0.056)	(0.046)	(0.045)
	N	858	720	1578	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

3. Score derived by awarding 1 point for each of the following answers: recommend check-ups for pregnant women, recommend at least 4 check-ups for pregnant women, aware of supplements for pregnant women, recommend 6 months exclusive breastfeeding, recommend salt, sugar or syrup solution to treat diarrhoea OR recommend health facility to treat diarrhoea. Extra point if they knew what supplements for pregnant women are. Max score is 6

Training on patients' rights and responsibilities

Table 56 Proportion of ANC patients that received any training on patient rights and entitlements in the past 12 months

Proportion of ANC patients that received any training on patient rights and entitlements in the past 12 months						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients that received any training on patient rights and entitlements in the past 12 months		20.07	21.33	1.263	0.005	-0.642
	SE			(4.407)	(4.394)	(4.477)
	N	304	286	590	581	581
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 57 Proportion of U5 patients that received any training on patient rights and entitlements in the past 12 months

Proportion of U5 patients that received any training on patient rights and entitlements in the past 12 months						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients that received any training on patient rights and entitlements in the past 12 months		27.63	28.21	0.586	-2.396	-1.283
	SE			(3.785)	(3.271)	(3.243)
	N	438	397	835	824	824
	Catchment population controls				*Yes*	*Yes*

	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 58 Proportion of ANC patients who received any training on health responsibilities in the past 12 months

Proportion of ANC patients who received any training on health responsibilities in the past 12 months						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients who received any training on health responsibilities in the past 12 months		39.97	46.15	6.186	7.267*	8.653**
	SE			(3.945)	(3.695)	(3.571)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 59 Proportion of U5 patients who received any training on health responsibilities in the past 12 months

Proportion of U5 patients who received any training on health responsibilities in the past 12 months						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients who received any training on health responsibilities in the past 12 months		39.97	46.15	0.707	1.07	0.085
	SE			(3.156)	(3.190)	(3.147)
	N	618	546	1555	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).

2. * = p<0.1, ** = p<0.05, ***=p<0.001

Patient support during the facility visit

Table 60 Proportion of ANC patients that were accompanied to the facility today

Proportion of ANC patients that were accompanied to the facility today						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients that were accompanied to the facility today		25.73	32.97	7.241**	6.730**	7.653**
	SE			(3.506)	(3.399)	(3.173)
	N	618	549	1167	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.3 Complaints mechanisms

Mechanisms for gathering patient feedback

Table 61 Proportion of HCCs that collect quality of care information about patients

Proportion of HCCs that collect quality of care information about patients							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
		98.75	98.55	-0.199	1.052	-0.718	0.774

Proportion of HCCs that collect quality of care information about patients	*SE*			(1.907)	(2.119)	(2.327)	(2.385)
	N	80	69	149	143	144	141
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 62 Proportion of HCCs that keep a record of complaints from community members

Proportion of HCCs that keep a record of complaints from community members							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that keep a record of complaints from community members		42.5	72.46	29.964***	31.530***	31.080***	32.668***
	SE			(7.737)	(7.570)	(7.782)	(7.726)
	N	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 63 Proportion of HCCs that keep a record of complaints from community members – seen by the evaluation team

Proportion of HCCs that keep a record of complaints from community members – seen by the evaluation team							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that keep a record of complaints from		6.25	14.49	8.243	4.97	7.848	5.267
	SE			(5.045)	(5.090)	(5.295)	(5.304)

community members – seen by the evaluation team	*N*	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 64 Proportion of HCCs that keep a record of complaints from community members, but was not seen by the evaluation team

Proportion of HCCs that keep a record of complaints from community members, but was not seen by the evaluation team							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs that keep a record of complaints from community members, but was not seen by the evaluation team		36.25	57.97	21.721***	26.560***	24.245***	28.092***
	SE			(8.039)	(7.997)	(8.096)	(8.054)
	N	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 65 Proportion of HCCs that have educated the community in how and where to register their complaints

Proportion of HCCs that have educated the community in how and where to register their complaints					
	Model			(1)	(2)
				Endline-data only specifications	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2
Proportion of HCCs that have educated the community in how		57.5	95.65	38.152***	33.372***
	SE			(6.068)	(6.462)
	N	80	69	149	143

and where to register their complaints					
	Catchment population controls				*Yes*
	District level fixed effects				*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001
3. Panel data specification not available for this outcome indicator, since the survey question was not asked during the baseline period

Table 66 Proportion of HCCs in which a mechanism exists to inform health facility staff of patient complaints (HCC perspective)

Proportion of HCCs in which a mechanism exists to inform health facility staff of patient complaints (HCC perspective)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs in which a mechanism exists to inform health facility staff of patient complaints		46.25	81.16	34.909***	38.863***	34.841***	40.123***
	SE			(7.321)	(7.520)	(7.394)	(7.386)
	N	80	69	149	143	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 67 Proportion of health facilities in which a mechanism exists for the HCC to inform staff of patient complaints (facility Head Nurse perspective)

Proportion of health facilities in which a mechanism exists for the HCC to inform staff of patient complaints (facility Head Nurse perspective)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
		67.9	94.2	26.302***	22.453***	24.016***	22.594***

Proportion of health facilities in which a mechanism exists for the HCC to inform staff of patient complaints (facility Head Nurse perspective)	*SE*			(5.921)	(6.495)	(5.997)	(6.600)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 68 Number of times facility staff were informed of patient complaints by the HCC in the past 12 months (facility Head Nurse perspective)

Number of times facility staff were informed of patient complaints by the HCC in the past 12 months (facility Head Nurse perspective)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Number of times facility staff were informed of patient complaints by the HCC in the past 12 months (facility Head Nurse perspective)		3.77	4.6	0.831	1.619*	0.961	1.325
	SE	SD=3.07	SD=4.09	(0.750)	(0.822)	(0.992)	(1.372)
	N	44	48	92	87	53	50
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Decision maker responses to patient feedback

Table 69 Number of times the HCC has informed health facility staff of patient complaints (HCC perspective)

Number of times the HCC has informed health facility staff of patient complaints (HCC perspective)							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of times the HCC has informed health facility staff of patient complaints (HCC perspective), among HCCs with a mechanism to inform staff of complaints		3.46	4.27	0.802	-0.13	-0.178	0.14
	SE	SD=4.49	SD=3.79	(1.019)	(1.045)	(1.726)	(1.453)
	N	28	45	73	68	42	41
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Complaints by facility users

Table 70 ANC patients who were ever unhappy with the health facility in the past 12 months

ANC patients who were ever unhappy with the health facility in the past 12 months						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients who were ever unhappy with the health facility in the past 12 months		16.34	15.57	-0.775	0.083	0.451
	SE			(2.992)	(3.035)	(2.734)
	N	618	546	1164	1142	1142
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 71 ANC patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)

ANC patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)

	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)		22.77	21.18	-1.596	0.179	-1.618
	SE			(6.315)	(6.241)	(6.573)
	N	101	85	186	184	184
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 72 U5 patients who were ever unhappy with the health facility in the past 12 months

U5 patients who were ever unhappy with the health facility in the past 12 months						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients who were ever unhappy with the health facility in the past 12 months		17.97	22	4.036	4.996	5.017*
	SE			(3.102)	(3.090)	(2.799)
	N	846	709	1555	1520	1520
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 73 U5 patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)

U5 patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients who reported any complaints (among those who were unhappy with the facility in the past 12 months)		16.45	14.1	-2.345	-2.021	-1.412
	SE			(4.294)	(4.541)	(5.079)
	N	152	156	308	304	304
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Likelihood of patients reporting complaints

Table 74 Proportion of ANC patients who would complain if not satisfied with the health facility

Proportion of ANC patients who would complain if not satisfied with the health facility						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of ANC patients who would complain if not satisfied with the health facility		60.36	62.57	2.21	2.468	4.656
	SE			(3.447)	(3.494)	(3.550)
	N	618	546	1158	1136	1136
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 75 Proportion of U5 patients who would complain if not satisfied with the health facility

Proportion of U5 patients who would complain if not satisfied with the health facility						
	Model			(1)	(2)	(3)
				Endline-data only specifications		

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Proportion of U5 patients who would complain if not satisfied with the health facility		62.9	67.71	4.809	4.638	3.076
	SE			(2.977)	(2.877)	(2.910)
	N	846	709	1544	1509	1509
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 76 Extent to which ANC patients feel they could complain to the HCC

Extent to which ANC patients feel they could complain to the HCC						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Extent to which ANC patients feel they could complain to the HCC if unsatisfied with the health facility (among those who have heard of the HCC) (Score out of 3 based on the following scheme: 0 = strongly disagree, 1 = slightly disagree, 2 = slightly agree, 3 = strongly agree)		2.1	2.28	0.178	0.18	0.141
	SE	SD=1.09	SD=.96	(0.135)	(0.130)	(0.129)
	N	89	104	193	191	191
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 77 Extent to which ANC patients feel that the HCC always acts on their complaints (among those who have heard of the HCC)

Extent to which ANC patients feel that the HCC always acts on their complaints (among those who have heard of the HCC)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3

Extent to which ANC patients feel that the HCC always acts on their complaints (among those who have heard of the HCC) (Score out of 3 based on the following scheme: 0 = strongly disagree, 1 = slightly disagree, 2 = slightly agree, 3 = strongly agree)		2.08	2.34	0.258	0.337**	0.308**
	SE	SD=1	SD=.83	(0.159)	(0.147)	(0.147)
	N	76	95	171	170	170
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 78 Extent to which U5 patients feel they could complain to the HCC if unsatisfied with the health facility (among those who have heard of the HCC)

Extent to which U5 patients feel they could complain to the HCC if unsatisfied with the health facility (among those who have heard of the HCC)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
Extent to which U5 patients feel they could complain to the HCC if unsatisfied with the health facility (among those who have heard of the HCC) (Score out of 3 based on the following scheme: 0 = strongly disagree, 1 = slightly disagree, 2 = slightly agree, 3 = strongly agree)		2.12	2.37	0.251**	0.213	0.115
	SE	SD=.95	SD=.94	(0.124)	(0.131)	(0.128)
	N	191	140	331	324	324
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 79 Extent to which U5 patients feel that the HCC always acts on their complaints (among those who have heard of the HCC)

Extent to which U5 patients feel that the HCC always acts on their complaints (among those who have heard of the HCC)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3

Extent to which U5 patients feel that the HCC always acts on their complaints (among those who have heard of the HCC) (Score out of 3 based on the following scheme: 0 = strongly disagree, 1 = slightly disagree, 2 = slightly agree, 3 = strongly agree)		2.11	2.37	0.257**	0.217*	0.142
	SE	SD=.91	SD=.83	(0.121)	(0.121)	(0.125)
	N	179	133	312	308	308
	Covariates				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.4 Inclusive decision making

Operational plan

Table 80 Proportion of facilities with an operational plan for the current year (reported by facility Head Nurse)

Proportion of facilities with an operational plan for the current year (reported by facility Head Nurse)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of facilities with an operational plan for the current year		95.06	94.2	-0.859	1.418	-1.538	1.316
	SE			(3.715)	(2.097)	(3.908)	(2.233)
	N	81	69	150	144	145	142
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 81 Proportion of facilities with an operational plan for the current year (reported by HCC)

Proportion of facilities with an operational plan for the current year (reported by HCC)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of facilities with an operational plan for the current year		96.25	100	3.750*	3.987*	4.101*	3.831
	SE			(2.131)	(2.324)	(2.306)	(2.419)
	N	80	68	148	142	141	138
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 82 Proportion of HCCs consulted in the development of the operational plan (reported by HCC)

Proportion of HCCs consulted in the development of the operational plan (reported by HCC)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs consulted in the development of the operational plan (reported by HCC)		96.05	98.53	2.477	1.851	2.921	1.259
	SE			(2.678)	(3.668)	(2.043)	(1.789)
	N	76	68	144	138	125	123
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 83 Among facilities with an operational plan, proportion that consulted the community in the development of the plan (reported by HCC)

Among facilities with an operational plan, proportion that consulted the community in the development of the plan (reported by HCC)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among facilities with an operational plan, proportion that consulted the community in the development of the plan (reported by HCC)		93.15	89.55	-3.598	-1.68	-4.343	-3.253
	SE			(4.782)	(5.753)	(5.035)	(5.831)
	N	73	67	140	134	134	131
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

RBF disbursements

Table 84 Health facility received any money from RBF, HSF or HTF in the past year (reported by facility head nurse)

Health facility received any money from RBF, HSF or HTF in the past year (reported by facility head nurse)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of health facilities that received any money from RBF, HSF or HTF in the past year (reported by facility head nurse)		98.77	100	1.235	1.626	1.383	2.063*
	SE			(1.231)	(1.371)	(0.975)	(1.158)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 85 Total amount of money received through RBF in past 4 quarters (reported by facility Head Nurse)

Total amount of money received through RBF in past 4 quarters (reported by facility Head Nurse)

	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among facilities that received any money from RBF in the past year, average amount received		5846.5	6707.4	860.904	-1165.25	888.715	-329.628
	SE	SD=4420.67	SD=7291.47	(1174.478)	(774.861)	(1511.802)	(936.490)
	N	58	51	109	104	74	73
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 86 Health facility received any money from RBF, HSF or HTF in the past year (reported by the HCC)

Health facility received any money from RBF, HSF or HTF in the past year (reported by the HCC)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of health facilities that received any money from RBF, HSF or HTF in the past year (reported by the HCC)		98.75	98.55	-0.199	-1.066	-0.289	-1.067
	SE			(1.907)	(2.362)	(2.043)	(2.550)
	N	80	69	149	143	141	138
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 87 Total amount of money received through RBF in past 4 quarters (reported by HCC)

Total amount of money received through RBF in past 4 quarters (reported by HCC)							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Among facilities that received any money from RBF in the past year, average amount received		5329.91	13319.23	7989.318	-1344.77	13101.24	-1145.04
	SE	SD=3966.77	SD=46512.71	(7207.453)	(1143.574)	(12312.805)	(1140.211)
	N	36	42	78	74	52	50
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 88 Proportion of HCCs reporting that RBF expenditure fully in line with their priorities

Proportion of HCCs reporting that RBF expenditure fully in line with their priorities							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Proportion of HCCs reporting that RBF expenditure fully in line with their priorities		83.33	89.55	6.219	6.067	7.677	6.791
	SE			(5.656)	(6.347)	(5.843)	(6.642)
	N	78	67	145	139	136	133
	Catchment population controls				*Yes*		*Yes*
	District level fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.5 Facility quality (MoHCC checklist)

Table 89 Facility quality (MoHCC Quality of Care checklist composite scores)

Facility quality (MoHCC Quality of Care checklist composite scores)							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average facility composite score per quarter		83.19	83.22	0.034	-0.637	-0.107	-0.501
	SE	SD=8.61	SD=8.78	(0.588)	(0.416)	(0.784)	(0.498)
	N	426	450	876	876	291	291
	District level fixed effects				*Yes*		*Yes*

1. The sample size at endline is from 142 comparison facilities and 150 intervention facilities over 3 quarters (Q1 2016, Q2 2016, and Q3 2016).
2. The sample size at baseline is 1from 141 comparison facilities and 150 intervention facilities over one quarter (Q3 2014)
3. The baseline sample is the first quarter for which data is available. We did not choose to consider any subsequent periods as part of the baseline period to minimise since implementation of the programme was beginning to get underway towards the end of 2014. The endline sample consists of multiple quarters, since this allows us to boost the sample size and better account for possible quality issues or noise in the data.
4. The sample is all facilities in which SCPH was implemented, matched to control facilities using the nihfa data, and linked to the quality of care checklist data. Of the original 166 intervention facilities, some could not be successfully linked with the nihfa data for matching, or with the quality of care checklist data
5. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
6. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.6 Patient satisfaction

Satisfaction with the health workers at the facility

Table 90 ANC patients overall satisfaction with the health workers at the facility. (Average score out of 3)

ANC patients overall satisfaction with the health workers at the facility. (Average score out of 3)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
ANC patients overall satisfaction with the health workers at the facility. (Average score out of 3)		2.32	2.38	0.059	0.035	-0.015
	SE	SD=.57	SD=.55	(0.044)	(0.044)	(0.043)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Satisfaction is measured using an average score out of 3 on a range of questions relating to satisfaction with health workers, based on the following scoring system: 0 = very dissatisfied, 1= somewhat dissatisfied, 2= somewhat satisfied, 3= very satisfied
2. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
3. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 91 U5 patients overall satisfaction with the health workers at the facility. (Average score out of 3)

U5 patients overall satisfaction with the health workers at the facility. (Average score out of 3)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
U5 patients overall satisfaction with the health workers at the facility. (Average score out of 3)		2.34	2.37	0.032	-0.006	-0.031
	SE	SD=.55	SD=.57	(0.042)	(0.040)	(0.039)
	N	847	710	1557	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Satisfaction is measured using an average score out of 3 on a range of questions relating to satisfaction with health workers, based on the following scoring system: 0 = very dissatisfied, 1= somewhat dissatisfied, 2= somewhat satisfied, 3= very satisfied
2. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
3. * = p<0.1, ** = p<0.05, ***=p<0.001

Satisfaction with the health facility

Table 92 ANC patients overall satisfaction with the health facility. (Average score out of 3)

ANC patients overall satisfaction with the health facility. (Average score out of 3)

	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
ANC patients overall satisfaction with the health facility. (Average score out of 3)		2.03	2.03	-0.008	-0.027	-0.049
	SE	SD=.56	SD=.55	(0.043)	(0.042)	(0.043)
	N	618	546	1164	1142	1142
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Satisfaction is measured using an average score out of 3 on a range of questions relating to satisfaction with the health facility, based on the following scoring system: 0 = very dissatisfied, 1= somewhat dissatisfied, 2= somewhat satisfied, 3= very satisfied
2. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
3. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 93 U5 patients overall satisfaction with the health facility. (Average score out of 3)

U5 patients overall satisfaction with the health facility. (Average score out of 3)						
	Model			(1)	(2)	(3)
				Endline-data only specifications		
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3
U5 patients overall satisfaction with the health facility. (Average score out of 3)		1.98	2.05	0.069	0.027	-0.001
	SE	SD=.57	SD=.6	(0.047)	(0.042)	(0.044)
	N	846	709	1555	1520	1520
	Catchment population controls				*Yes*	*Yes*
	District level fixed effects					*Yes*

1. Satisfaction is measured using an average score out of 3 on a range of questions relating to satisfaction with the health facility, based on the following scoring system: 0 = very dissatisfied, 1= somewhat dissatisfied, 2= somewhat satisfied, 3= very satisfied
2. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
3. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.7 Total RBF disbursements to health facilities

Table 94 RBF processed invoices – total disbursement amounts

RBF processed invoices – total disbursement amounts							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average facility total RBF disbursement amount		1953.44	1993.07	39.627	92.461	7.833	40.435
	SE	SD=1221.74	SD=1329.41	(86.706)	(79.277)	(120.646)	(103.619)
	N	423	444	867	867	268	268
	District level fixed effects				*Yes*		*Yes*

1. The sample size at endline is from 142 comparison facilities and 150 intervention facilities over 3 quarters (Q1 2016, Q2 2016, and Q3 2016).
2. The sample size at baseline is 1from 124 comparison facilities and 134 intervention facilities over one quarter (Q3 2014)
3. The baseline sample is the first quarter for which data is available. We did not choose to consider any subsequent periods as part of the baseline period to minimise since implementation of the programme was beginning to get underway towards the end of 2014. The endline sample consists of multiple quarters, since this allows us to boost the sample size and better account for possible quality issues or noise in the data.
4. The sample is all facilities in which SCPH was implemented, matched to control facilities using the nihfa data, and linked to the RBF disbursements data. Of the original 166 intervention facilities, some could not be successfully linked with the nihfa data for matching, or with the disbursement data
5. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
6. * = p<0.1, ** = p<0.05, ***=p<0.001

3.3.8 Utilisation of health facilities

Antenatal care

Table 95 Antenatal care first visits under 16 weeks – OPM registry data

Antenatal care first visits under 16 weeks – OPM registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of ANC visits at under 16 weeks per facility per month		8.26	8.1	-0.156	-0.743	0.14	-0.14
	SE	SD=6.02	SD=7.01	(1.081)	(1.117)	(0.980)	(1.110)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 96 Antenatal care first visits under 16 weeks – OPM T5 data

Antenatal care first visits under 16 weeks – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of ANC visits at under 16 weeks per facility per month		8.31	8.13	-0.177	-0.861	0.419	0.062
	SE	SD=6.11	SD=7.12	(1.097)	(1.133)	(0.937)	(1.041)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 97 Antenatal care first visits 16 – 27 weeks – OPM registry data

Antenatal care first visits 16 – 27 weeks – OPM registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of ANC visits at 16 to 27 weeks per facility per month		10.77	11.15	0.385	-2.343	0.507	-0.635
	SE	SD=10.59	SD=7	(1.452)	(1.507)	(0.856)	(0.874)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 98 Antenatal care first visits 16 – 27 weeks – OPM T5 data

Antenatal care first visits 16 – 27 weeks – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of ANC visits at 16 to 27 weeks per facility per month		10.51	10.72	0.209	-2.438	-0.028	-1.007
	SE	SD=10.53	SD=6.69	(1.426)	(1.509)	(0.803)	(0.862)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 99 Antenatal care first visits at 28 weeks and over – OPM registry data

Antenatal care first visits at 28 weeks and over – OPM registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of ANC visits at 28 weeks and over per facility per month		2.94	2.61	-0.329	-1.242**	-0.219	-0.627*
	SE	SD=3.72	SD=3.5	(0.592)	(0.544)	(0.339)	(0.354)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 100 Antenatal care first visits at 28 weeks and over – OPM T5 data

Antenatal care first visits at 28 weeks and over – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of ANC visits at 28 weeks and over per facility per month		3.25	2.87	-0.374	-1.445**	-0.251	-0.895**
	SE	SD=4.17	SD=3.73	(0.648)	(0.602)	(0.413)	(0.416)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 101 Second antenatal care visits - OPM Registry data

Second antenatal care visits - OPM Registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of second antenatal care visits per facility per month		17.54	17.8	0.267	-3.503*	0.141	-2.014
	SE	SD=13.53	SD=10.9	(2.003)	(1.932)	(1.250)	(1.235)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 102 Second antenatal care visits – OPM T5 data

Second antenatal care visits – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of second antenatal care visits per facility per month		16.79	16.97	0.185	-3.359*	-0.181	-1.186
	SE	SD=13.77	SD=10.57	(1.997)	(1.976)	(1.208)	(1.437)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 103 Third antenatal care visits – OPM Registry data

Third antenatal care visits – OPM Registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of third antenatal care visits per facility per month		14.25	14.93	0.681	-2.363	0.911	-1.182
	SE	SD=10.41	SD=9.56	(1.637)	(1.500)	(1.265)	(1.158)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 104 Third antenatal care visits – OPM T5 data

Third antenatal care visits – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of third antenatal care visits per facility per month		13.59	14.41	0.821	-2.164	0.905	-0.302
	SE	SD=10.5	SD=9.31	(1.623)	(1.473)	(1.067)	(1.269)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 105 Fourth or more antenatal care visits – OPM Registry data

Fourth or more antenatal care visits – OPM Registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	

		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of fourth or more antenatal care visits per facility per month		17.85	20.06	2.215	-2.794	2.508	-2.665
	SE	SD=14.92	SD=17.31	(2.672)	(2.217)	(2.462)	(1.999)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 106 Fourth or more antenatal care visits – OPM T5 data

Fourth or more antenatal care visits – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of fourth or more antenatal care visits per facility per month		17.55	18.74	1.197	-3.477	1.745	-1.582
	SE	SD=15.2	SD=18.29	(2.784)	(2.289)	(2.477)	(2.415)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Postnatal care

Table 107 Postnatal care visits at 3 days – OPM Registry data

Postnatal care visits at 3 days – OPM Registry data							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of postnatal care visits at 3 days per facility per month		10.65	10.71	0.064	-2.044	0.765	-0.607
	SE	SD=10.08	SD=7.93	(1.477)	(1.431)	(1.003)	(1.208)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 108 Postnatal care visits at 3 days – OPM T5 data

Postnatal care visits at 3 days – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of postnatal care visits at 3 days per facility per month		10.97	10.67	-0.308	-2.424	0.536	-0.022
	SE	SD=10.41	SD=7.72	(1.488)	(1.513)	(0.883)	(1.150)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 109 Postnatal care visits at 7 days – OPM Registry data

Postnatal care visits at 7 days – OPM Registry data							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of postnatal care visits at 7 days per facility per month		12.26	12.09	-0.17	-2.523*	0.061	-1.465
	SE	SD=9.77	SD=7.67	(1.430)	(1.375)	(1.054)	(1.126)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 110 Postnatal care visits at 7 days – OPM T5 data

Postnatal care visits at 7 days – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of postnatal care visits at 7 days per facility per month		11.66	11.48	-0.181	-2.519*	0.405	-0.44
	SE	SD=9.25	SD=7.25	(1.353)	(1.288)	(0.859)	(1.060)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 111 Postnatal care visits at 6 weeks – OPM Registry data

Postnatal care visits at 6 weeks – OPM Registry data							
	Model			(1)	(2)	(3)	(4)

				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of postnatal care visits at 6 weeks per facility per month		11.13	11.37	0.242	-1.893	1.356	-0.304
	SE	SD=8.87	SD=7.17	(1.315)	(1.270)	(1.089)	(1.131)
	N	81	69	150	144	146	143
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 112 Postnatal care visits at 6 weeks – OPM T5 data

Postnatal care visits at 6 weeks – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of postnatal care visits at 6 weeks per facility per month		11.52	11.09	-0.426	-2.517*	0.196	-0.597
	SE	SD=9.39	SD=7.26	(1.365)	(1.305)	(0.921)	(1.143)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

New outpatients

Table 113 New outpatients – OPM Registry data

New outpatients – OPM Registry data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		464.91	482.92	18.004	-38.954	-16.56	-19.861
	SE	SD=279.66	SD=217.23	(41.619)	(40.831)	(28.583)	(29.154)
	N	77	67	144	138	136	133
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 114 New outpatients – OPM T5 data

New outpatients – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		464.45	494.21	29.765	-21.608	4.106	9.611
	SE	SD=287.08	SD=227.06	(42.150)	(44.321)	(26.583)	(30.071)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Immunisations

Table 115 BCG immunisations – OPM T5 data

BCG immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		14.1	14.84	0.736	-1.845	-0.032	-1.307
	SE	SD=10.72	SD=10.67	(1.758)	(1.487)	(0.974)	(0.986)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 116 OPV1 immunisations – OPM T5 data

OPV1 immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		16.82	17.49	0.666	-2.971**	0.244	-1.219
	SE	SD=11.42	SD=10.48	(1.795)	(1.483)	(0.875)	(0.800)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 117 OPV2 immunisations – OPM T5 data

OPV2 immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		15.96	16.87	0.911	-2.651*	0.855	-0.486
	SE	SD=10.27	SD=10.43	(1.703)	(1.387)	(0.816)	(0.764)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 118 OPV3 immunisations – OPM T5 data

OPV3 immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		15.44	16.66	1.225	-1.985	0.94	-0.286
	SE	SD=9.59	SD=10.37	(1.647)	(1.294)	(0.841)	(0.797)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 119 Pentavalent1 immunisations – OPM T5 data

Pentavalent1 immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		17.13	17.73	0.604	-2.974*	0.06	-1.269
	SE	SD=11.97	SD=10.41	(1.833)	(1.532)	(0.868)	(0.836)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 120 Pentavalent2 immunisations – OPM T5 data

Pentavalent2 immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		16.82	17.4	0.576	-3.149**	0.123	-1.035
	SE	SD=10.99	SD=10.42	(1.757)	(1.454)	(0.753)	(0.744)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 121 Pentavalent3 immunisations – OPM T5 data

Pentavalent3 immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		16.17	17.28	1.113	-2.348*	1.011	-0.54
	SE	SD=10.21	SD=10.35	(1.690)	(1.335)	(0.838)	(0.806)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.001

Table 122 Measles immunisations – OPM T5 data

Measles immunisations – OPM T5 data							
	Model			(1)	(2)	(3)	(4)
				Endline-data only specifications		Panel dataset specifications (ANCOVA)	
		Comparison mean at endline	Intervention mean at endline	Treatment effect 1	Treatment effect 2	Treatment effect 3	Treatment effect 4
Average number of new outpatients per facility per month		24.58	24.44	-0.136	-4.855**	-1.652	-4.496**
	SE	SD=15.29	SD=14.59	(2.451)	(2.062)	(1.735)	(1.967)
	N	81	69	150	144	147	144
	Catchment population controls				*Yes*		*Yes*
	District fixed effects				*Yes*		*Yes*

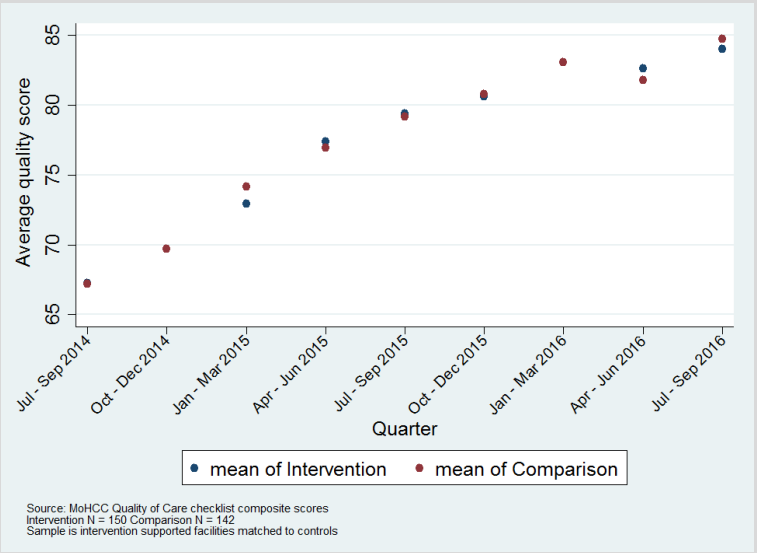
1. Standard errors for all regressions computed using cluster robust standard errors, with clustering at the level of the health facility (at which the intervention was assigned).
2. * = p<0.1, ** = p<0.05, ***=p<0.00

4 Additional figures

4.1 MoHCC Quality of Care Checklist data

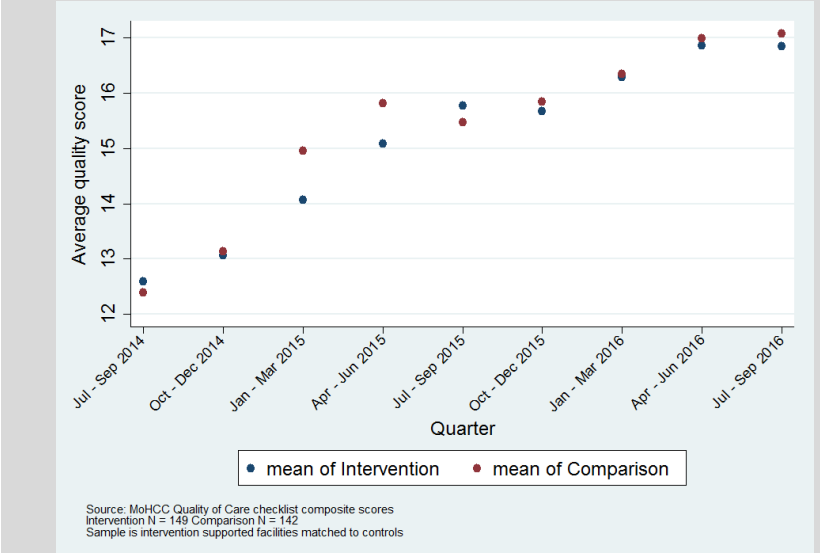
Figure 2 MoHCC quality of care checklist scores (1)

MoHCC Quality of Care Checklist composite scores



Source: MoHCC Quality of Care checklist composite scores

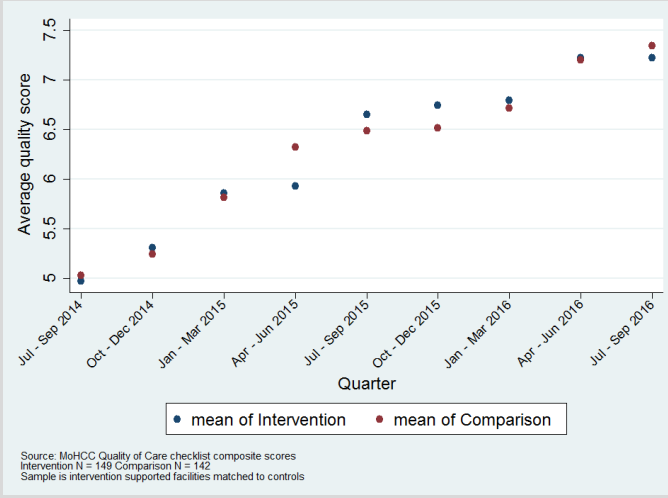
Administration, finance and planning (Structural domain)



Source: MoHCC Quality of Care checklist composite scores

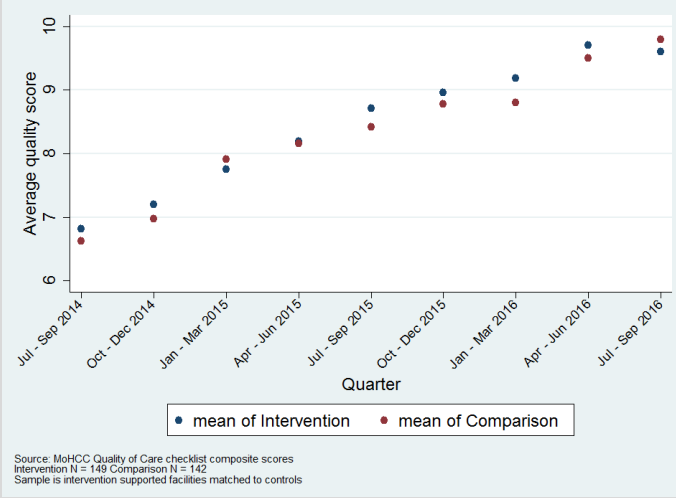
Figure 3 MoHCC quality of care checklist scores (2)

General appearance (Structural domain)



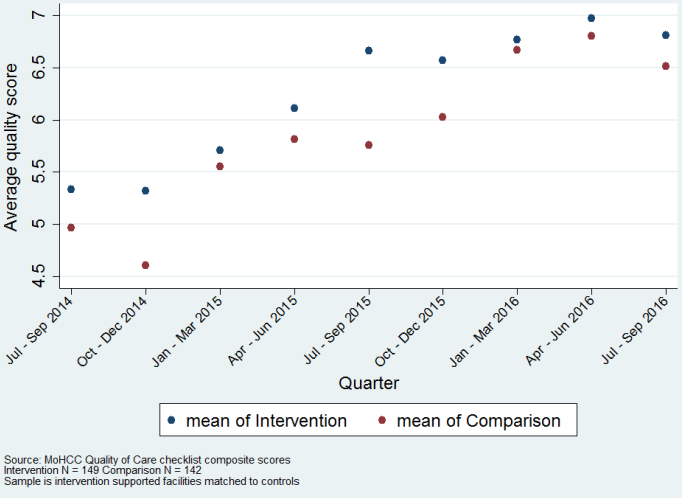
Source: MoHCC Quality of Care checklist composite scores

Community services (Structural domain)



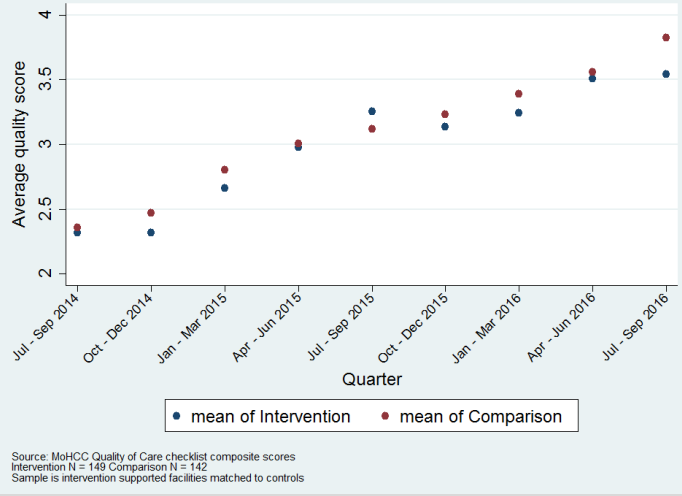
Source: MoHCC Quality of Care checklist composite scores

Environmental health services (Structural domain)



Source: MoHCC Quality of Care checklist composite scores

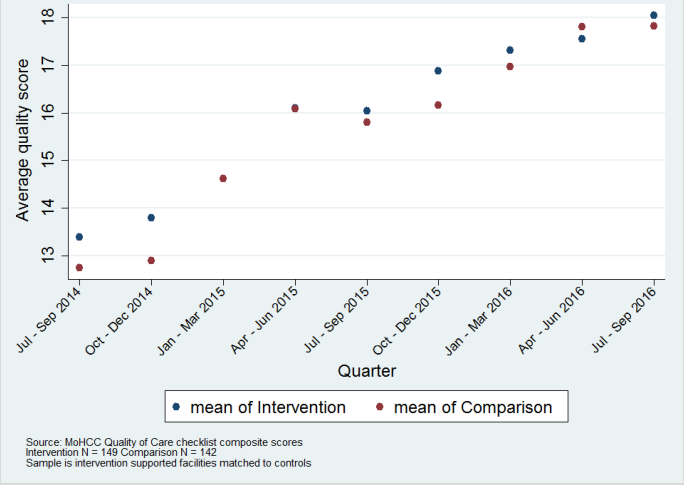
Family health (ANC, PNC, Family planning, Immunisations) (Structural domain)



Source: MoHCC Quality of Care checklist composite scores

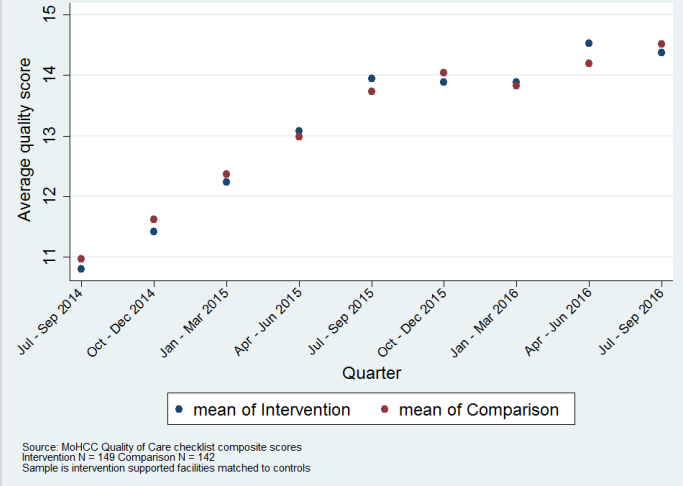
Figure 4 MoHCC quality of care checklist scores (3)

Health management information system (Structural domain)



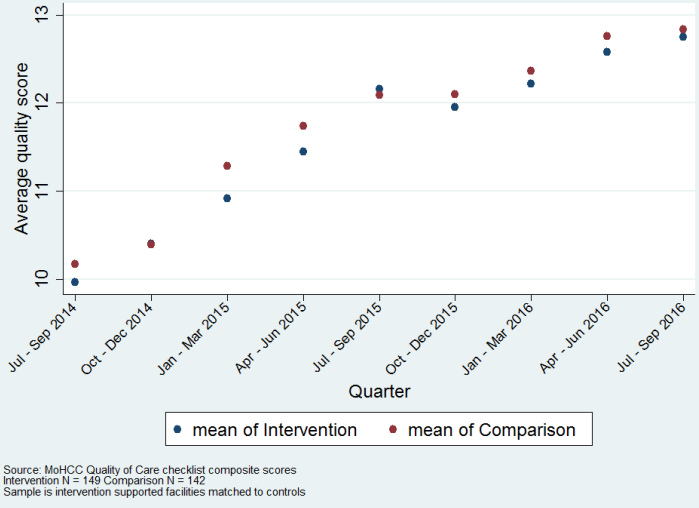
Source: MoHCC Quality of Care checklist composite scores

Infection control and waste management (Structural domain)



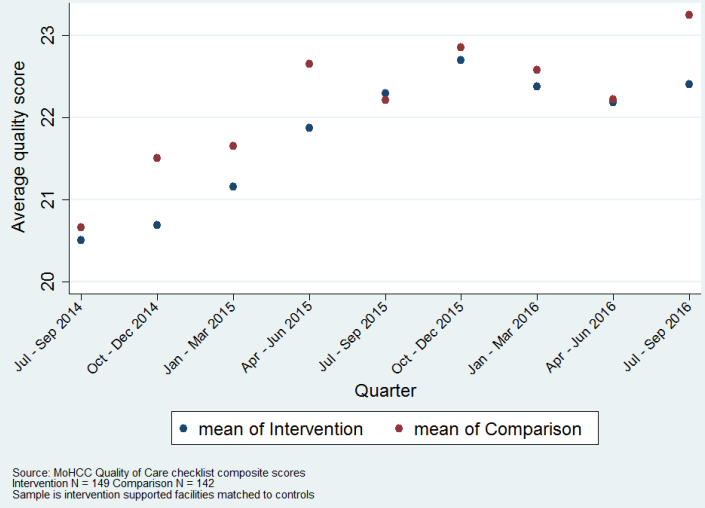
Source: MoHCC Quality of Care checklist composite scores

Maternity service (routine maternal newborn best practices, PPH, sepsis) (Structural domain)



Source: MoHCC Quality of Care checklist composite scores

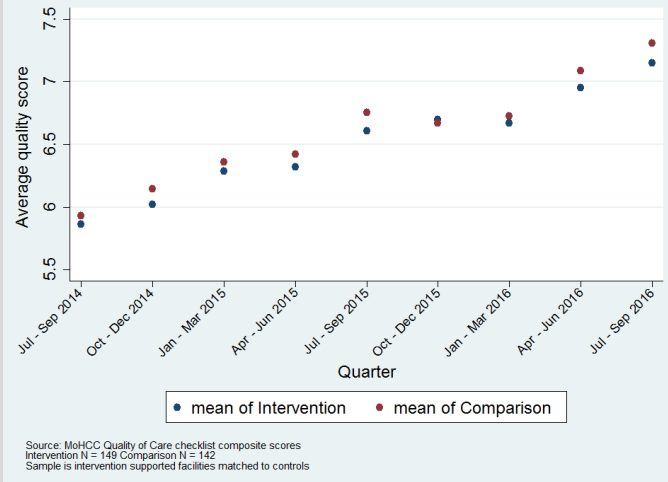
Medicines and sundries stock management (Structural domain)



Source: MoHCC Quality of Care checklist composite scores

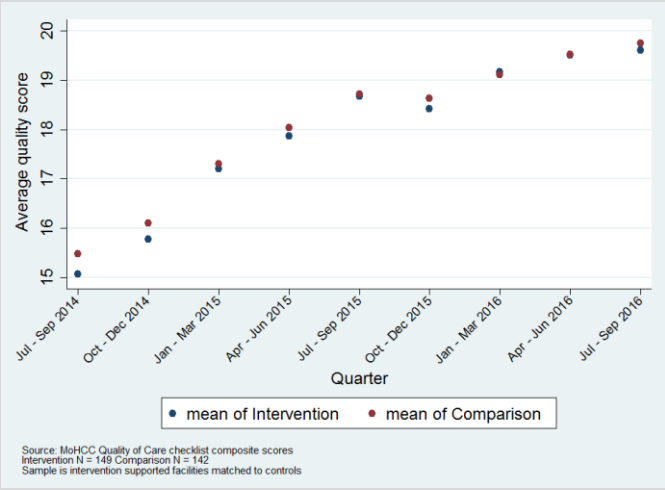
Figure 5 MoHCC quality of care checklist scores (4)

Observation/ inpatient services (Structural domain)



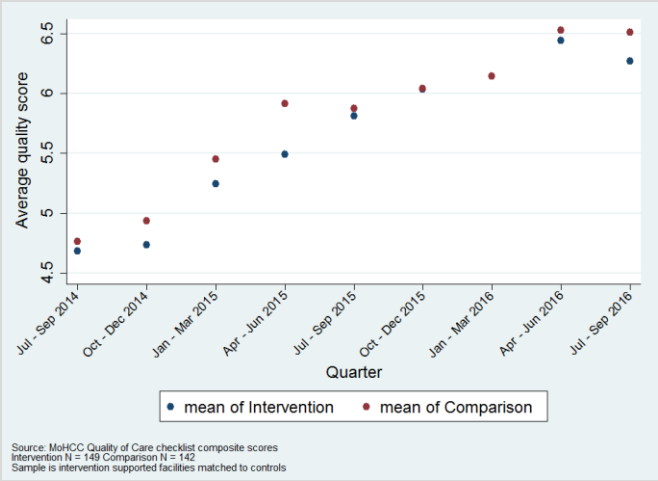
Source: MoHCC Quality of Care checklist composite scores

Outpatient department/ consultation area (Childhood pneumonia, TB, referral criteria, PEP) (Structural domain)



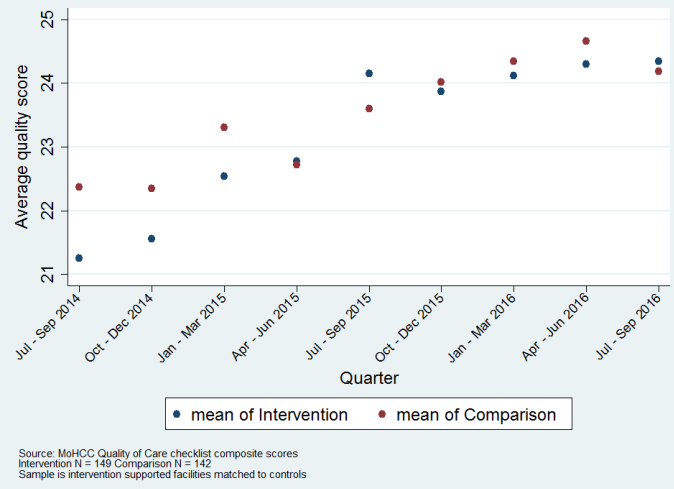
Source: MoHCC Quality of Care checklist composite scores

Referral services (Structural domain)



Source: MoHCC Quality of Care checklist composite scores

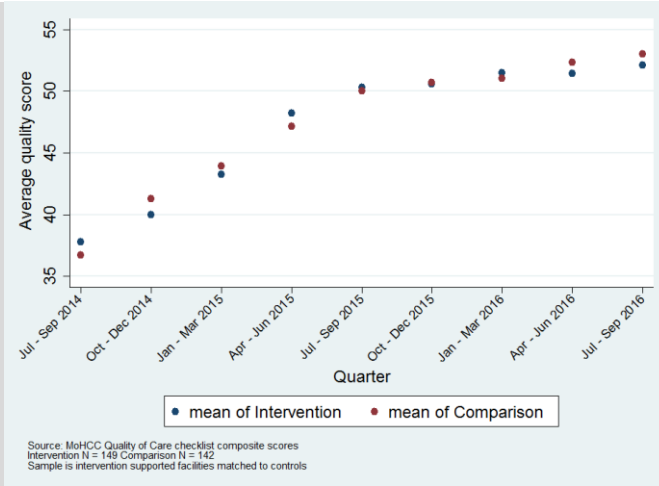
EPI (Clinical quality of care domain)



Source: MoHCC Quality of Care checklist composite scores

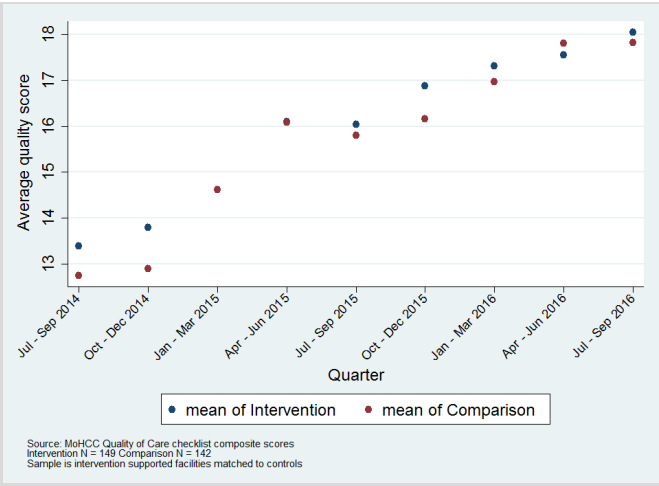
Figure 6 MoHCC quality of care checklist scores (5)

Family health (ANC, PNC, Family planning, Immunisations) (Clinical quality of care domain)



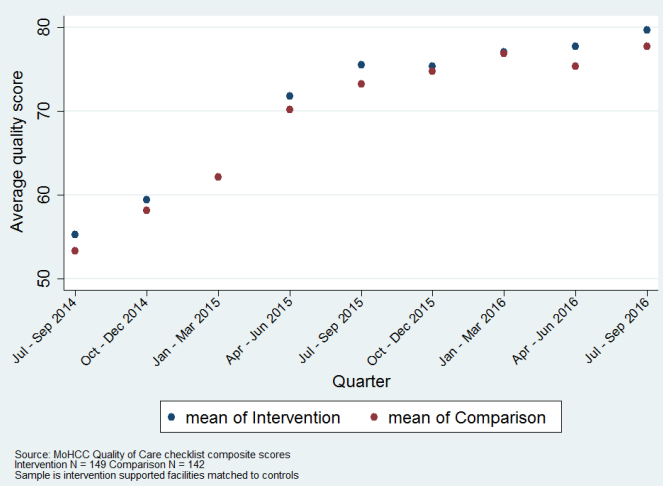
Source: MoHCC Quality of Care checklist composite scores

Health management information system (Clinical quality of care domain)



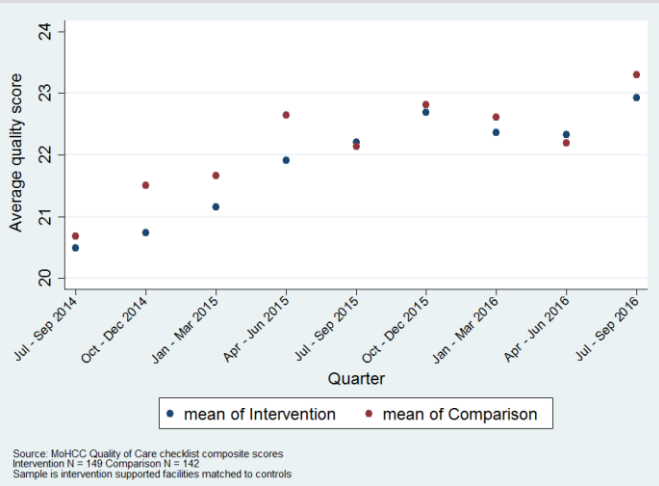
Source: MoHCC Quality of Care checklist composite scores

Maternity service (routine maternal newborn best practices, PPH, sepsis) (Clinical quality of care domain)



Source: MoHCC Quality of Care checklist composite scores

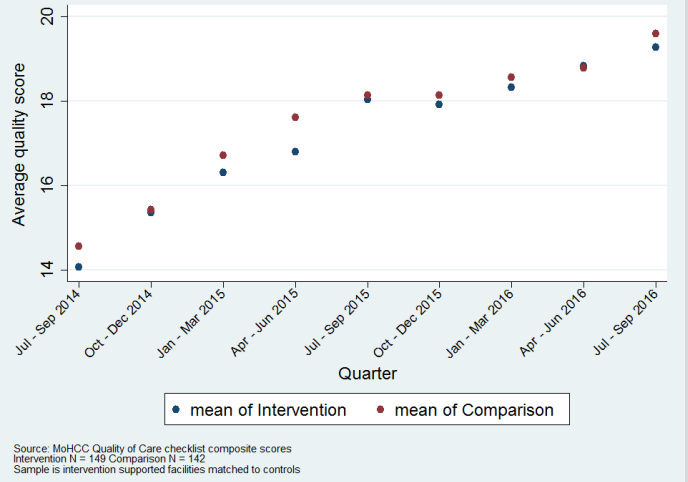
Medicines and sundries stock management (Clinical quality of care domain)



Source: MoHCC Quality of Care checklist composite scores

Figure 7 MoHCC quality of care checklist scores (6)

Outpatient department/ consultation area (Childhood pneumonia, TB, referral criteria, PEP) (Clinical quality of care domain)

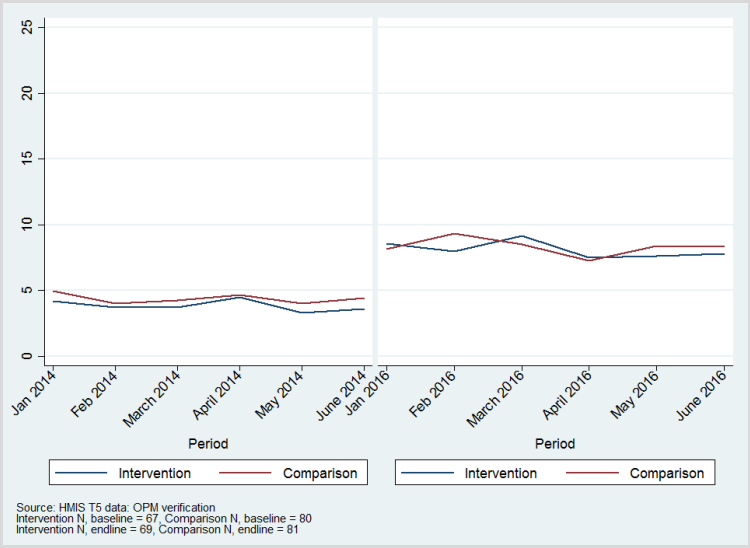


Source: MoHCC Quality of Care checklist composite scores

4.2 Facility utilisation graphs – T5 data (OPM verification)

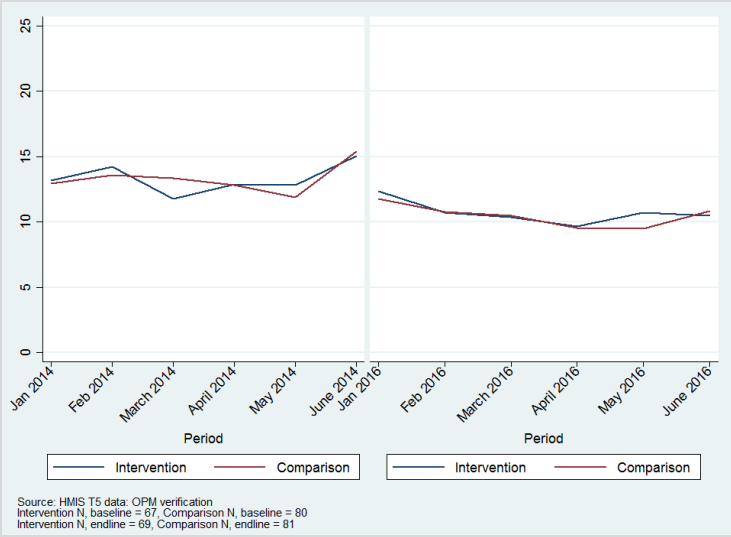
Figure 8 First ANC visits – T5 data (OPM verification)

Average first ANC visits under 16 weeks, per facility, per month



Source: HMIS T5 data: OPM verification

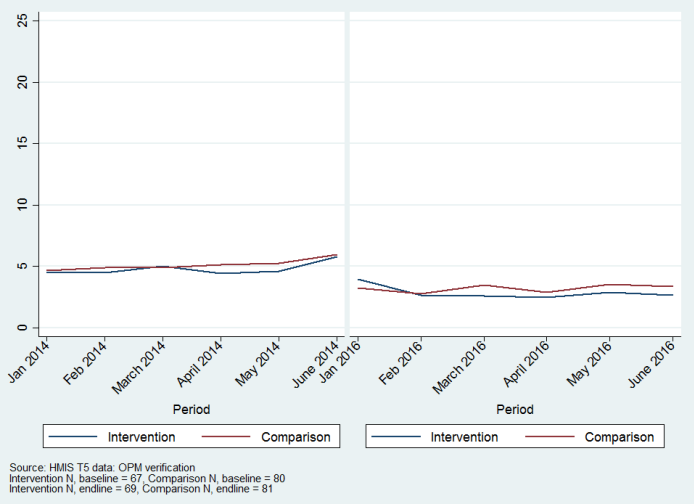
Average first ANC visits, 16 - 27 weeks, per facility, per month



Source: HMIS T5 data: OPM verification

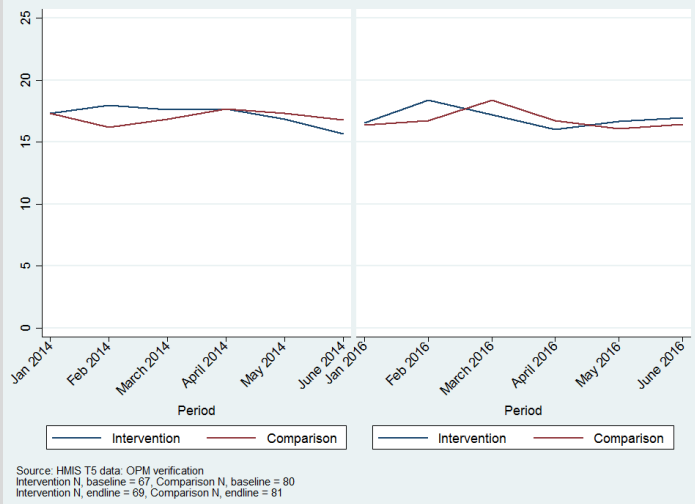
Figure 9 Second, Third and Fourth ANC visits – T5 data (OPM verification)

Average first ANC visits over 28 weeks, per facility per month



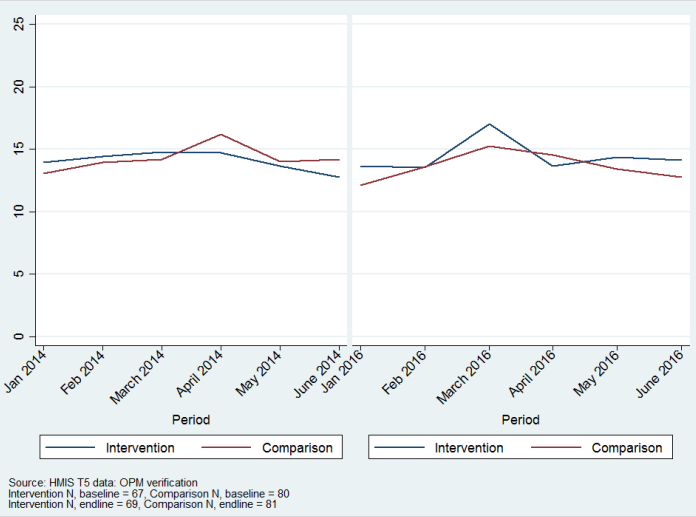
Source: HMIS T5 data: OPM verification

Average number of second ANC visits per facility per month



Source: HMIS T5 data: OPM verification

Average number of third ANC visits per facility per month



Source: HMIS T5 data: OPM verification

Average number of fourth ANC visits per facility per month

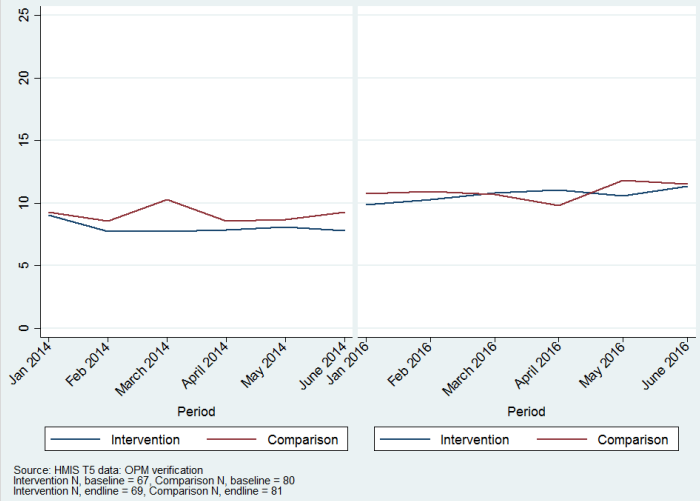
Source: HMIS T5 data: OPM verification

Figure 10 PNC visits – T5 data (OPM verification)

Average total number of ANC visits, per facility per month

Source: HMIS T5 data: OPM verification

Average PNC visits at 3 days per facility per month

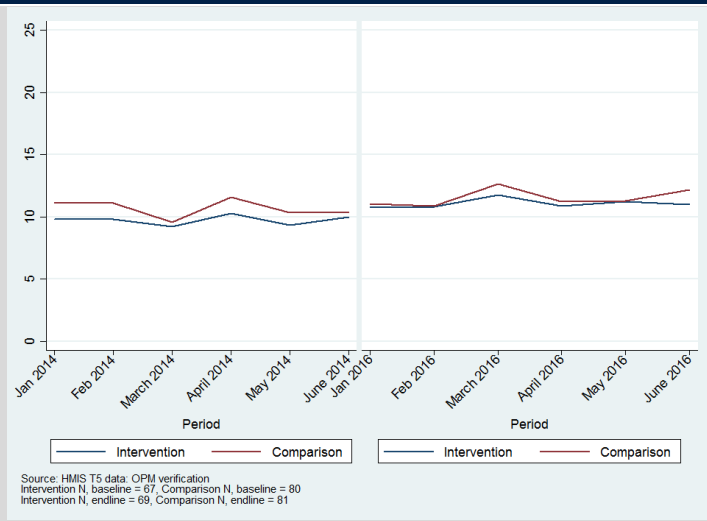


Source: HMIS T5 data: OPM verification

Average PNC visits at 7 days per facility per month

Source: HMIS T5 data: OPM verification

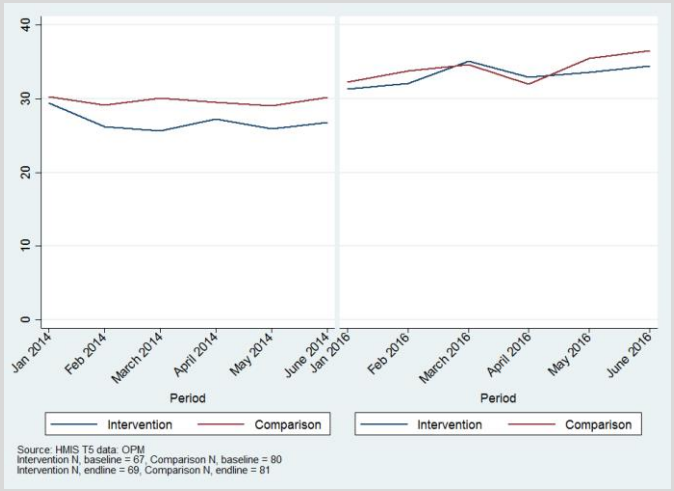
Average PNC visits at 6 weeks per facility per month



Source: HMIS T5 data: OPM verification

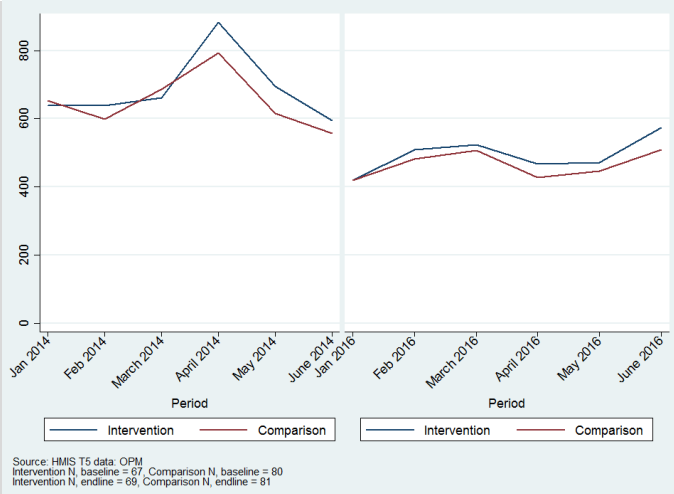
Figure 11 Total PNC, OPD, BCG and OPV1 visits – T5 data (OPM verification)

Average total number of PNC visits per facility per month



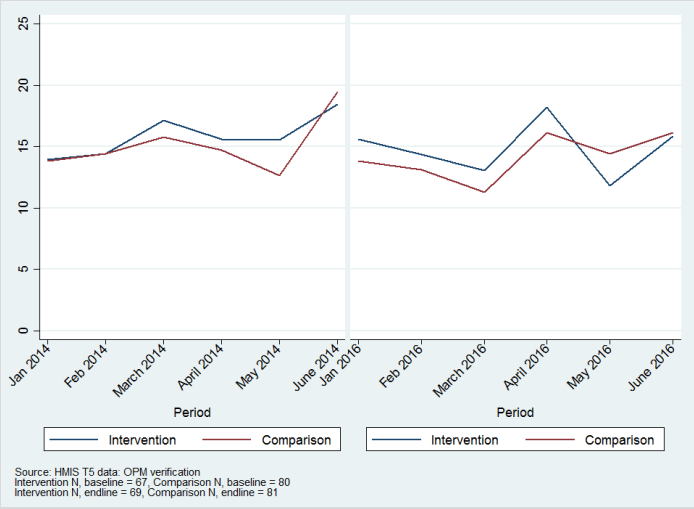
Source: HMIS T5 data: OPM verification

Average total number of new outpatients per facility per month



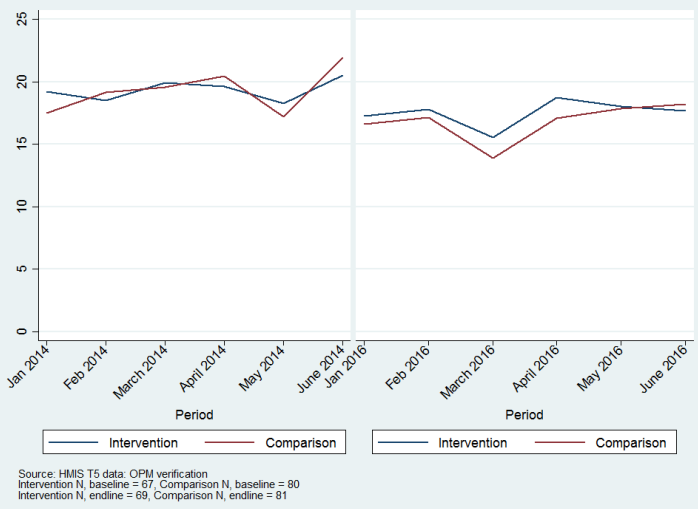
Source: HMIS T5 data: OPM verification

Average BCG immunisations per facility per month



Source: HMIS T5 data: OPM verification

Average OPV1 immunisations per facility per month



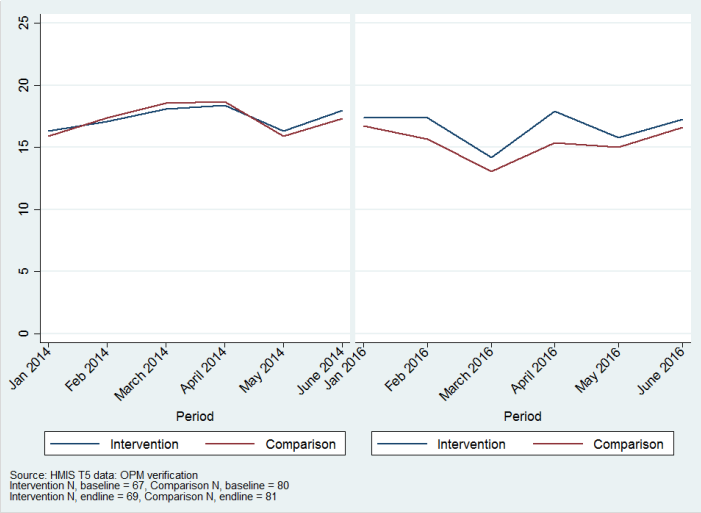
Source: HMIS T5 data: OPM verification

Figure 12 OPV and PENTA visits – T5 data (OPM verification)

Average OPV2 immunisations per facility per month

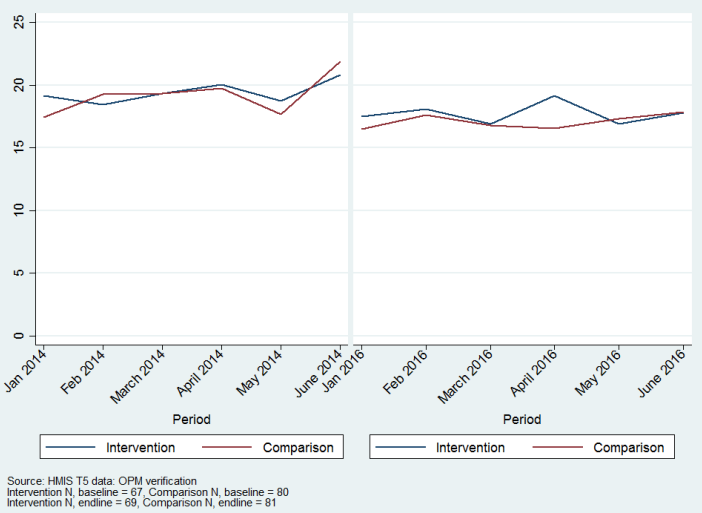
Source: HMIS T5 data: OPM verification

Average OPV3 immunisations per facility per month



Source: HMIS T5 data: OPM verification

Average PENTA1 immunisations per facility per month



Source: HMIS T5 data: OPM verification

Average PENTA2 immunisations per facility per month

Source: HMIS T5 data: OPM verification

Figure 13 PENTA and Measles visits – T5 data (OPM verification)

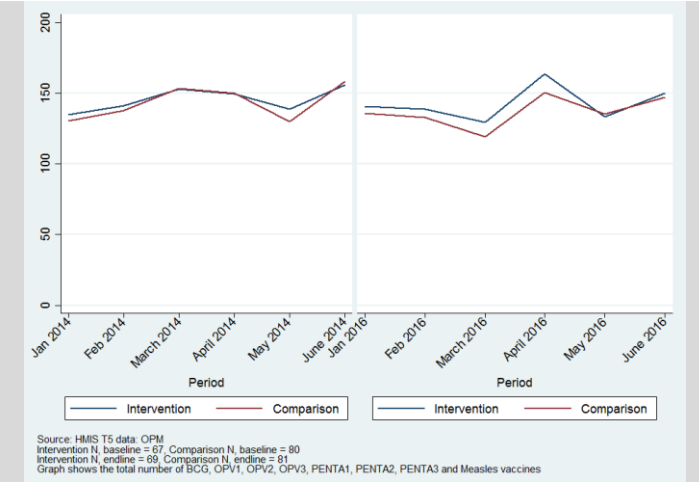
Average PENTA3 immunisations per facility per month

Source: HMIS T5 data: OPM verification

Average Measles immunisations per facility per month

Source: HMIS T5 data: OPM verification

Average total number of immunisations per facility per month

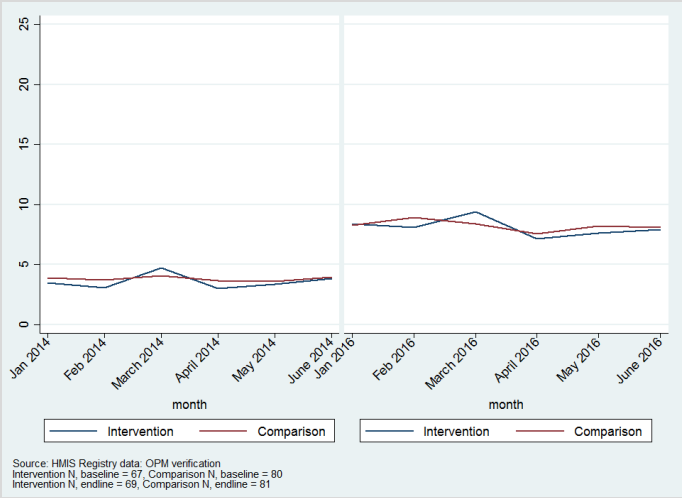


Source: HMIS T5 data: OPM verification

4.3 Facility utilisation graphs – Registry data (OPM verification)

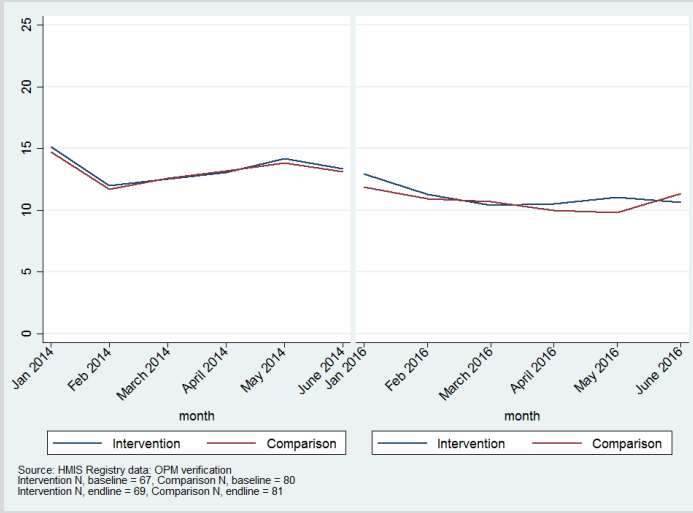
Figure 14 First ANC visits – Registry data (OPM verification)

Average first ANC visits under 16 weeks, per facility, per month



Source: HMIS Registry data: OPM verification

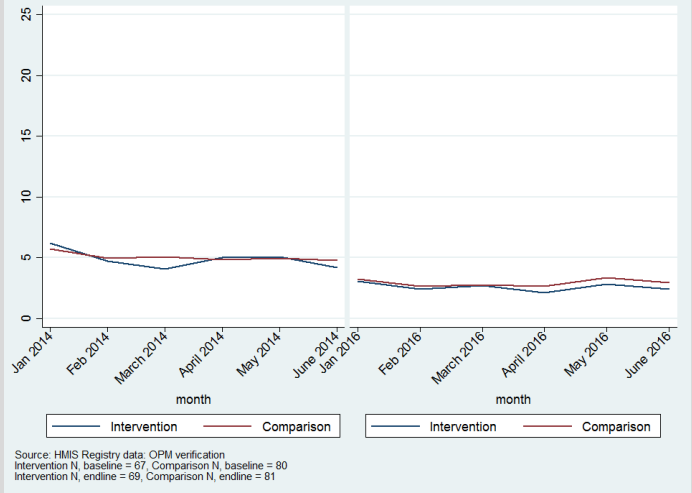
Average first ANC visits, 16 - 27 weeks, per facility, per month



Source: HMIS Registry data: OPM verification

Figure 15 Second, Third and Fourth ANC visits – T5 data (OPM verification)

Average first ANC visits over 28 weeks, per facility per month

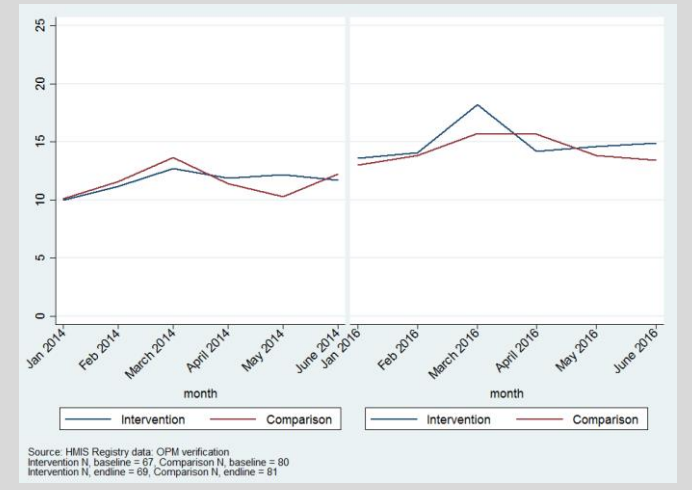


Source: HMIS Registry data: OPM verification

Average number of second ANC visits per facility per month

Source: HMIS Registry data: OPM verification

Average number of third ANC visits per facility per month



Source: HMIS Registry data: OPM verification

Average number of fourth ANC visits per facility per month

Source: HMIS Registry data: OPM verification

Figure 16 PNC visits – Registry data (OPM verification)

Average total number of ANC visits, per facility per month

Source: HMIS Registry data: OPM verification

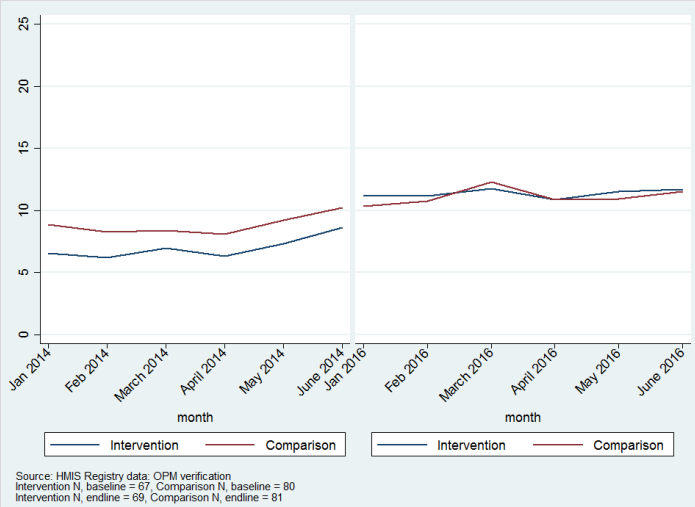
Average PNC visits at 3 days per facility per month

Source: HMIS Registry data: OPM verification

Average PNC visits at 7 days per facility per month

Source: HMIS Registry data: OPM verification

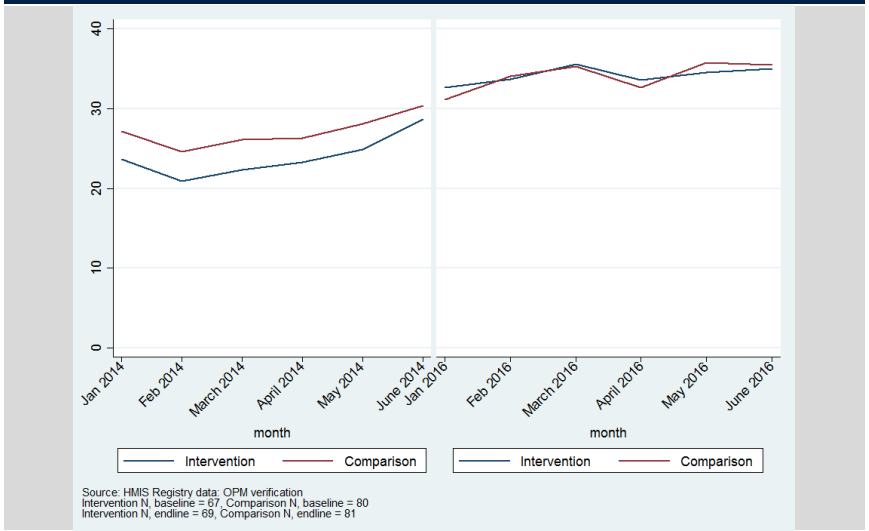
Average PNC visits at 6 weeks per facility per month



Source: HMIS Registry data: OPM verification

Figure 17 Total PNC and OPD visits – Registry data (OPM verification)

Average total number of PNC visits per facility per month



Source: HMIS Registry data: OPM verification

Average total number of new outpatients per facility per month

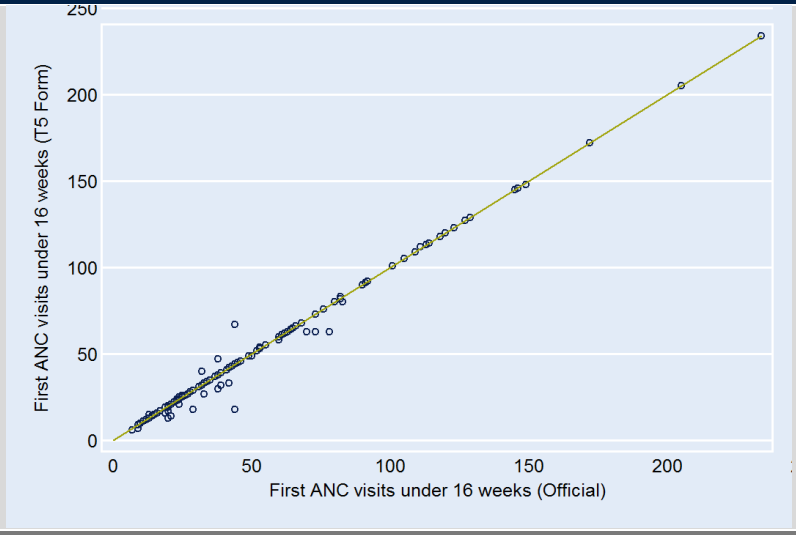
Source: HMIS Registry data: OPM verification

4.4 HMIS quality check

4.4.1 Comparing OPM verification data with official HMIS data (ANC variables only)

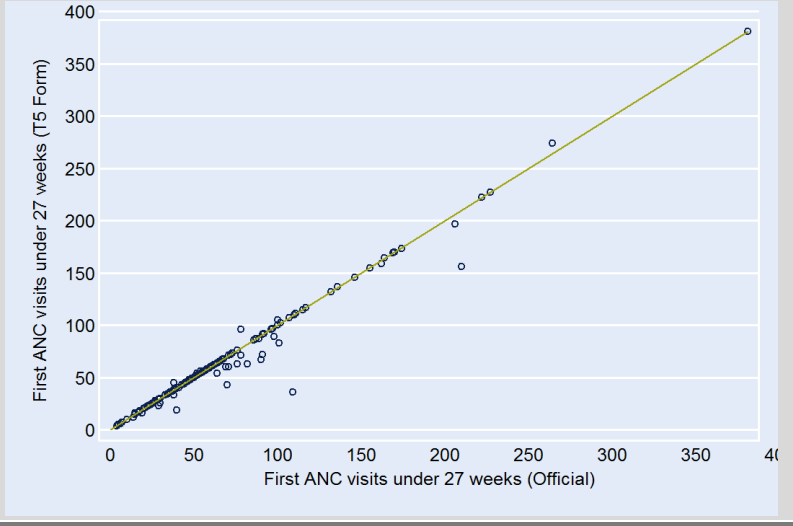
Figure 18 Verification graphs: ANC first visits, comparison between OPM T5 verification and official HMIS

Average first ANC visits under 16 weeks, per facility over 6 months of the endline period (January – June 2016)



Source: HMIS T5 data: OPM verification, HMIS official data

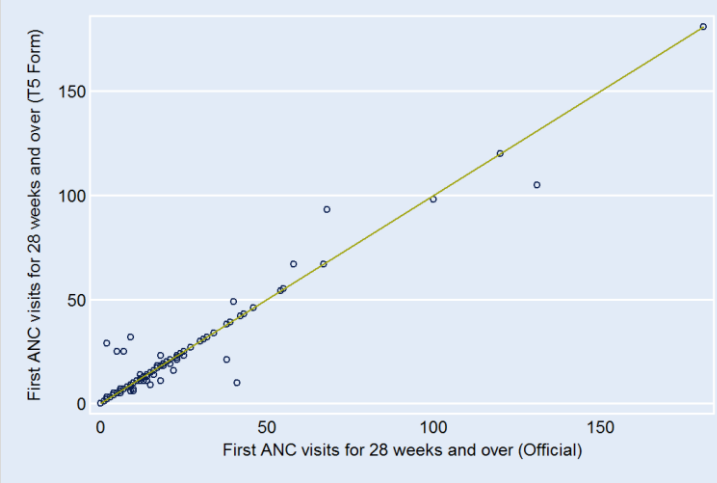
Average first ANC visits, 16 - 27 weeks, per facility over 6 months of the endline period (January – June 2016)



Source: HMIS T5 data: OPM verification, HMIS official data

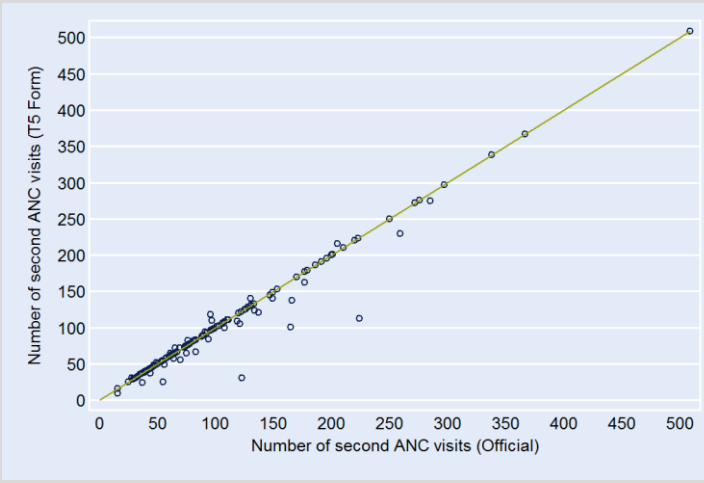
Figure 19 Verification graphs: ANC visits, comparison between OPM T5 verification and official HMIS

Average first ANC visits over 28 weeks, per facility over 6 months of the endline period (January – June 2016)



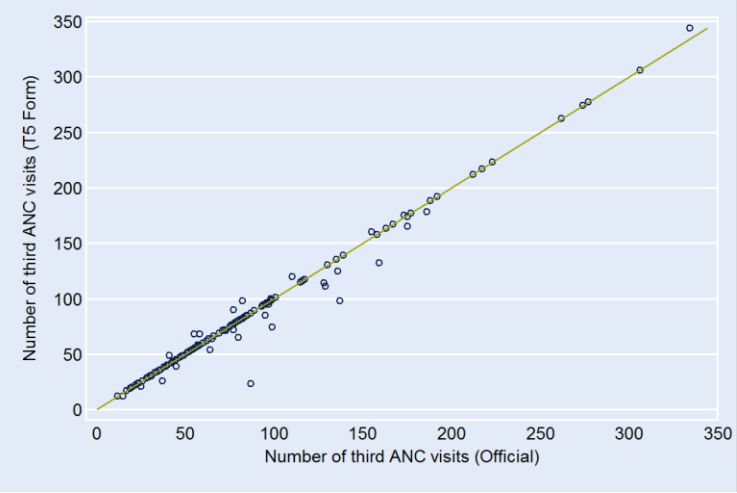
Source: HMIS T5 data: OPM verification, HMIS official data

Average number of second ANC visits per facility over 6 months of the endline period (January – June 2016)



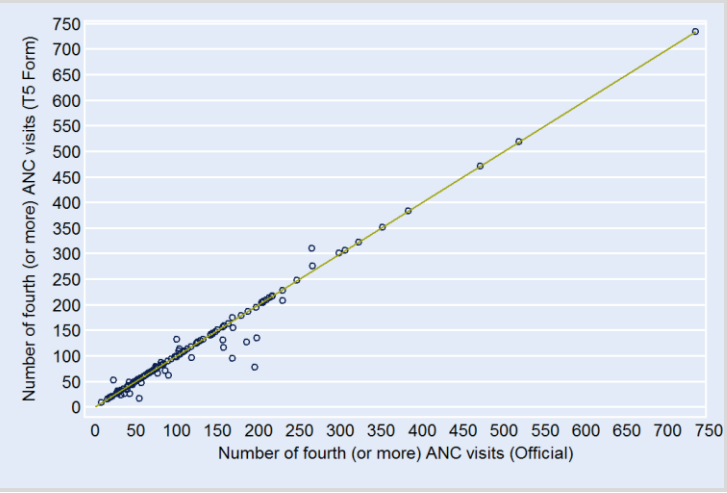
Source: HMIS T5 data: OPM verification, HMIS official data

Average number of third ANC visits per facility over 6 months of the endline period (January – June 2016)



Source: HMIS T5 data: OPM verification, HMIS official data

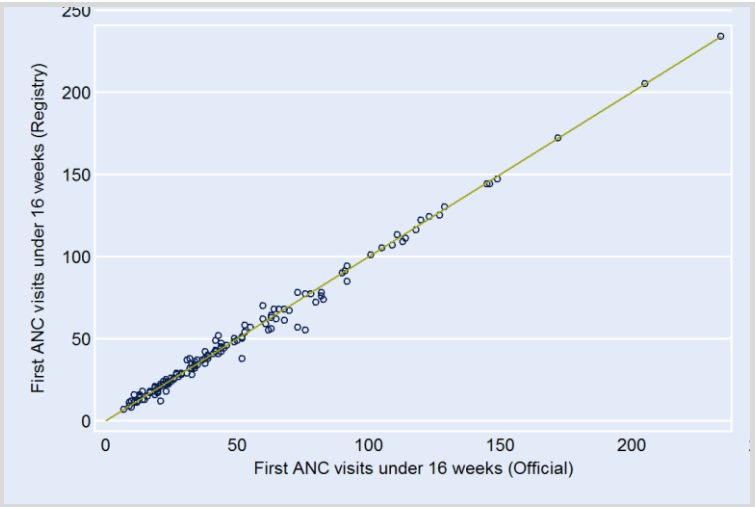
Average number of fourth ANC visits per facility over 6 months of the endline period (January – June 2016)



Source: HMIS T5 data: OPM verification, HMIS official data

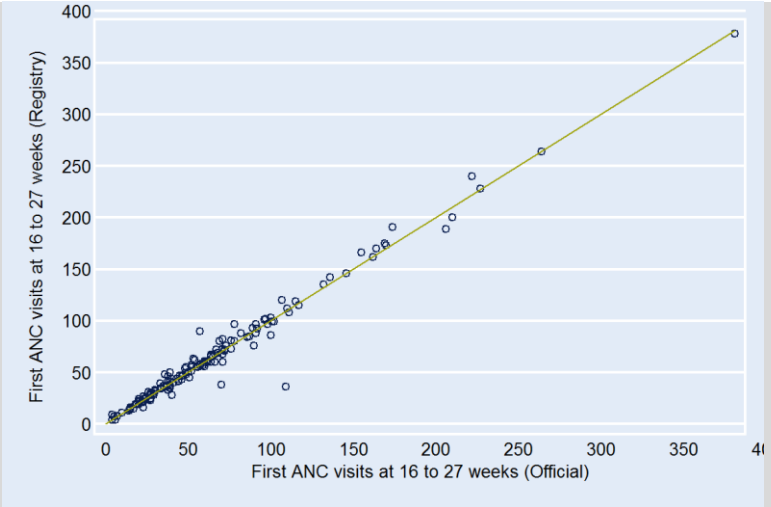
Figure 20 Verification graphs: ANC first visits, comparison between OPM Registry verification and official HMIS

Average first ANC visits under 16 weeks, per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry data: OPM verification, HMIS official data

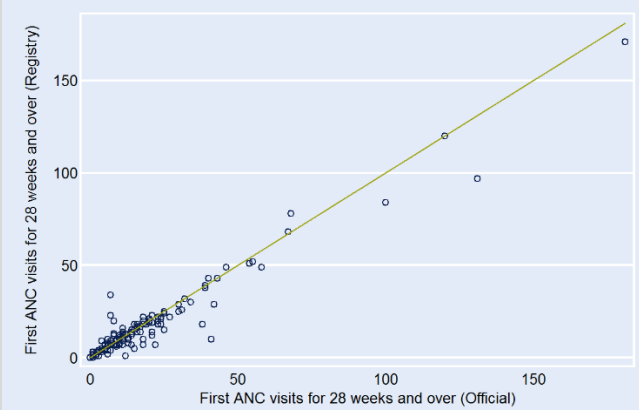
Average first ANC visits, 16 - 27 weeks, per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry data: OPM verification, HMIS official data

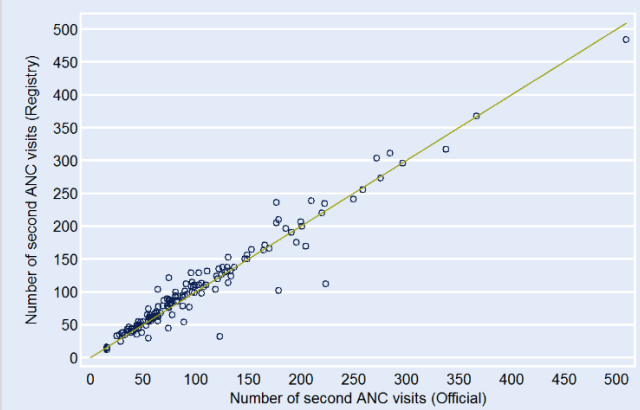
Figure 21 Verification graphs: ANC visits, comparison between OPM Registry verification and official HMIS

Average first ANC visits over 28 weeks, per facility over 6 months of the endline period (January – June 2016)



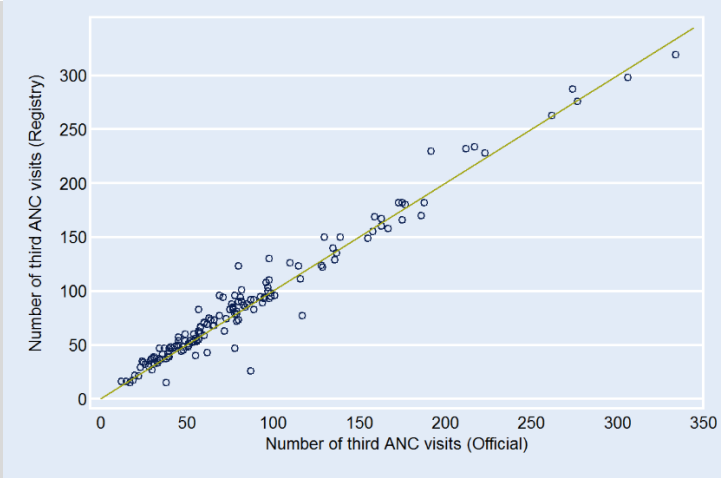
Source: HMIS Registry data: OPM verification, HMIS official data

Average number of second ANC visits per facility over 6 months of the endline period (January – June 2016)



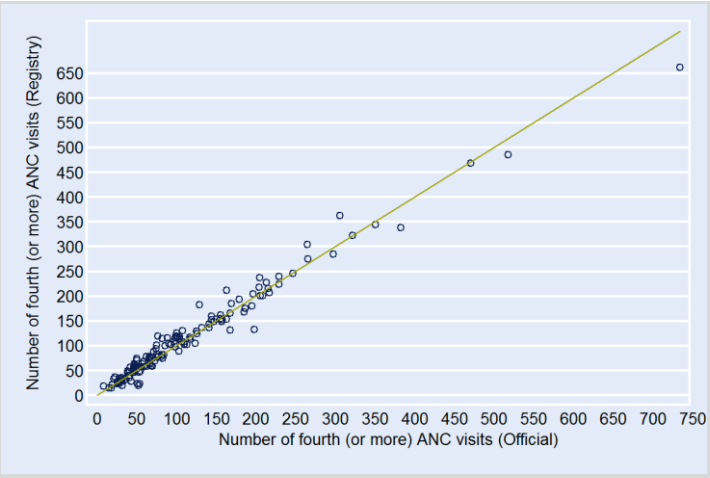
Source: HMIS Registry data: OPM verification, HMIS official data

Average number of third ANC visits per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry data: OPM verification, HMIS official data

Average number of fourth ANC visits per facility over 6 months of the endline period (January – June 2016)

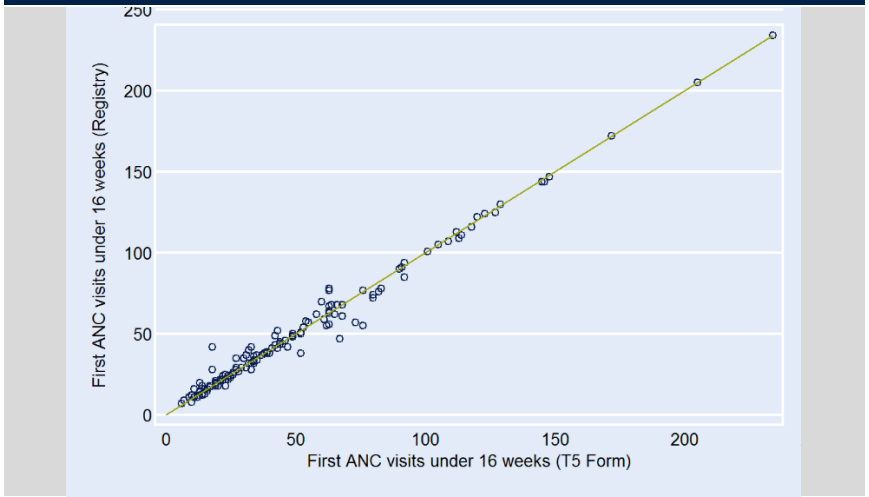


Source: HMIS Registry data: OPM verification, HMIS official data

4.4.2 Comparing OPM T5 verification data with OPM Registry verification data

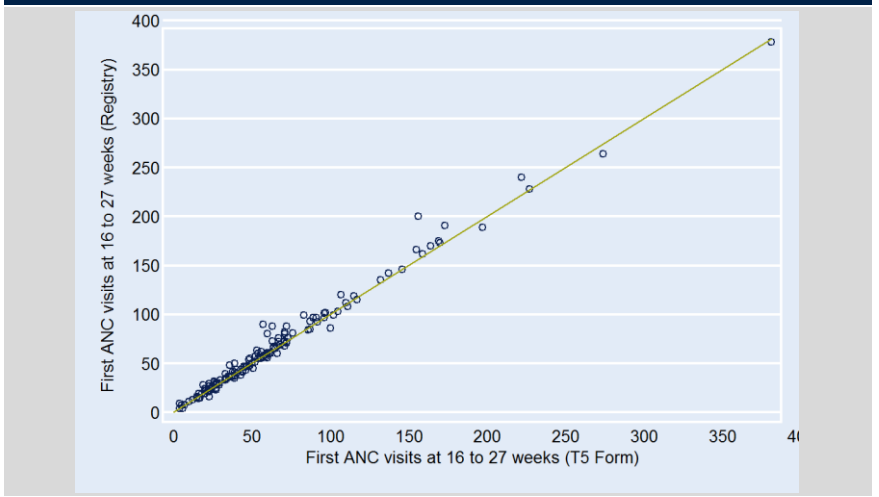
Figure 22 Verification graphs: ANC first visits, comparison between OPM Registry verification and T5 verification

Average first ANC visits under 16 weeks, per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry and T5 data: OPM verification

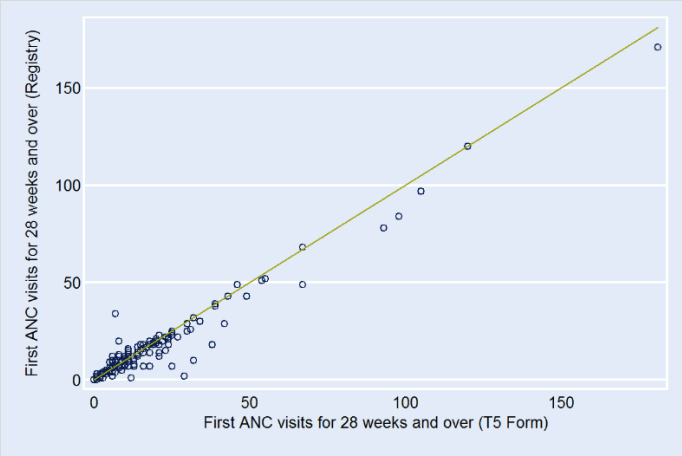
Average first ANC visits, 16 - 27 weeks, per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry and T5 data: OPM verification

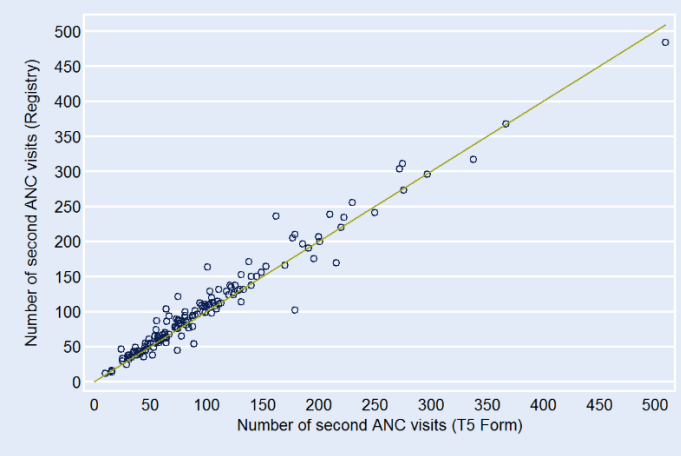
Figure 23 Verification graphs: ANC visits, comparison between OPM Registry verification and T5 verification

Average first ANC visits over 28 weeks, per facility over 6 months of the endline period (January – June 2016)



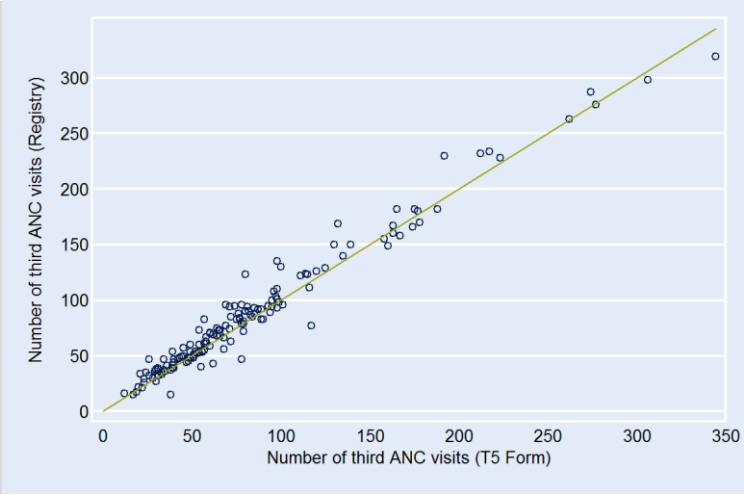
Source: HMIS Registry and T5 data: OPM verification

Average number of second ANC visits per facility over 6 months of the endline period (January – June 2016)



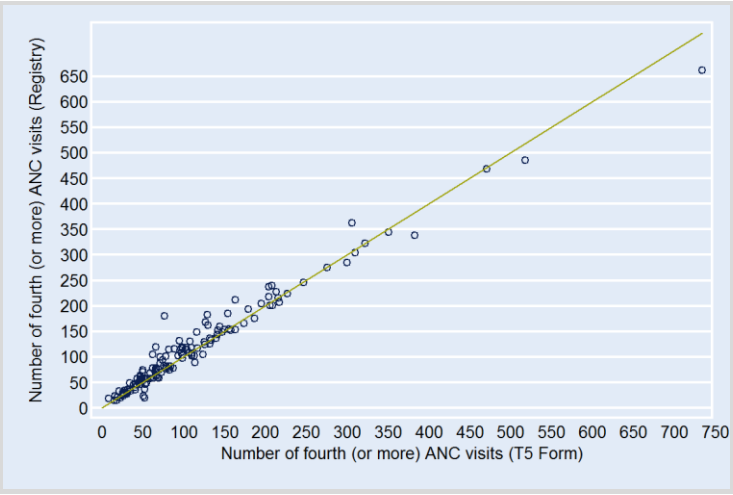
Source: HMIS Registry and T5 data: OPM verification

Average number of third ANC visits per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry and T5 data: OPM verification

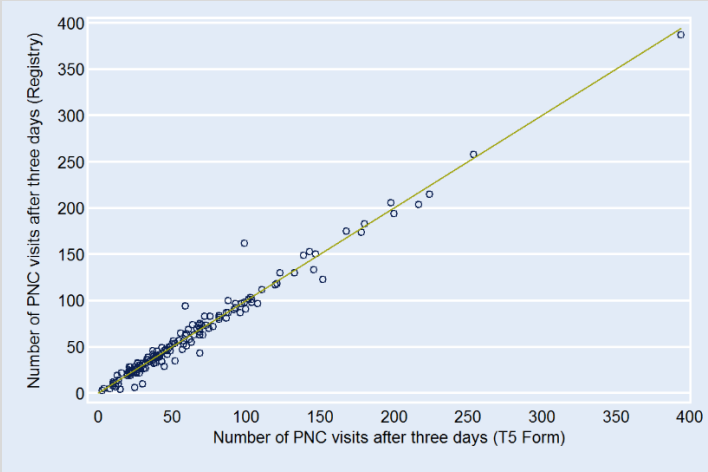
Average number of fourth ANC visits per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry and T5 data: OPM verification

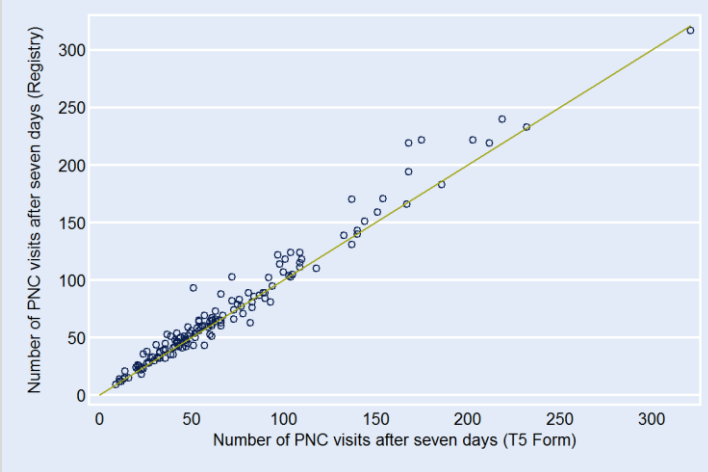
Figure 24 Verification graphs: PNC and OPD visits, comparison between OPM Registry verification and T5 verification

Average PNC visits at 3 days per facility over 6 months of the endline period (January – June 2016)



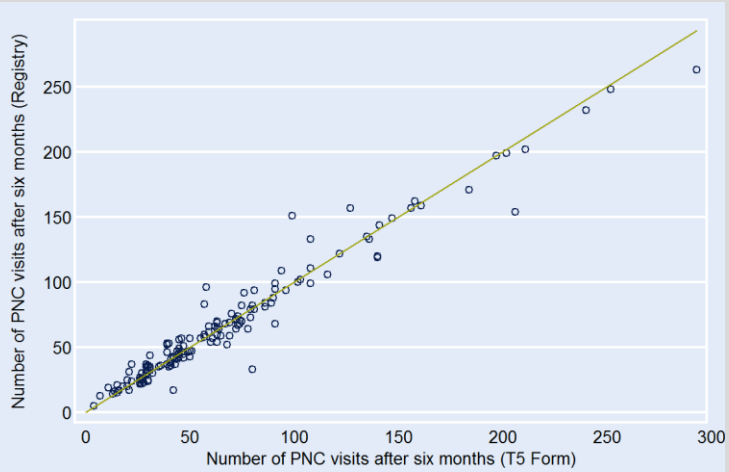
Source: HMIS Registry and T5 data: OPM verification

Average PNC visits at 7 days per facility over 6 months of the endline period (January – June 2016)



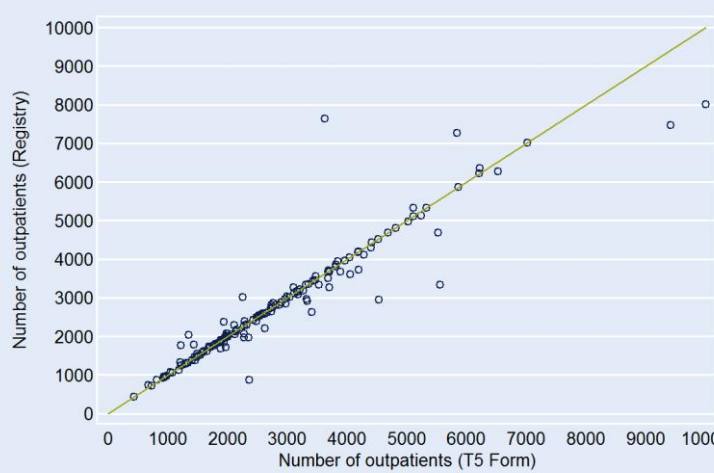
Source: HMIS Registry and T5 data: OPM verification

Average PNC visits at 6 weeks per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry and T5 data: OPM verification

Average total number of new outpatients per facility over 6 months of the endline period (January – June 2016)



Source: HMIS Registry and T5 data: OPM verification

Annex A Original Terms of Reference

Note that this evaluation report responds to the 'in-depth evaluation' component of the ToRs only.

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 (e.g. 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

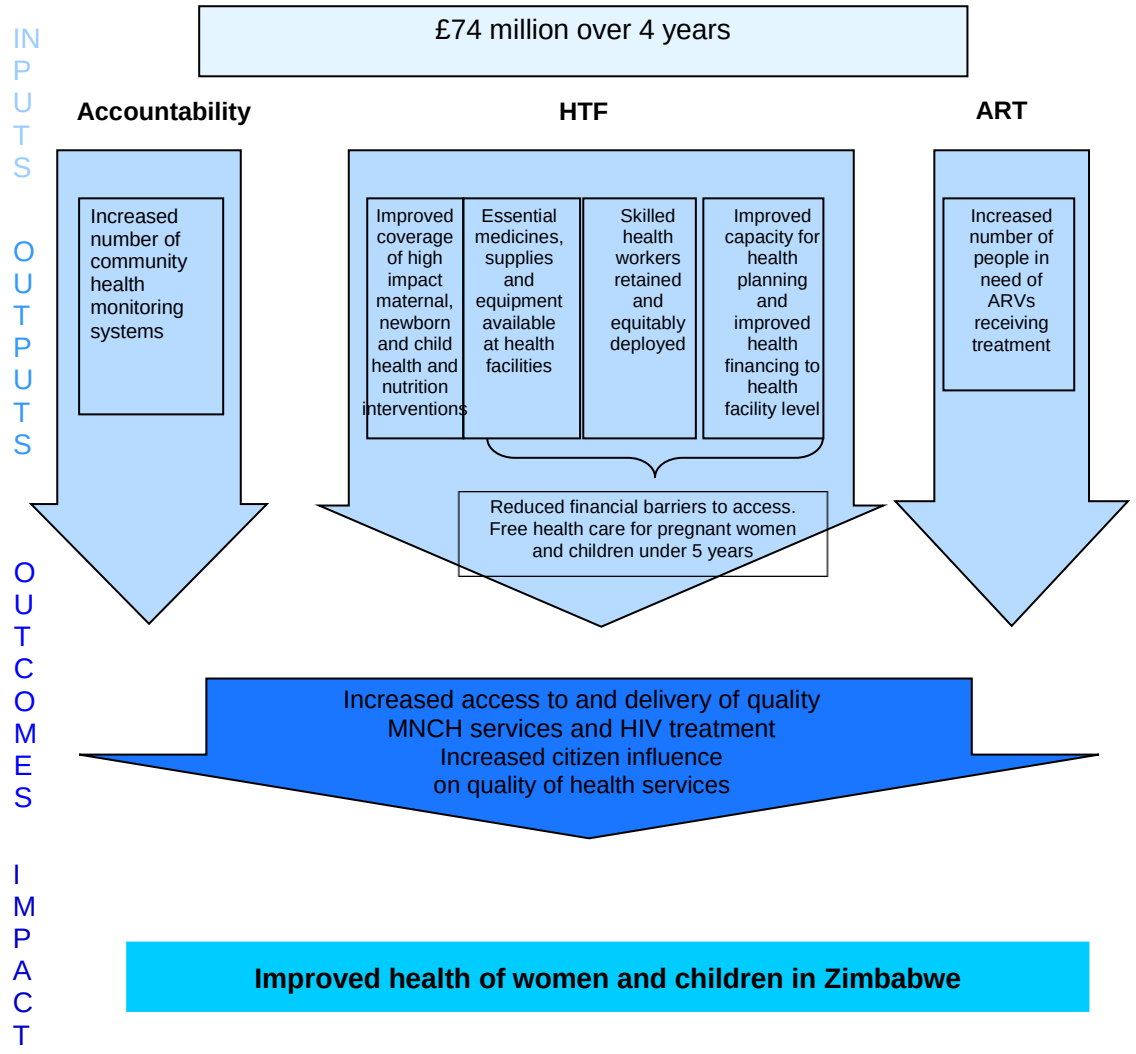
and a decrease in key health worker vacancies.

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.[5]
- 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;

[5] 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 multi-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[6]	**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

[6] 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 specific objectives 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 (cost benefit);* *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 Departures from the ToR

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 I.

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. So as not to replicate existing data collection, we agreed that we would rely on secondary data sources to measure service utilisation and the technical quality of health facilities.

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. The rationale for the J curve hypothesis is that the programme may raise citizen's expectations on what they can expect from health facilities and thus initially reduce satisfaction and perceived quality, before improvements in facility quality have occurred that will cause satisfaction to increase again. 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 rely on primary data, we only have two observations at baseline and endline; therefore we are not be able to measure if impact follows a J curve.

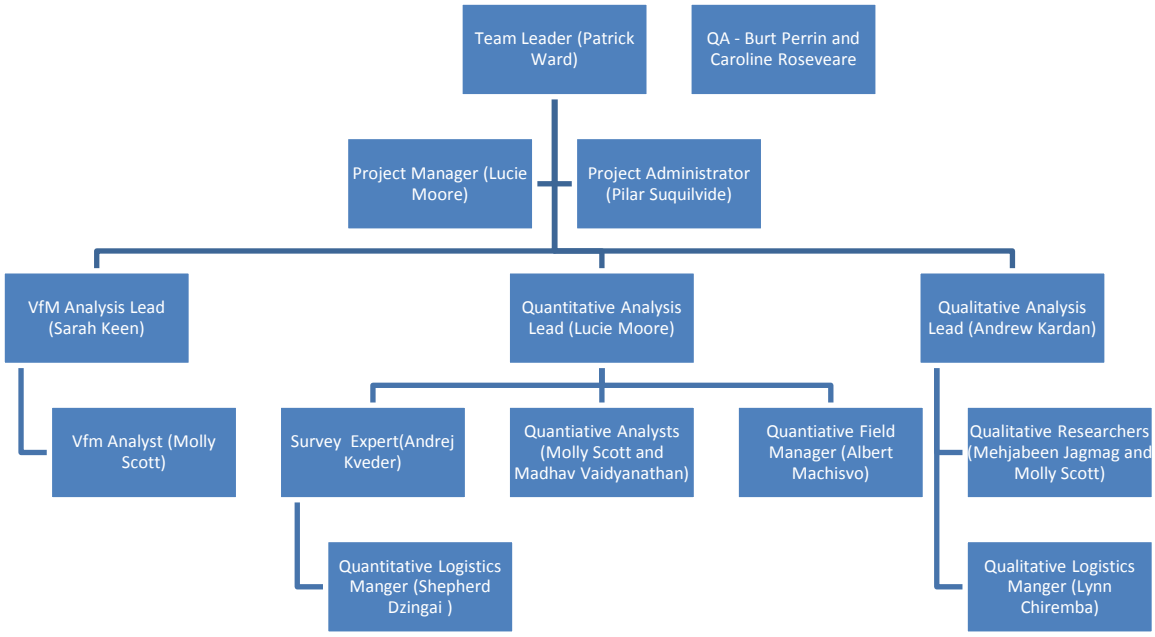
Annex C The evaluation team

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 25: 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. **Molly** supported the training of the enumerators, quality assured the data collection, lead the data cleaning, conducted the data analysis and helped draft the report. **Albert** managed the in-country data collection team. **Madhav** worked with Lucie and Molly on the data analysis of the Health Facility Survey and the analysis of the HMIS data. **Andrew** led the quantitative component of the evaluation, including the design of the qualitative tools, as well as reviewing the report. **Molly and Mehjabeen** each led one of the qualitative data collection teams, conducted the qualitative

analysis and contributed to the report writing. **Molly and Mehjabeen** were supported by Lynn, managed the logistics for the qualitative data collection. **Sarah** has overall responsibility for the VfM analysis and is supported by Molly.

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 manages the Quantitative Impact Evaluation team in the Monitoring and Evaluation portfolio 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 also has experience in theory-based approaches to evaluation using mixed methods. 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 randomised impact evaluation of the Child Development Grant Program in Nigeria, an unconditional cash transfer program for pregnant women and mothers with young children. She has also worked on the impact evaluation of a five year, £50m child nutrition programme, which is operating in 5 states of 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: **Andrew Kardan** is a senior consultant within the Social Policy Programme at OPM. Andrew's thematic interest lies in social policy with particular focus on social protection. During his time at OPM, Andrew has worked on different aspects of social

protection, including budgetary and fiscal sustainability analysis, capacity assessments, process review of mechanisms, as well as qualitative impact evaluation and assessments of social protection programmes. Andrew has a particular interest in using qualitative or mixed methods approaches to research and evaluations, drawing on participatory approaches. He has undertaken a large number of theory based evaluations, including programme and project level evaluation of multi-stakeholder and multi-country evaluations under social protection, health and education. Prior to OPM, Andrew worked as a senior analyst within the Ministry of Finance and Development Planning in Lesotho through the ODI fellowship programme and subsequently as a macroeconomic advisor within the Government.

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.

Quantitative, qualitative and VfM Analyst Molly Scott is an Assistant Consultant with OPM working in the Monitoring and Evaluation portfolio. She has experience of both quantitative and mixed methods approaches to evaluation, primarily in areas of early child development, maternal health and social protection. Her recent work has included impact evaluations of the Strengthening Community Participation in Health programme in Zimbabwe, the phase 2 evaluation of the Hunger Safety Nets Programme in northern Kenya, and the Delivering Reproductive Health Results programme in Pakistan, all of which have employed quasi-experimental methods and involved large-scale quantitative surveys. Molly has also worked on the theory-based evaluation of the DFID-funded 3DE programme, an innovative model of conducting rapid impact evaluations to respond to identified evidence needs of the ministries of health in Zambia and Uganda. Prior to joining OPM, Molly was a Research Assistant at the Institute of Fiscal Studies, where she worked on two randomised controlled trial evaluations of interventions targeting pregnant women and mothers, to improve maternal and child health outcomes. She holds an MSc in Economics from University College London.

Quantitative Field Manager: Albert Machisvo is a senior researcher in statistics at the University of Zimbabwe. He is an experienced and skilled professional with extensive research, data analysis and NGO experience. He is trained in statistical methodologies. He has experience in project planning, grants management, designing budgets and project financial analysis using the value for money measures.

Qualitative Researcher Mehjabeen Jagmag is a consultant at Oxford Policy Management in Oxford, UK. Mehjabeen works as a qualitative research specialist, with cross-sectoral experience in child protection, maternal and neo-natal health and financial inclusion. Prior to this, Mehjabeen managed the qualitative research hub for OPM in India, where she led the design and implementation of several mixed method evaluations. Mehjabeen has worked across the research cycle, developing and delivering qualitative analysis, tool development, fieldwork management and dissemination. At Centre for Policy Research, India, Mehjabeen managed two large public expenditure tracking exercises for the Ministry of Human Resource Development. She has also participated in developing community-led monitoring systems of the Right to Education Act in India. Previously, Mehjabeen has worked as an associate with Centre for Civil Society where her work involved liaising with both civil society and local governments across the country. Mehjabeen has completed her Masters in Anthropology of Development at the School of Oriental and African Studies as a Felix Scholar and has worked as a writer for leading national dailies in Mumbai.

Quality assurance: Burt Perrin is 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.

Quality assurance: Caroline Roseveare. 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).

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?**	**Has the context in which the programme is implemented changed since baseline?** • Have there been any changes to legislation, budget processes, nature of the interaction between this programme and district, province and national structures in the health sector?	KIIs with: • SC and CWGH staff. • National, Provincial and District level health staff • DFID staff Document review: • MNCH Annual Review • Social Accountability Approach Review Report (2015) • Government of Zimbabwe policy documents.
	• Have there been any significant socio-economic changes (e.g. drought, economic conditions and political instability) that have influenced the propensity of community members to use the facility, or how empowered they feel to raise complaints?	FGDs with: • Members of HCCs • Service and non-service users Document review: • SC Barrier analysis research (Dec 2015),
	Has the design or implementation model of the programme changed since baseline?	KIIs with SC and CWGH staff Key programme documents (for example: programme design documents, annual reviews).
	What are the implications of changes to context or programme design/implementation on the extent to which the programme is designed to best achieve its goals?	Qualitative assessment based on evaluators assessment of the above data sources

DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
	Were the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives, given the context in which it is implemented?	Interviews with: • SC and CWGH staff. • National, Provincial and District level health staff • DFID staff We will also draw on secondary evidence from programme reports (including the Annual Review)

EFFECTIVENESS
 	
What worked well and what worked less well and why?
 	
What were the major factors influencing the achievement or non-achievement of the objectives?
	Did the programme achieve intended outputs?
	
	• Quality and functionality of HCCs
	  ○ HCCs are well trained to understand their functions
	  ○ HCCs hold regular meetings with the community and health facility staff to discuss community health issues
	  ○ HCCs keep records of their meetings
	  ○ Community members are engaged with the HCCs and attend meetings
	  ○ HCCs monitor service quality at the facility
	  ○ HCCs carry out initiatives, where needed, to respond to community health priorities
	
	• Inclusive decision making regarding community and health facility resources
	  ○ The HCC and facility work together to develop an operational plan that reflects the needs and priorities of the community
	
	• Complaints and monitoring mechanisms at health facilities
		FGDs with:
		• HCC members
		• Facility users and non-users
		
		Interviews with:
		• Health facility staff
		• HCC heads
		• Facility users and non-users
		• Opinion leaders
		• HLFs and CMs
		
		Quantitative survey instruments:
		• ANC exit survey
		• U5 exit survey
		• HCC survey
		• Facility survey.

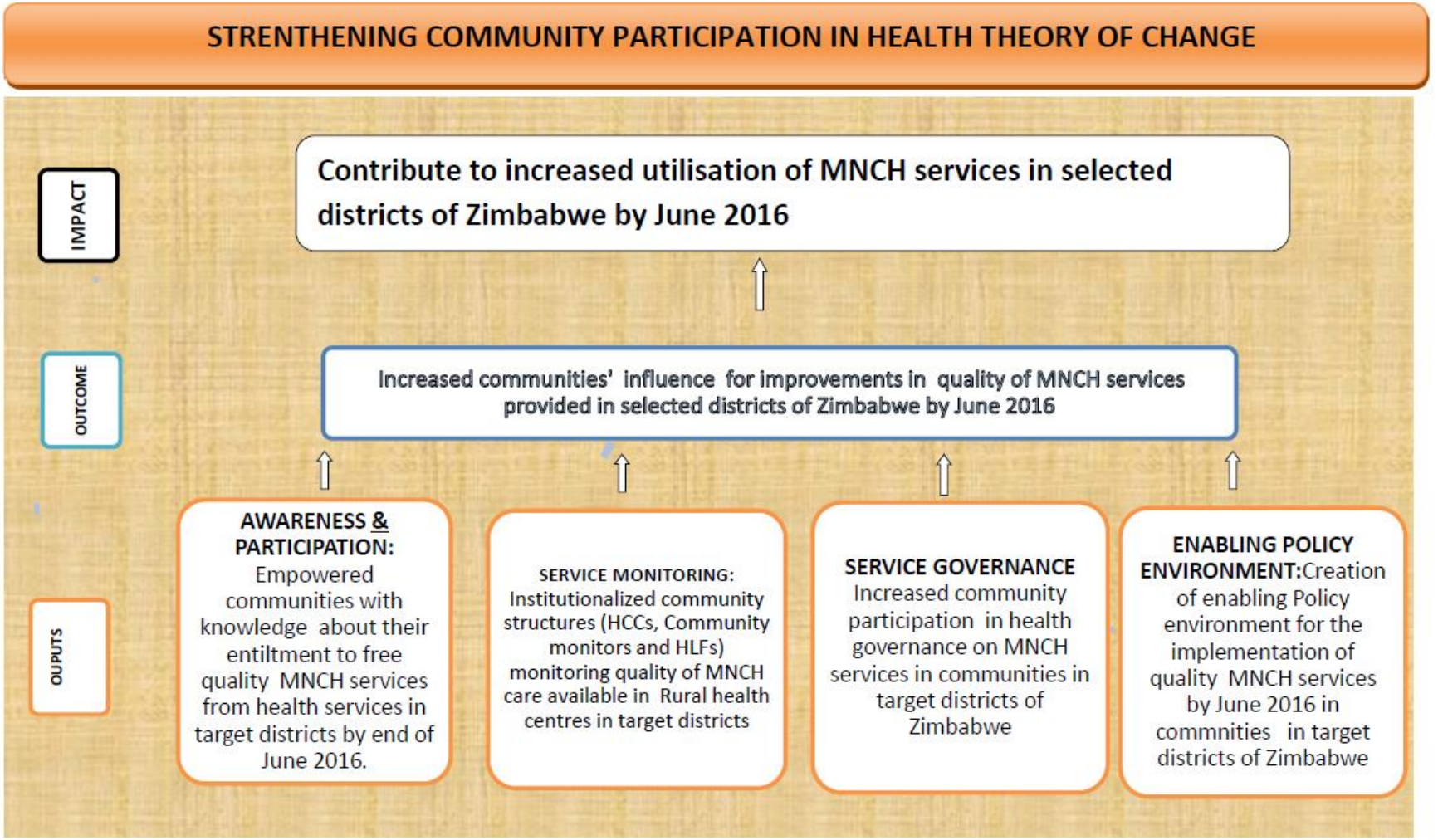
DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
	○ Complaints mechanisms are established at the facility (suggestion boxes, HCC Feedback forms, Community Scorecards and others). ○ Complaints mechanisms are used by community members ○ HCCs gather community feedback and discuss it with facility staff, to work together on a solution ○ Any concerns not addressed at the facility level are elevated to the DHE	
	• Knowledge of rights and entitlements ○ Community members are aware of their rights at the facility ○ Community members are aware of key maternal and IYCF behaviours	Quantitative survey instruments: • ANC exit survey • U5 exit survey
	• Enabling policy environment for MNCH services ○ The advocacy and communication strategy for SCPH is implemented.	Interviews with: • SC and CWGH staff. • National, Provincial and District level health staff • DFID staff
	Why and how did the programme achieve the observed outputs (or why were planned outputs not realised?) • Was the programme implemented and managed effectively to achieve the intended outputs? ○ What activities took place, where were they conducted and how often?	Interviews with: • SC and CWGH staff. • HCC heads • HLFs and CMs • Project records (monthly, quarterly reports, status of intervention reports

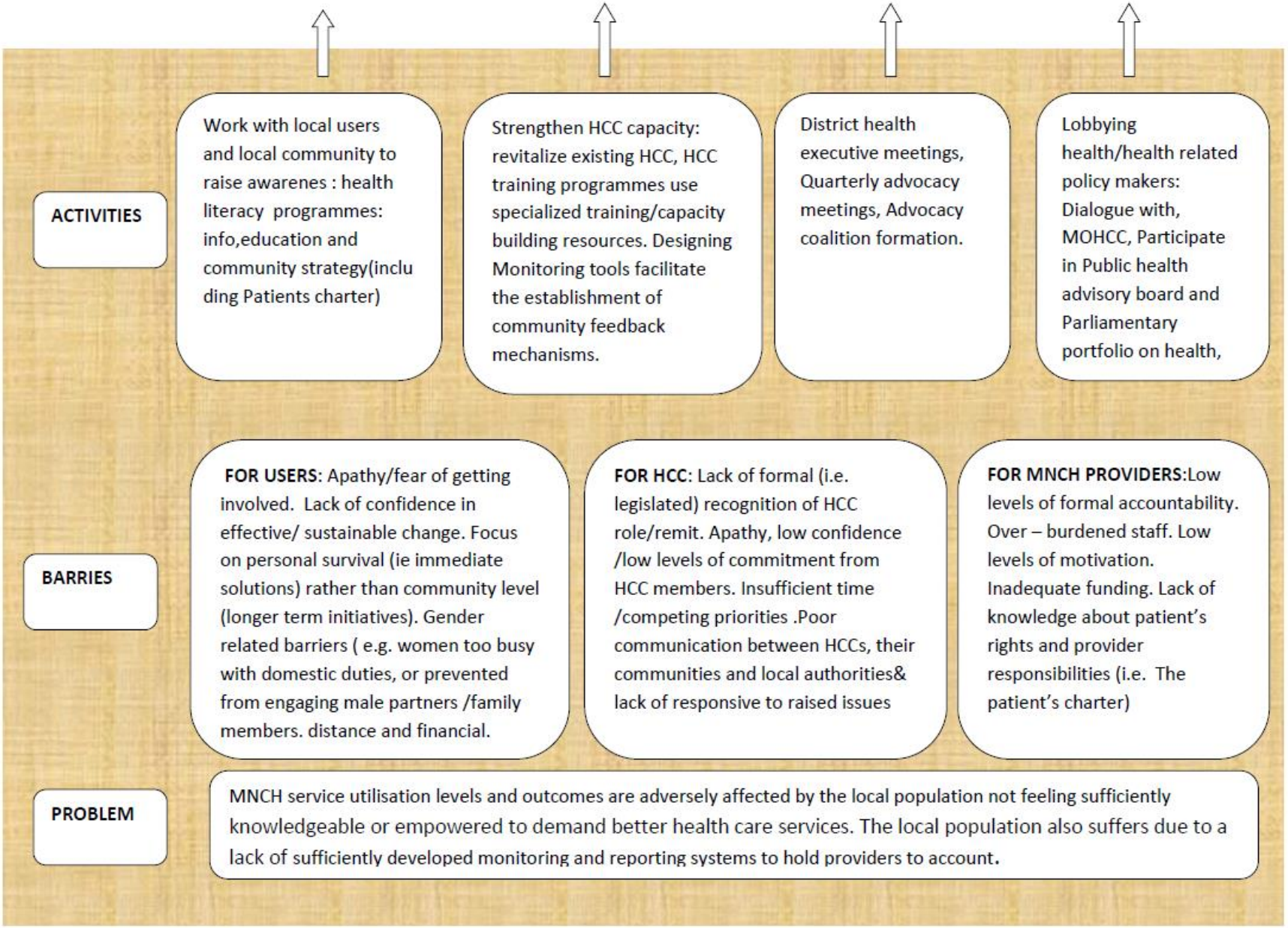
DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
	• Did the assumptions underlying the attainment of outputs hold in reality?	We will assess how the programme achieved or did not achieve its planned outputs using a combination of the data sources given above to reach an evaluative judgement.
EFFICIENCY **Was it good VfM?** **How could VfM have been improved?**	**Did the programme represent good VfM?** **How could VfM have been improved?**	Implementing partner programme expenditure accounts Quarterly Milestone and Financial Reports to DFID (to measure total programme cost) KIIs with SC/CWGH staff Key output indicator data from impact evaluation (to measure overall cost effectiveness of achieved results). Crown Agents RBF survey (which reports quality of care index) Annual Review (which reports on the annual cost per person supported by each HCC). Save the Children estimates on the number of volunteers (HLF and CM). The number of HCC members at each facility, as measured by quantitative HCC questionnaire. Average amount of time per month spent by HLFs and CMs volunteering, as measured by the quantitative HLF and CM surveys(to estimate the time-costs of taking part in the programme)

DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
IMPACT **What was the causal effect and contribution of the programme on the expected outputs, outcomes and impact along its theory of change?**	**What was the causal effect of the programme on community-level outcomes and impacts?** Intended and outcomes are: • Service utilisation • Technical quality of health facilities • Perceived quality of care	To measure service utilisation, we will assess the HMIS and HMIS Compilation To measure the technical quality of facilities we will use MoHCC Quality Checklist data, together with some of the information from the quantitative survey with Heads of Facility. To measure perceived quality of care, we will use satisfaction data from our ANC and U5 Quant survey instruments:
	Why and how did the programme achieve the observed outcomes and impacts (or why were expected impacts and outcomes not realised?) • Do the assumptions underlying the attainment of outcomes and impacts in the ToC hold? • Are there alternative explanations not outlined in the ToC which could explain the outcomes and impacts observed? **Were there any unexpected effects?** • What, if any, unanticipated effects (positive or negative) has the programme had, for example: ○ On gender norms. ○ On community dynamics (for example, changes to traditional social norms or power relations) ○ On the nature of decision-making processes?	We will gather evidence from all data sources that we are using to understand whether the assumptions underpinning the ToC were met, and if there were any unexpected effects. This includes all primary quantitative, qualitative and secondary data sources. In order to test whether the assumptions outlined in the ToC held, we will review all evidence at our disposal against each specific assumption that is identified. Understanding whether the programme had any unexpected or negative effects will also draw on all data sources. The quantitative data can be used to identify whether there were any negative effects of the programme. It may also shed some light on unexpected effects if a pattern of answers emerges that is not consistent with the ToC. However since the quantitative survey consists of fully structured questionnaires, it is not well suited to providing a rich source of information on outcomes that were not anticipated by the evaluators or programme stakeholders in advance. The qualitative research and secondary data sources

DAC Criteria and key evaluation questions	Evaluation sub-questions	Data sources
		will therefore be crucial to drawing meaningful conclusions around unexpected effects.
	To what extent were there spillovers as a result of the programme? • Are programme activities being replicated in facilities where the intervention is not being implemented, and if so to what extent?	KIIs with MNCH decision-makers at district and provincial level. Quant district level survey
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?**	**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?	FGDs with: • HCC members Interviews with: • Facility staff • HCC heads • SC and CWGH staff. • National, Provincial and District level health staff • DFID staff
	To what extent is the programme itself likely to continue, and for how long? • Has the programme successfully leveraged further funding? • Is their sufficient motivation and will among programme staff and stakeholders to continue the programme?	
	How likely are the institutional arrangements under MNCH to continue beyond the lifetime of the programme? • Will HCCs continue to support monitoring initiatives without external funding and 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? • Have there been any changes to the resourcing or financing model for the health sector, particularly in relation to supporting HCCs?	

Annex E SC and CWGH programme theory of change diagram




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 and OPM comments

F.1 Programme logframe

This is the logframe as completed by Save the Children 16 Nov 2016

PROJECT NAME	**Strengthening Voice and Accountability for Improved Maternal, Newborn and Child Health Services in Zimbabwe**						
IMPACT	**Impact Indicator 1**		**Baseline 2014**	**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	**0%**	**N/A**	**N/A**	**2%**	**5%**
		Achieved				**12%**	**14%**
			Source:				
			Baseline and Endline : Crown agents				
	Impact Indicator 2		**Baseline 2014**	**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	**0%**	**N/A**	**N/A**	**5%**	**10%**
		Achieved				**8%**	**15%**
			Source:				
			Baseline and endline: Crown agents				
	Impact Indicator 3		**Baseline 2014**	**Milestone Dec 13**	**Milestone June 14**	**Milestone June 15**	**Target Jun 16**
	% Increase of children under one year that are fully immunised greater than unsupported/control sites	Planned	0%	**N/A**	**N/A**	**2%**	**5%**
		Achieved				**-18%**	**29%**
			Source:				
			Baseline : Crown agents				
	Impact Indicator 4		**Baseline 2014**	**Milestone Dec 13**	**Milestone June 14**	**Milestone June 15**	**Target Jun 16**

	Increase in number of new OPD cases ~~of children under 5~~ seen in the past year within the targeted catchment population greater than unsupported/control sites	Planned	**0%**	**N/A**	**N/A**	**2%**	**5%**	
		Achieved				**-4**	**5%**	
			Source					
			Baseline and endline: OPM					
	Impact Indicator 5		**Baseline 2014**	**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 in the past year	Planned	**TBC**	**N/A**	**N/A**	**2%**	**5%**	
		Achieved				**0%**	**5%**	
			Source					
			Baseline: Crown agents/ RBF database					
OUTCOME	**Outcome Indicator 1**		**Baseline 2014**	**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				**67%**	**98%**	
			Source					
			District level feedback database, HCC Meeting minutes, District Level Advocacy Meeting					
	Outcome Indicator 2		**Baseline 2014**	**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	**80%**	**N/A**	**N/A**	**85%**	**90%**	
		Achieved				**87%**		
			Source					
			Score card					
	Outcome Indicator 3		**Baseline 2014**	**Milestone Dec 13**	**Milestone June 14**	**Milestone June 15**	**Target Jun 16**	
	% % increase in overall quality of care composite score of RHC HSF quality assessment in the past year compared to control sites [5]	Planned	**0**		**N/A**	**102**	**166**	
		Achieved				**1%**	**1%**	
			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 2014**	**Milestone Dec 13**	**Milestone June 14**	**Milestone June 15**	**Target Jun 16**	**Assumption**
Empowered communities with knowledge about their entitlement 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 targeted catchment population in the past year**	Planned	**66%**	**N/A**		**70%**	**75%**	**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				**75%**	**87%**	
			Source:					
			Scorecard,					
	Output Indicator 1.2		**Baseline 2014**	**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	**74%**	**N/A**	**N/A**	**80%**	**85%**	
		Achieved				**83%**	**95%**	
			Source					
			Scorecard,					
	Output Indicator 1.3		**Baseline 2013**	**Milestone Dec 13**	**Milestone June 14**	**Milestone June 15**	**Target Jun 16**	
	Number of MNCH service users who are utilising the feedback mechanisms within the targeted catchment population past year	Planned	**5881**	**N/A**	**N/A**	**30%**	**40%**	
		Achieved				**-5%**	4643	
			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 entitled to at RHC level within targeted catchment area in the past year	Planned	**81%**	**N/A**		**83%**	**85%**	
		Achieved				**87%**	**96%**	
			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**	**N/A**	**40%**	**40%**	
		Achieved				**40%**	**41%**	
			Source					
			MoHCC RHC Catchment population estimates					
INPUTS (£)			**Govt (£)**			**Other (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**							
OUTPUT 2	**Output Indicator 2.1**		**Baseline 2014**	**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 targeted catchment area in the past year**	Planned	**0**	**N/A**	0	102	166	**Political stability, Economic stability promoting Government efforts to finance the health sector, Non-politicisation of Health service fund. Community and MOHWC acceptance of CBMI board**
		Achieved				**102**	**166**	
			Source:					
			Checklist designed by SC- HCC database, 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 targeted catchment area in the past year	Planned	**0**	**N/A**		102	166	
		Achieved				**102**	**166**	
			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**	
	Number of HCCs analysing status on MNCH services using the community score card in the past year	Planned	**0%**			**102**	**166**	
		Achieved				102	**166**	
			Source:					
			Community Score Card Report, RHC data analysis reports, 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 targeted catchment area in the past year	Planned	**0%**			**50%**	**80%**	
		Achieved				**67%**	**98%**	
			Source:					
			HCC complaints feedback register and quarterly 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				102	**166**	
			Source:					
			HCC complaints feedback database and quarterly 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 health governance on MNCH services in 166 communities HCCs (102 DFID, 64 EC) in 21 districts of Zimbabwe (14 DFID, 7 EC)	**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 qualified, No strike by the civil service.**
		Achieved				**102**	**166**	
			Source:					
			Minutes of meetings					
	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				**1**	**2**	
			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				**16**	**7**	
			Source					
			Data source: Advocacy strategy action plan, stakeholder mapping Project records (reports by the PEC and output tracker), 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**		**28**	**84**	
		Achieved				**29**	**76**	
			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 communities (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				7	**41**	
			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				**1**	**3**	
			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**	**0**	**1**	
		Achieved				**0**	**0**	
		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 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 difference 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								
4. Initial review of HMIS data shows that there are inaccuracies in the data. Our ability to measure the impact indicators will therefore be dependent on OPM and Crown Agents work to verify the accuracy of 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. 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							
	Indicators 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							

F.2 OPM verification of Save the Children logframe indicators

Where OPM has had access to the same data sources, we have conducted a verification of the impact and outcome indicators reported by Save the Children for 2016.

In doing so, we noted some disparities between the logframe indicators calculated by Save the Children and our own. In order to better understand the reasons for these differences, Save the Children have assisted us in providing information and data to support their calculations so that we can compare with our own.

The top level observations from this comparison are:

- The main reason for observed differences between OPM and SC estimates is that the SC team were not in many cases, able to access the complete data needed to calculate each indicator exactly as defined.
- This meant that for some indicators, the reference period used in the data did not align with the date of each indicator shown in the logframe, and the full sample of intervention-supported facilities was not available.

Our recommendation to the SC M&E team is to make it clear what data has been used to construct each indicator: including the time period and sample size used. We appreciate that there can be challenges around obtaining data when relying on secondary data sources, and therefore that the team sought to produce the best estimate they could with the available data. But any departures from the precise indicator definition and time period presented in the logframe should be thoroughly documented so that the indicators can be interpreted accordingly.

Table 123 Summary of logframe verification

					June 2016 estimate	
	Indicator	Data source	SC indicator calculation information	OPM verification possible?	SC	OPM
Impact Indicator 1	% Increase of births at target health facilities delivered by a skilled birth attendant in the past year greater than unsupported/control sites	Crown Agents	The June 2016 indicator value is constructed by calculating the percentage difference between treatment and control facilities between Q1 2016 and Q2 2014, and then subtracting the percentage point difference between Q2 2014 to Q4 2014. • This equates to comparing the difference between Q1 2016 and Q4 2014, expressed this as a percentage of the Q2 2014 figure. • **It is not the correct indicator as defined for the June 2015 – June 2016 period.** The correct time period would be to compare Q2 2016 with Q2 2015, expressed as a percentage of the Q2 2015 value. The sample for these indicators is 69 Treatment facilities and 70 Controls. The team were not able to identify all 166 intervention facilities in the data. • **There is a risk that the smaller sample used to calculate these indicators is not representative** of the full 166 intervention facilities, and that the selected control facilities do not form a suitable comparison group.	OPM is not able to verify this indicator as we did not collect data on skilled delivery.	14%	
Impact Indicator 2	% Increase of women who attended at least four antenatal care visits in target health facilities **in the past year** greater than unsupported/control sites	Crown Agents		No – we can only calculate this indicator over 6 months of endline data collection (January – June 2016) and 6 months of baseline data (January – June 2014). Therefore we cannot calculate this indicator in relation to the difference in the past year.	15%	
Impact Indicator 3	% Increase of children under one year that are fully immunised greater than unsupported/ control sites	Crown Agents		No – OPM only gathered data in respect of all children under 5, not children under 1 year.	29%	
Impact Indicator 4	Increase in number of new OPD cases seen **in the past year** within the targeted catchment population greater than control sites	Crown Agents		No – we can only calculate this indicator over 6 months of endline data collection (January – June 2016) and 6 months of baseline data (January – June 2014).	5%	
Impact Indicator 5	% point increase in output based disbursement to supported RHC greater than the unsupported/control facilities **in the past year**	Crown agents/ RBF database	The June 2016 figure is based on comparing Q1 2015 with Q3 2015. • This is **not the correct time period** to calculate the indicator for 2016. The correct time period would be to compare Q2 2016 with Q2 2015, expressed as a percentage of the Q2 2015 value. The sample used is 52 Treatment and Control sites. The team were not able to identify all 166 intervention facilities form the data, which is why the sample is smaller.	OPM estimate is based on comparing Q2 2016 with Q2 2015 in a sample of 142 comparison facilities and 150 intervention facilities. The sample is all facilities in which SCPH was implemented matched to control facilities using nihfa data (to try to ensure that the two groups are readily comparable in the absence of the intervention), and then linked to the RBF database.	5%	-18.39%

					June 2016 estimate	
	Indicator	Data source	SC indicator calculation information	OPM verification possible?	SC	OPM
			• Control sites were identified by attempting to identify the facilities in the OPM evaluation control group. Where these could not be identified, sites were chosen at random. • **As above, there is a risk that the sample chosen is not representative** of the full 166 intervention facilities, and that the selected control facilities are not comparable.	Some loss in sample from the full 166 intervention facilities occurred due to difficulties in successfully linking with the nihfa or RBF disbursement data.		
Outcome Indicator 1	% of formally recorded complaints in target facilities signed-off by the DHE/ RDC as fully addressed **in the past year**	District level feedback database, HCC Meeting minutes, District Level Advocacy Meeting		No. Though OPM did collect this indicator in respect of the facility level complaints database, the sample sizes of HCCs that kept a record of complaints and could present it to the survey team is too small to calculate this indicator using our data.	98%	
Outcome Indicator 2	% of community members (score card respondents) report satisfaction with quality of MNCH services provided in target facilities in the past year	Score card		No	missing	
Outcome Indicator 3	% increase in overall quality of care composite score of RHC HSF quality assessment in the past year compared to control sites	Crown Agents Report on Quality of Care indicators,	As far as we can tell, the June 2016 indicator was calculated based on average scores between Q1 2015 and Q3 2014. • This is **not the correct time period** to calculate the June 2016 indicator. The sample is 70 intervention facilities and 69 comparison facilities. • **As above, there is a risk that the sample chosen is not representative** of the full 166 intervention facilities, and that the selected control facilities are not comparable.	The OPM estimate is based on comparing Q2 2016 with Q2 2015 in a sample of 142 comparison facilities and 150 intervention facilities. The sample is all facilities in which SCPH was implemented matched to control facilities using nihfa data (to try to ensure that the two groups are readily comparable in the absence of the intervention), and then linked to the quality of care checklist data.	1%	0.42%

					June 2016 estimate	
	Indicator	Data source	SC indicator calculation information	OPM verification possible?	SC	OPM
				Some loss in sample from the full 166 intervention facilities occurred due to difficulties in successfully linking with the nihfa or quality of care checklist data.		

Annex G Health Facility Survey power / sample size calculations

G.1 Power / sample size calculations

From our sample size calculations, we determined that it was 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. After conducting these calculations, we added 10 facilities to our sample in order to mitigate the difficulty in some low volume facilities in obtaining the target sample size of ANC and U5 patients.

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

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 have been 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 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 important.

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

(performed prior to the baseline fieldwork) we assumed the ICC would be 0.05 and also included estimates for an ICC of 0.1 as a precautionary measure.

The below sample size calculations show the number of facilities that would be required assuming 10 and 20 exit interviews of each type per facility. Table 124 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 have needed a sample size of 570 facilities. Table 125 shows the same calculations for 20 exit interviews of each type per heath facility. Table 126 and Table 127 show the same calculations, assuming a very high ICC, which we included as a precautionary check.

Table 124 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 125 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 126 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 127 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. This is why we chose to increase the number of facilities from 60, as initially in our tender.

Table 128 shows the effect size that we would expect to detect by visiting 140 facilities for outcomes derived from exit interviews. The table shows that we are able to detect changes are that greater than 10 percentage points. This means that if the programme has an effect that that results

in less than a 10 percentage point change on an individual level outcome of interest, we cannot measure the effect as significantly different from zero.

Table 128 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 129 shows the effect size that we would expect to detect by visiting 140 facilities for outcomes derived from head of facility interviews or health centre committee interviews. The table shows that we are 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 cannot 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 more than doubled the number of health facilities sampled as compared with our tender to address this as much as possible.

Table 129 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 130 shows the effect size that we would expect 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). The table shows that we are able to detect changes are

that greater than 12 percentage points. This means that if the programme has an effect that that results in less than a 12 percentage point change on an individual level outcome of interest, we cannot disaggregate results by gender or wealthiest/poorest

Table 130 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 131 shows the effect size that that we would expect to detect by visiting 140 facilities for outcomes derived from exit interviews, where results are disaggregated into quintiles (for example wealth or age quintiles). The table shows that we are able to detect changes are that greater than 17 percentage points. This means that if the programme has an effect that that results in less than a 17 percentage point change on an individual level outcome of interest, we cannot disaggregate results by quintiles.

Table 131 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

Annex H Evaluation Ethical Considerations and Datasets

H.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.

H.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 I VFM framework

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	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	This allows us to conduct the analysis from a broader (societal) perspective—to understand not just the (financial) costs to DFID, but the

		Local wage data				Facilitators. We are still establishing for which types of volunteers Save the Children monitor numbers and time spent.	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	Without quantitative indictors, a qualitative assessment of economy allows something to be said for this domain.

						this information to be captured.	
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 not assessing impact on health outcomes.
		Key outcome indicator data from impact evaluation: e.g. number of additional deliveries by a skilled birth attendant; number of additional children immunised	As described in Section 3				
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,	
		Service utilisation data from impact evaluation	As described in Section 3				
		Data required for LiST modelling (e.g. population structure,	Default values in LiST				

		effectiveness of health interventions)				using standard assumptions about the effectiveness of the health interventions.	
Equity	Service utilisation, disaggregated by: Gender Age Poverty level	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)	Gender, age and poverty level are being collected in the user survey but we may not have enough power to disaggregate results. HMIS may be an alternative source of this but data quality has yet to be assessed.	This will allow us to assess the equity dimension of VFM—the extent to which benefits are distributed fairly.

Annex J Qualitative non-participant observation checklist

Facility observation checklist	
Section 1: Facility buildings and infrastructure	
Are the facility buildings in good repair?	
Is there is sufficient space for the patients who are waiting • Do all the waiting patients have somewhere to sit? • How many people (roughly) do not have somewhere to sit?	
Is there running water at the facility?	
Is there reliable power?	
Is there network signal at the facility?	
Section 2: Facility displays	
Is the Patients Charter displayed on the facility walls? • Is this in an area where it is visible to patients who are waiting? • Is it displayed in local languages as well as or instead of in English?	
Are graphs of MNCH outcomes presented on facility walls? (E.g. maternal mortality rate in the catchment area, immunisation rates etc.) • Is this in an area where it is visible to patients who are waiting?	

• Are the graphs for the current month? What date are they from?	
Please take a picture of the catchment area map on the wall in the facility.	
Section 3: The facility grounds and surroundings:	
Are the facility surroundings clean and presentable?	
Is there a suggestion box installed at the facility? • Where is it placed? • Please take a picture of it, showing where it is placed in relation to the facility buildings.	
Is there a mothers waiting home attached to the facility? • How many rooms does it have? • Is it clean and presentable? • Are there any waiting mothers staying there at the moment? • Do waiting mothers need to provide their own food, linen or anything else in order to stay there? What do they need to provide?	
Is there a fence surrounding the facility? • What condition is it in?	
Is there a security guard at the facility?	
What is the condition of the road to the facility? How accessible is the facility by road?	
Do you have any other observations about the facility and its surroundings?	

Annex K Qualitative informant interview and focus group question guides

K.1 Focus Group Discussions (FGDs)

FGD with HCC members

Material required: Flip chart, 20 stones, marker pens, note book and camera

Before starting, provide an introduction on why you are here and what you are trying to learn, capture the list of HCC members, including those that are not participating in your group discussion, including: their role; how long they have been involved; the community from which they come from; their gender; age, and; whether they are actually present in this FGD.

Moderator: Only have a discussion with the HCC members who are not part of the health centre. Members from the health centre will be interviewed separately.

Name	Role (e.g. secretariat, religious leader, etc.)	Year became member	Village (from where the person comes from)	Gender (M/F)	Age	Present in FGD (Y/N)

Roles and functions

1. How were you **selected to become an HCC**? What were the **reasons for deciding** to become a member?

2. Describe the **roles and responsibilities** of your committee?

3. Does your committee **carry out all of these roles and responsibilities**? List the activities and tasks that you as the committee have carried out in the last year?

4. Of these tasks you just mentioned which does your committee spend **most time carrying out?** Why?

    - *Moderator list all the activities they carried out, using a pile of 50 stones, ask the respondents to place these across the activities, go through most time spent carrying out the task, observe the discussion around how they place these and capture the final position of stones.*

Tasks carried out	Most time spent carrying out

5. **Have the tasks** you undertake as a committee **changed in the past year or two**? Why? Why not? How has this changed?

6. **How regularly** do you **meet**? **Where** does this meeting take place? Do you **keep minutes**? **When** was the **last time** you held a meeting? **What** did you **discuss** during this meeting?

Moderator and note taker following the FGD try to see the minutes of the meetings and note the type of issues covered and discussed by the HCC.

7. **Who are the people involved on health matters** in your community, ward, facility and district level that you engage with? How do you engage with them, how often? Are there **some** that are **easier to engage with than others?** Why? Does anything happen as a result? What? Can you provide examples? If nothing happens why not?

Moderator list all those actors that they mention, explore the nature of that interaction and challenges related to each and the purpose and outcome of these interactions.

Community engagement

8. How do you as **HCC engage** with the **communities**? **What do you do**? **Who** do you talk to? **How often**? Does the **entire community attend**? Why? Why not?

Moderator this is following from above so rather than repetition build on what you have learned so far. If you've already learned about this move to the next questions.

9. Are these **engagements useful?** Why? Why not?

10. Are there any **challenges in engaging with the community members?** Can you describe these? Why are these challenges there? What can you do to rectify them?

11. Do you think the community is **aware of you as an entity?** Why? Why not?

    - Has this **changed in the past two years**? Why? Why not?

12. Does the community **know you as the HCC?** Are there other possible ways in which they may know you? What are these?

Support and help

13. Does your committee receive any support or help from any group or organisation? Who from? And in what form? When was the last time you received this?

Moderator: probe for support from Government, health facilities, NGOs, Communities, also capture what support was provided, when?

14. Have you **received any training in the past two years**? If yes, who provided this training? For how long? What did you learn from this?

15. What were the **most useful things** you learned from this training? Where there **things that you were not clear about?** Or **things** that **could have been done better?**

16. Is your **HCC likely function without** the above mentioned **support**? Why? Why not?

Health planning and budget

17. Have you as a HCC been involved in planning and budgeting for health issues? How have you been involved? What inputs did you provide? What was the outcome of this? Do you think facility and district staff are able to make changes? How? If not, why not?

Moderator explore about their engagement with the community, Nurse in charge, District Health Executive

Thank you very much for all the very useful information you have provided? Do you have anything else you would like to add? Any questions you have for us?

FGD with health facility users

For this FGD we will use a participatory tool called institutional mapping. This tool will help us:

- understand the **importance and value attached by health facility users / non-users** to the key individuals and entities involved in health related issues in their community;
- to understand the **nature and significance of social connectedness/exclusion among users and non-users** with the above mentioned stakeholders in their communities; and
- to **understand the impact of programme on the users (non-users)**

Materials required: flip chart paper, pens, cards (circular, in three sizes); tape (to hold the circles down), camera (could be a smart phone camera)

Step-by-step guidance: After introducing the purpose of the evaluation/research and explaining your presence in the community, proceed broadly along the following steps, while using your own best judgement at all times.

Work in pairs with one facilitator and one note taker.

Step 1 - list formal and informal institutions

Begin by asking the community members to list the **important** individuals and institution involved in health related matters including: **related to promoting healthy behaviour**, **providing advice** or **treatment** (these are the individuals and entities that the community goes to and seeks help from), and **decision making related to health priorities** and **resource allocation** for their community.

Explain that these actors could be physically present in the area or could be associated directly or indirectly (such as district authorities) and could be individuals, groups, or organisations/institutions.

Ask the group to list the actors. Probe and make sure that they include both ***formal and informal institutions.*** Possible examples include (don't read out but continue probing who else/ anything else):

- Friends and family
- Traditional healers
- Chief
- Health Centre Committees
- Community monitors
- Health Learning Facilitators
- Environment health community nursing
- Ward Health Committees (WHC)
- Village Health Committees (VHC)
- Village Health Worker

- Nurse in Charge
- Councillor
- District hospital
- Private health facilities
- District Health Executive
- District Medical and Nurse Officers
- Religious leaders
- Teachers

Step 2 - determine importance

Next, introduce cards (circular) in three sizes (small, medium and large) and ask the analysts to write the name of each of those mentioned 'actor' on a card (if literacy is a problem you could use symbols), with the size of the card relating to the relative importance of that actor in their lives (i.e. large cards are most important and small cards least important).

Importance here means those that are **in a position to make decisions**, **help the community and the individuals on health related matters.**

Ensure that everyone participates in the discussion regarding the size of circle. Note also the basis for the analysts determining the relative importance.

Step 3 - determine social connectedness

Now working with your group draw a large circle on large sheet of paper to represent their community. Draw two rings inside the circle so that you have an 'archery target'. Place a small circle in the middle. This represents them as community members (this is the group within the focus group and not the entire population). Ask the analysts to put the cards representing actors onto the large circle drawn earlier that represents the community. The placement of the cards in relation to the archery target rings provides a scale of 1-3 representing *social distance* factors such as accessibility and cooperation/contact with these institutions.

Social connectedness/closeness means they are people that this group can:

- Reach when they have a problem
- They can rely and depend on
- They know will take care of them

For example, actors that are felt to be very inaccessible or not trusted should be placed farther away (on the outer ring or middle ring) than the actors that are felt to be very accessible and trusted (who would be placed on the inner ring). Emphasise that the ***distance*** of a paper disc from the circle that represents the village ***does not necessarily mean geographical distance***.

The actors can be related to each other through overlaps where these exist, through incorporation where one institution lies entirely within another, and through separate locations where there is no overlap. For example, actors with no or very little contact or cooperation should be placed farther apart from each other than those with closer contact or cooperation, which should overlap to some degree.

The analysts should change the position of the paper discs if desired (for example, after a second round of discussion) until they are happy with the diagram.

Step 4 - Analyse the Institutional map

Many aspects of the relationships between actors and community members can be explored using the institutional map (for example, power and influence, flows of money or information, social or cultural bonds or constraints, legal or institutional mandate, fear, mutually beneficial collaboration, altruism). Overall during the analysis it will be useful to ask:

- Ask for **reasons** as to why each stakeholder is **deemed important or not and the reasons** for where they place them on the diagram, why are they close? Why are they far?
- As part of the positioning of papers ask whether it has always been like this or **whether this has changed in the past year or two** and to ask as to reasons for this?
- Is the social connectedness and closeness of these different actors **different for different people in this community?** For which groups is it different? Why?

Moderator: you are exploring issues around power relations, religious background and level of welfare of the groups

Do ask questions to the whole group to encourage further analytical discussions and ask other questions around the evaluation themes:

Utilising (non-utilisation) health facilities

1. Do you or community members have **access to health services**? Do you use these facilities?
    a. If you don't use the services, what are the reasons? What can be done about this? Why? Why not?
    b. If you do use the services, are you happy with the services you receive or the way you are treated? Have you seen any changes to this in the past two years? In what ways? Why? Why not?

Rights, complaints and actions

2. Where do you get **information related to health issues and about services available** to your community? How often? How useful is this?
3. Are you ever **consulted or involved in decisions related to the health priorities** in this community? How? Who is involved? Does anything happen as a result? Why, why not? Is this useful?

4. Do you know whether as a patient at a health facility you **can expect anything** from the doctors and nurses, for example in terms of how they treat you, talk to you or more generally deal with you? What are these expectations? Where did you hear about these?

5. What do you do if these **expectations are not met**, or if you are unhappy about the way you or your community has been treated?

    a. If you do not do anything why is this the case?

    b. If you do something, what is the results of this? Why?

6. Have you or anyone else in your community ever **tried to improve or influence the services provided to your community?**

    c. How? What happened? Who was involved? When was this? Where did you go? What was the result?

    d. If not, why not?

FGD with opinion leaders

Who: we are interested in the leaders of the community that are involved in decisions related to health issues in the community, these could include the chief, village health worker, teachers, traditional birth attendance, religious leaders and others who may be members of existing group

Moderator: if this includes HCC members you have already interviewed, exclude these individuals from the group

Using social mapping
Objectives:

- to understand the **important infrastructure and social assets** within the community;
- to understand **perceptions of the characteristics of the different groups of people** in terms of **wellbeing in the community**;
- to **understand access to health related issues** including, information, decisions and access and whether there are variations across the community; and
- to prompt broader discussion on all other research questions.

Materials: flip chart paper, pens, recorder and camera

Step-by-step guidance: After introducing the purpose of the research and explaining your presence in the community, proceed broadly along the following steps, while using your own best judgement at all times. Work in pairs with one facilitator and one note taker.

Step 1 - Draw the map

Working with your group first decide *what area the map will show in relation to the 'community'.* This may be the health catchment area or just the specific village. **Social maps begin as physical maps of the residential area of a community**.

Ask the local analysts to *start by preparing the outline or boundary of the map*. Another option is to ask the analysts to draw a simple map showing some features such as roads, paths, and watercourses for orientation. **Starting with the main road sometimes facilitates the process**.

Ask the analysts to ***identify and draw on the map other institutions and landmarks*** that are important to them. This could include main markets, fields, schools, health centres, bus depots, NGO offices, child care centres, the house of community elders, etc.

Once completed then *ask for the* ***location of the different communities in the catchment area*** and ask the analysts to mark each as a small empty square. Try and explore about different well-being categories across communities *(such as rich, better-off, poor, and very poor).*

Explore whether some of the communities have particularly different social categories or ethnicity than others. Ensure that the criteria used by local analysts to distinguish different well-being criteria are noted on the map and that they all have the same understanding of the criteria and characteristics.

Step 2 - Analyse the Social Map

As the map is being produced (or perhaps once it has been completed), facilitate a group discussion to explore the following areas and ask prompting questions to encourage analytical discussions around the research themes. Probe for further explanations (always ask Why and How) and examine differences between various social groups. In particular:

- Ask about the community **poverty profile including: Income streams-livelihood strategies**;
- Ask about where they **access health from both within the community and outside**? How long it takes to get there, how they get there. If inside the community where in the map are the individuals or facilities, can everyone access them?
- Ask about patterns: Are there **particular household types or distinct social, ethnic or religious groups with different access to resources, assets, income and power?** Which groups are in wealthier than others and why?
- Ask about trends in the community: has the **health situation** of the community changed? Or has the **distribution of wealth** changed in recent years? If so, why? If not, why not?

Once done then ask the following groups of questions

Utilising (non-utilisation) health facilities

1. Do you or community members have access to health clinics or health volunteers? Do you use these facilities?

    a. If your community does not use the services, what are the reasons? What can be done about this? Why? Why not? Has this changed at all in the past year? Why? Why not?

    b. If your community does use the services, are you happy with the services you receive or the way you are treated? Have you seen any changes to this in the past two years? In what ways? Why? Why not?

2. Is this different for the different groups we just talked about? Is it different for the poorer households compared to better off? Is it different for people from different religious groups? Do they use the same facilities? Why? Why not?

3. Overall has there been any change in your community's use of health facilities in the past two years? Why?

Rights, complaints and actions

4. Where do you get information related to health issues and about services available to your community? How often? How useful is this?

    a. Does this reach the entire community? Are there parts of your community that have less access than others? Why?

5. Are you ever consulted or involved in decisions related to the health priorities in this community? How? Who is involved? Does anything happen as a result? Why, why not? Do you find this consultation useful? If yes, how does it help your community?

6. Do you know whether as a patient at a health facility you can expect anything from the doctors and nurses, for example in terms of how they treat you, talk to you or more generally deal with you? What are these expectations? Where did you hear about these?

7. What do you do if these expectations are not met, or if you are unhappy about the way you or your community has been treated?

    a. If you do not do anything why is this the case?

   b. If you do something, what is the results of this? Why?

8. Have you or anyone else in your community ever tried to complain about, improve or influence the services provided to your community?

   a. How? What happened? Who was involved? When was this? Where did you go? What was the result?

   b. If not, why not?

   c. Does it matter, who makes a complaint? Or takes an issue forward? How? Why?

9. Do you have any groups or committees that work on health issues? What are these? What do they do? Do they function well? Why? Why not?

Step 3 - Conclude

Bring the discussion to an end. Ask participants if anything has been left out? Or if they have any other suggestions or recommendation. If not ask what the participants have learned from their analysis. Thank them for their time and conclude.

K.2 Interviews

Interviews with the Provincial Engagement Coordinator

Role and functions

1. How long were you part of the programme?
2. What are the main activities that your role consists of?
3. Can you tell me a bit about your engagement with the community volunteers (HCC members, CMs and HLFs) working on the SCPH project? Did you provide them with training? How do you meet with them? How often?
    - Are there any facilities in this province that you have not been able to engage with this year? How many?
4. What do you do when you meet with these volunteers? In what ways do you try to support them?
5. Have you provided any supervisory work too? What elements do you check for when you supervise them?
6. Do you participate in any meetings with the DHE? When was the last time you met with the DHE? What did you discuss that time? Which people were at that meeting?

Performance of the programme

7. When you visit CMs working on this project, are there any aspects of their role where you have felt that they have needed more support and supervision compared to others? What were these?
8. When you visit HLFs working on this project, are there any aspects of their role where you have felt that they have needed more support and supervision compared to others? What were these?
9. When you visit HCC members working on this project, are there any aspects of their role where you have felt that they have needed more support and supervision compared to others? What were these?

Training

10. Did you receive training in your roles and responsibilities? When was that held? Was the training useful in helping you to understand your role?
11. Is there anything that could have made the training you received more useful? What?

Sustainability

12. In your opinion do you think that the interventions that the programmes supported will be sustained once the programme stops? Will the HCCs/CM/HLFs function? How about the meetings with DHEs?

13. [In Bulilima]. Are you still active in your role as a PEC?

    - How likely would you say it is that you are still active in your role in one year's time? What makes you say that?

Relevance

14. Are there any barriers that make it difficult for this programme to achieve its goals in this province? What are the main barriers?

Interviews with the Provincial Medical Officer and DNO

Patient complaints

1. Do you in the DHE/PHE hear of any complaints that patients have about health services in this province?
    - What are these complaints?
    - How do you get to hear about these complaints? Are these different for different complaints?
2. In the past 12 months, have there been any changes in the feedback you are hearing from patients in this district/ province?
    - Are there any complaints which you used to hear often, but don't hear much of anymore? What were these? Why do you think these changes have occurred?
    - Are there any complaints which you didn't used to hear about often, but now hear about more? What were these? Why do you think these changes have occurred?
    - Have there been any changes in the way that you get to hear of patient feedback? What were those changes?
3. What do you usually do when you have received a complaint? What happens if a complaint goes unaddressed?
4. Is there an example of a recent complaint or health issue that was discussed at the district/province level, which you were able to address?
    - What was the issue and how did you address it?
    - How did you communicate the action taken? Is there a mechanism to do so?
    - Was there any reward or recognition for being able to successfully resolve a problem? If yes, what?
5. Is there an example of a recent complaint or health issue that was discussed at the district/province level, which you were able to address?
    - What was the issue and how did you address it?
6. Is there an example of a recent complaint or health issue that was discussed at the district/province level that you were not able to address?
    - Why were you not able to resolve it?
    - What did you do next?
    - What are the repercussions of not being able to resolve a health issues - on you and on the people who raise these complaints?
7. How often do the HCC members meet with you? What do they meet with you for?
8. Is there a mechanism in place to inform district level staff/ facility level staff about the actions taken to respond to patient complaints?

- What is this mechanism?

Interaction with HCCs

9. What is your opinion about HCCs in this province? Would you say that they are functioning effectively or not functioning so effectively? Why?

    - Is there anything you think would need to change to make them more effective? What?

Interaction with SCPH

10. Before today, had you heard about the Strengthening Community Participation in Health programme? What is your opinion of the programme?

11. Are there any barriers that make it difficult for this programme to achieve its goals in this province? What are the main barriers?

12. When was the last time you met with project staff from SCPH? What did you discuss with them that time? Who was present at that meeting?

Relevance

13. Since this programme started operating in this province, have there been any major changes in the ways that the PHE interacts with the DHE, or with national level staff? What kinds of changes? Why? Why not?

14. What in your opinion is the biggest challenge for improving health services in the province/ district? How can this be overcome?

Interviews with health facility staff

Start by learning about the person you are interviewing, what is their role? How long have they been there?

Interaction with the HCC

1. Are you a member of the HCC in this facility? How long have you been an HCC member?
    - What is your role on the HCC?
    - Have the members of the HCC changed (grown or dropped out) in the time you have been a member? What were the reasons for these changes?
2. When was the last time the facility and the HCC had a meeting together?
    - Who was present at that meeting? Was this different from how it is normally? How?
3. Can you tell me a bit about the meetings that you have with the HCC?
    - Who sets the agenda for the meeting? If it is a fixed agenda, what is the agenda?
4. What did you discuss in the last meeting? Did you make any decisions?
5. Can you tell me how you came to that decision?
    - Did everyone have the same point of view about the issue?
    - If there was a difference in opinion, how was it resolved?
6. Do you find the HCC useful for the facility? What makes you say that?
7. Is there anything that you think would need to change in order for the HCCs to be more useful? What do you think would need to change?

Patient feedback

8. Do you hear of any suggestions, feedback or complaints from patients in the catchment area of this facility?
    - What are these complaints?
    - How do you normally get to hear of those complaints? Is this different for different complaints? Has this changed in the past year?
9. How likely do you think it is that the facility will still be using these ways of getting patient feedback in one year's time? In five years' time? Why?
10. Is there an example of a recent complaint or health issue that arose at this facility, which you were able to address?
    - What was the issue and how did you address it?

- How did you communicate the action taken? Is there a mechanism to do so?
- Was there any reward or recognition for being able to successfully resolve a problem? If yes, what?

11. Is there an example of a recent complaint or health issue that arose at this facility, which you were not able to address?
    - What was the issue and why were you not able to resolve it? What did you do next?
    - What are the repercussions of not being able to resolve a health issues - on you and on the people who raise these complaints?
12. What do you usually do when you have received a complaint? What happens if a complaint goes unaddressed?
13. Is there a mechanism to inform community members about decisions made at the facility? What is that mechanism? How useful is it? Why? Why not?

Operational plan

14. Do you have an operational plan for the current year?
    - Can you tell me a bit about how it was developed?
    - Who was consulted?
    - How did you decide what to prioritise this year?

Sustainability

15. How likely do you think it is that there will be a functioning HCC at this facility in one year's time? In five years' time? Why?
16. What in your opinion is the biggest challenge for improving health services in the district? How can this be overcome?
17. What in your opinion has been the programme's biggest success? Why?

Interviews with opinion leaders

Following introduction begin by learning about the informant's role in the community

Background

1. Tell me a little bit about yourself, what is your role in this community? What do you do, for how long have you been doing this?

Utilising (non-utilisation) health facilities

2. Does your community have access to health clinics? Do you use these facilities? Is this same for everyone within the community? How is it different? Why?

    a. If your community does not use the services, what are the reasons? What can be done about this? Why? Why not? Has this changed at all in the past year? Why? Why not?

    b. If your community does use the services, are they happy with the services they receive or the way they are treated? Have you seen any changes to this in the past two years? In what ways? Why? Why not?

3. Is this different for the different groups in your community for example the better or poorer households?? Is it different for people from different religious groups? Do they use the same facilities? Why? Why not?

4. Overall has there been any change in your community's use of health facilities in the past two years? Why?

5. In your community do you have a Village Health Worker? If not why not? If yes, what do they do? How useful is this to your community? Why? Why not?

6. Do you have any other individual, groups or committees that work on health issues? What are these? What do they do? Do they function well? Why? Why not?

7. Do you have any other health related projects or initiatives in your community? What do they do? How useful are they?

Rights, complaints and actions

8. Where does your community get information related to health issues and about services available to your community? How often? How useful is this?

    b. Does this reach the entire community? Are there parts of your community that have less access than others? Why?

9. Is your community ever consulted or involved in decisions related to the health priorities in this community? How? Who is involved? Does anything happen as a result? Why, why not? Do you find this consultation useful? If yes, how does it help your community?

10. Do you know whether as a patient at a health facility your community members can expect anything from the doctors and nurses, for example in terms of how they treat them, talk to them or more generally deal with them? What are these expectations? Where did your community hear about these?

11. What does your community do if these expectations are not met, or if your community is unhappy about the way it has been treated?

    c. If your community does not do anything why is this the case?

    d. If it does something, what is the results of this? Why?

12. Have you or anyone else in your community ever tried to complain about, improve or influence the services provided to your community?

    d. How? What happened? Who was involved? When was this? Where did you (they) go? What was the result?

    e. If not, why not?

    f. Does it matter, who makes a complaint? Or takes an issue forward? How? Why?

Interviews with HCC chairperson

HCC membership and formation

1. When was this HCC formed? How long have you been the Chairperson of the HCC?

2. How many members do you have on the HCC? Can you tell me a bit about how HCC members are appointed? Which kinds of people are nominated to be a member of the HCC? Which people get to decide or vote on who is chosen? How often are HCC members replaced?

3. When the HCC meets together, do all members normally attend? Are there any members who normally take the lead in the discussions you have or decisions that you make? Who are they? Are there any members that contribute less to the discussions that you have, or decisions that you make? Who are they?

Decision making and interaction with facility staff

4. When was the last time the facility and the HCC had a meeting together?

    - Who was present at that meeting?

5. Can you tell me a bit about the meetings that you have with health facility staff?

    - What is the format of the meeting?
    - Who sets the agenda for the meeting?

6. What did you discuss in the last meeting? Did you make any decisions?

7. Can you tell me how you came to that decision?

    - Did everyone have the same point of view about the issue?
    - If there was a difference in opinion, how was it resolved?

8. Is there an operational plan at this facility? Which people worked on developing this?

Interviewer: probe to find all the people who were consulted in developing the operational plan. DHE members, NGOs, CMs, HLFs, VHWs, community members?

9. Was the community consulted in developing the operational plan? Which members were consulted? In what ways were they consulted?

10. Are there any barriers that prevent the HCC from contributing to decisions made at the facility? What are they?

11. Do you face any challenges in your interactions with facility staff? What about with other stakeholders who you work with?

    - Do you think there is anything that could change to improve the HCCs interactions with these stakeholders?

Monitoring visits to facilities

12. Do HCC members visit the facility for monitoring?

    - When was the last time someone visited the facility for monitoring?
    - What did you check for when you visited? How do you decide what to check for?

13. How do you provide feedback to the health facility after a monitoring visit?

    - Can you tell me a bit about the last time you provided feedback after monitoring the facility? Who did you speak to and what happened as a result?

14. Do you face any challenges in monitoring the health facility? What are they?

Interviewer: probe to find out if the task is clear, if there are difficulties around interfering with the normal workings of the facility, if facility staff are receptive to hearing feedback?

Relevance

15. Have there been any changes in the role that the HCC performs in the past 12 months?

    - What were those changes and who decided on them?

16. Have there been any changes in the support that the HCC receives to carry out its functions in the past 12 months?

    - What were those changes and why?

17. What are the main challenges that you as an HCC face in carrying out your functions?

Sustainability

18. How likely do you think it is that there will be a functioning HCC at this facility in one year's time? In five 'time? Why?

19. How likely do you think it is that the facility will still be using these ways of getting patient feedback in one years' time? In five years' time? Why?

Interviews with community monitors and health literacy facilitators

Start by getting some further information on the background of the interviewee.

Moderator: Note that this person is likely to be a VHW who undertakes HLF and CM activities as some of its functions.

Role and functions

1. How long have you been a ….? Why did you choose to become a ….?

2. What are the main activities that your role consists of?

Community meetings

3. How often do you normally hold meetings with the community?

4. How do you normally inform people that the meeting is happening?

5. Can you tell me a bit about what normally happens during these meetings?

    - What is the format?
    - What do you discuss?

6. When you hold these meetings, what kind of people normally attend?

    - Do the same people come to meetings each time or do you notice that different people come each time?
    - Are there any groups of people who you feel are excluded from these meetings? Why is that? Could anything be done to help include them?

7. When you meet with the community, to what extent do you feel that people actively participate in the discussions and speak out?

    - What kind of people are normally the ones who speak out and participate? Does everyone participate equally or are there some people who speak up more than others?
    - Are there any groups of people who you feel are not comfortable to speak up? Why is that? Could anything be done to help encourage them to participate?

8. Do you think there are any barriers that prevent community members from coming to the meetings that you hold? What are they?

9. Do you think there are any barriers that prevent people from honestly speaking out during meetings about issues that affect them or suggestions they have? What are they?

Sharing feedback

10. [To CMs]: when you have completed a community scorecard, what do you do with the information?

11. Do you meet with HCC members to discuss health issues in the community? How often would you say you meet with them? What do you discuss when you meet?

Support and training

12. Did you receive training in your roles and responsibilities?

    - When was that held?
    - Was the training useful in helping you to understand your role?
    - Is there anything that would have made it more useful?

13. Do you receive any support or help from anyone? Who from? And in what form? When was the last time you received this?

Sustainability

14. Do you have another job or role that you play in this community, apart from being an HLF/ CM? What role is that?

15. [In Bulilima]. Are you still active in your role as a CM/HLF?

16. How likely would you say it is that you are still active in your role in one year's time? What makes you say that?

Relevance

17. In the time since you started working as a CM/ HLF, have there been any major changes in what you do in your role?

    - What were those changes?
    - Do you know who decided on the changes?
    - Why?

18. Are there any barriers that you face in carrying out your role? What are those barriers?

Interviews with the VHW

Role and functions

1. How long have you had this role as a VHW? Why did you become a VHW? Do you also have any other roles in this community? What are they?

2. What are the main activities that your role consists of?

Community engagement

3. If you hold meetings with the community, where do you hold these meetings? How community members are informed that a meeting is happening?

4. Who can attend such meetings? Are these open to any community members or to specific groups?

5. What do you generally discuss during these meetings? What did you discuss the last time you had a meeting?

6. When you meet with the community, do you notice that the same kinds of people come each time, or do different people come each time? Do you notice that both men and women come, or is it mainly men, or mainly women?

7. Are there some groups who do not usually come to the meetings that you hold? Why is that?

Livelihoods in the community

8. What are the main livelihoods activities that people do in this community to make money or access food? Have people's activities changed at all in the last two years?

9. Are there any particular household types or distinct social, ethnic or religious groups with different access to resources in this community? That includes assets, income or power. Which groups are wealthier than others?

10. Has the distribution of wealth in the community changed in recent years? Why is that?

Utilising (non-utilisation) health facilities

11. Are there any groups who do not normally use health facilities when they need healthcare? Who are these groups? What are the barriers that prevent these people from using health facilities?

12. Overall has there been any changes in the use of health facilities in this community in the past two years? Why?

13. Are there any members who you, the VHWs in this community, are not able to reach or who do not come to the meetings that you hold? Who are these groups? What are the reasons for this?

Role in decision making

14. Do you meet with other community volunteers in health in this community? Who do you meet with? How often do you meet together? What do you discuss?

15. Do you meet with HCC members to discuss health issues in the community? How often would you say you meet with them? What do you discuss when you meet?

Interviews with facility users

Start by learning about the person, their background, family, livelihoods, how long they have been in this community? The reasons for using the facilities?

Use of health services and satisfaction

1. If you need to seek treatment for your health, what are the sources or people that you would normally use? Which of these sources do you see as the most important in providing your healthcare? Why is that?

2. In the past 2 years have there been any changes in which sources of healthcare you feel are most important to you? Have the sources of healthcare that you normally use changed at all? What was the change? Why is that?

3. Are there any barriers that ever prevent you from accessing a healthcare provider when you need one? What are those barriers?

4. Overall, are you happy with the services you receive or the way you are treated? Have you seen any changes to this in the past two years? In what ways? Why? Why not?

Engagement with HCC and community health workers

5. Are there any groups, people, or committees in this community who are working to improve the health of the community? This means by helping to make decisions about healthcare, helping to improve the health facility, or holding community meetings to spread health messages? Who are those groups or people?

6. Have you ever attended a community meeting to discuss health issues?

    a. If yes, who were the people that held the meeting and what was discussed? Did you find it useful?

    b. If no, why not?

Rights, complaints and actions

7. Where do you get information related to health issues and about services available to your community? How often? How useful is this?

8. Are you ever consulted or involved in decisions related to the health priorities in this community? How? Who is involved? Does anything happen as a result? Why, why not? Is this useful?

9. Do you know whether as a patient at a health facility you can expect anything from the doctors and nurses, for example in terms of how they treat you, talk to you or more generally deal with you? What are these expectations? Where did you hear about these?

10. In the past year, have you ever been unsatisfied with the services you received at this facility or with the quality of healthcare in your community?

    a. What were you unsatisfied with?

    b. Did you do anything about it?

i. What did you do, and what happened next?

ii. If not, what was the reason for not mentioning your complaint to anyone?

11. Have you or anyone else in your community ever tried to improve or influence the services provided to your community?

    a. How? What happened? Who was involved? When was this? Where did you go? What was the result?

    b. If not, why not?

Interviews with facility non-users

Start by learning about the person, their background, family, livelihoods, how long they have been in this community?

Use of health services and satisfaction

1. If you need to seek treatment for your health, what are the sources or people that you would normally use? Which of these sources do you see as the most important in providing your healthcare? Why is that?

2. In the past 2 years have there been any changes in which sources of healthcare you feel are most important to you? Have the sources of healthcare that you normally use changed at all? What was the change? Why is that?

3. Are there any barriers that ever prevent you from accessing health facilities? What are those barriers? Are there any other reasons why you don't normally use health facilities?

Engagement with HCC and community health workers

4. Are there any groups, people, or committees in this community who are working to improve the health of the community? This means by helping to make decisions about healthcare, helping to improve the health facility, or holding community meetings to spread health messages? Who are those groups or people?

5. Have you ever attended a community meeting to discuss health issues?

    a. If yes, who were the people that held the meeting and what was discussed? Did you find it useful?

    b. If no, why not?

Rights, complaints and actions

6. Where do you get information related to health issues and about services available to your community? How often? How useful is this?

7. Are you ever consulted or involved in decisions related to the health priorities in this community? How? Who is involved? Does anything happen as a result? Why, why not? Is this useful?

8. In the past year, have you ever been unsatisfied with the services you received at this facility or with the quality of healthcare in your community?

    a. What were you unsatisfied with?

    b. Did you do anything about it?

        i. What did you do, and what happened next?

        ii. If not, what was the reason for not mentioning your complaint to anyone?

9. Have you or anyone else in your community ever tried to improve or influence the services provided to your community?

    a. How? What happened? Who was involved? When was this? Where did you go? What was the result?

Annex L List of respondents for national-level interviews

Table 132 List of respondents for national-level interviews

List of respondents for national-level interviews		
Institution	**Role**	**Name**
MoHCC	Director, Policy and Planning, M&E	Dr Banda
Parliamentary Portfolio Committee	Chairperson	Dr Ruth Labode
CWGH	Monitoring and Evaluation Officer	Esther Sharara
Crown Agents	HDF-RBF-HRH Deputy team leader	Caroline Mubiara
Cordaid	Country Director	Arjanne Rietsema
UNICEF	Chief of Health and Nutrition	Nejmudin Bilal
UNICEF	Coordinator of HDF	Patricia Dankwa
Global Fund	M&E manager for Global Fund programme coordination unit	Davies Dhlakama
	Independent consultant and health economist	Shepherd Shamu
Source: OPM		