**Determinants of effectiveness and sustainability of a novel Community Health Workers programme in improving Mother and Child Health in Nigeria**

**PROJECT PHASE 2**

**IDI GUIDE-HEALTH WORKERS**

**IDI guide for Health workers aimed at testing theories S2, S3, S4**

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| **QUESTIONS** | **Logic behind questions** |
| **Introduction by Interviewer** |  |
| **Introduction by respondent**  For the tape, please introduce yourself, and describe your work/what you do? | This question is to get respondents talking |
| **S2- Improved staff motivation-**In the context of staff shortages and lack of material resources, if adequate numbers and mix of skilled health workers are recruited, deployed to health facilities (that have security men, comfortable accommodation, regular electricity and water supply and transportation for emergency referrals); and if health workers receive adequate equipment, supplies and consumables for their work and are regularly trained, supervised and rewarded for good performance (C), then health staff will feel motivated (i.e. appreciated and happy) to increase and maintain their performance (M) which is likely to lead to increased provision and utilisation of quality MCH services, ultimately contributing to improved service and health outcomes (O) | |
| **1a.** How long have you been in this facility? (if less than 4 years, ask where they were before)  **b.** What are your main tasks in this facility? Have these changed in any way in the last 4 years? If yes, how?  **c. What was your involvement with the SURE-P MCH project?** |  |
| **2a.** What motivates you to carry out your duties well?  Which of these (Motivators enumerated) were present during SURE-P? How did they make you feel then? How do feel now?  **b.** What about other staff; how did they feel during SURE-P; and how do they feel now?  **If poorly motivated or not motivated at all, probe for reasons (during SURE-P and now**)  **c.** In what other ways did your (i) facility and (ii) you ,benefit from SURE-P? How did these affect your motivation? How did these affect the motivation of other staff? | Probe for similarities/diffs across different staff cadres (midwives, nurses, CHEWs) |
| **3a.** How did the sudden stoppage of the SURE-P affect your motivation to work well, and why? (probe for specific examples)  Are you able to compare your motivation during SURE-P and now (no SURE-P). Please give examples.  **b**. What about the other staff; what can you tell us about their levels of motivation during SURE-P and now? | Checking for Mechanism |
| **4.** Some staffs say that adequate staff numbers; availability of equipment and supplies, and regular training and supervision make staff feel appreciated and motivated work well.  **a.** How do you feel about this?  **b.** Can you bring specific examples from your experience in this (or previous) facility?  **Prompts**  **i.** Clarify adequacy of numbers and mix of staff in facility and change over time (during and post SURE-P) and probe for effects on motivation.  **ii.** Probe for effect of availability of equipment/supplies on motivation  **iii.** Probe for effect of training and supervision on motivation | Checking for Mechanism |
| **5.** Reports suggest that motivated staff work better and this leads to improved service delivery and utilization  **a.** How does this compare to the situation in this facility? Please give examples | Checking for outcome |
| **6.** We have also read from other places that when improved delivery and utilisation of services are consistent; this will result in better health outcomes.  **a.** Can you tell us what the situation is in this facility? (probe along respondent’s responses) | Checking for outcome and for link between service delivery and better health outcomes |
| **S3- Health workers feeling safer to work-**In the context where health facilities or communities ensure employment of security men, erection of perimeter fences and availability of accommodation for health workers in the facility premises (C), then health workers are likely to feel safer and therefore willing to work (i.e. provide MCH services) during night hours (M), thus ensuring the provision of round the clock MCH services, and improved access to MCH services (O) | |
| **7.** Now, I will like us to discuss safety at work.  **a.** How secure do you feel in your facility presently and why?  **b.** What key safety issues do you think can ensure provision of round the clock services, and why? | Checking for Context |
| **8.** Our analysis suggests that a secure facility compound and availability of staff accommodation increases staff safety and preparedness to work at odd hours.  **a**. What do you feel about this?  **b.** How did the SURE-P affect your feeling of safety in this facility and why? | Checking for Mechanism |
| **9**. It is suggested that provision of round the clock services improve access to services by pregnant women.  **a.** How do you think these two are related?  **b.** What was your experience of this relationship during SURE-P?  **c**. What about presently? | Checking for Outcome |
| **S4-Implications of withdrawal of support -**In a context where basic support to health facilities (e.g. staff salaries, electricity, equipment and supplies etc.) is dependent on project funding, a sudden withdrawal of political and financial support to previously-funded MCH programme will limit availability of human and material resources (C), making health workers feel unappreciated and unsupported (M), resulting in low morale and distrust among health workers and reduced performance, which can ultimately constrain the sustained provision of MCH services (O) | |
| **10**. A common pattern in interviews with different staff groups is that nurses and midwives who work in health facilities previously supported by SURE-P programme feel demoralized after suspension of funds to the SURE-P.  **a.** What do you feel led to withdrawal of political and financial support to SURE-P?  **b.** How did this affect service delivery?  **c.** What has been your personal experience since the sudden withdrawal?  **d.** How does this compare with the experiences of other staffs? | Checking for context |
| **11.** We find from our analysis that health workers who are demoralised (unappreciated) also distrust government and are unhappy with the health system.  **a.** How does low staff morale affect trust in the health system in this facility?  **b.** From your experience, how does low staff morale and distrust in the government affect Performance? What about your colleagues? | Checking for outcome |
| **12.** Are there other things you think we need to know, to really understand how this programme worked here? |  |
| **HMIS** |  |
| 13 a.**We discovered from reports that facility were sometimes incomplete and poorly kept?**  1.Can you tell me how you manage data in your facility and what has been your experience?.  2. What challenges have you or other staff faced in collecting and summarizing data in this facility?  ( Probe for i) frequency of data summary; daily; weekly; monthly, ii) any particular staff dedicated to data management) iii) probe for healthworkers opinion of the number of variables to be collected on the HMIS form iv) how is data managed between out-going facility manager/staff and new ones?  b. **We have also observed from reports that data were more complete and better kept during SURE-P than before SURE-P.**  1. What was your experience of this during SURE-P?  2. What is the situation presently (post SURE-P)? |  |

**FGD GUIDE FOR SERVICE USERS**

**Adapted questions for Service Users aimed at testing theories D1, D3, D4**

| **Example questions and prompts for demand side theories** | **Logic behind the questions** |
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| Introduction by respondent | |
| For the tape, can you introduce yourself, and describe your work/what you do? | This question is to get respondents talking |
| **D1-Supporting women to access health care**  In the context of pregnant women’s inability to pay for transportation to health facilities, or for medicines and MCH services, if WDCs are mobilized and trained; and pregnant women are provided CCT; and if VHWs encourage and support women to attend MCH services **(C)**, then pregnant women will feel safer and confident to regularly attend health facilities **(M)**, thus leading to increased and sustained utilization of health facility-based MCH services (such as ANC, deliveries and postnatal care), and ultimately to better MCH service outcomes **(O)**. | |
| **Broader questions to establish/confirm common starting point about sub-theory**   * What makes it easierfor women to attend and use the MCH services that are available in health centers/hospitals? What makes it difficult for them to attend and use these services? And what are your reasons for saying so?   OR  What makes women feel safe and confident to attend and use................................? What makes them feel unsafe about attending and using (or not confident to attend and use)........................   * Do you think that ANC use (outcomes) have been the same for all type of women: disadvantaged groups, rural/urban (depending on location of facility, choose one), first users vs multiparous women, employed/full-time housewives * What makes you think so? * What makes you feel more confident to use services? | To get respondents talking about insight related to the information needs matrix |
| 1. Discussion with community members suggest that pregnant women feel more confident to access health services when they receive monetary incentives to attend the hospital/health centre. How does this compare to your experience of the situation in this locality?   **Prompts:**  - Probe for types of and availability financial incentives for supporting pregnant women (CCT registers). Any difference with other localities? Why?  - probe link between incentives and women’s confidence to use services  - Have there been any unexpected users /consequences of this service?  - In CCT cluster, we’ve seen this programme works differently in different places, and we have also seen that some women who were getting ANC somewhere else, moved here because they could get payments. What is it about this place that made this happen?  We’ve seen a high attendance of PNC in this facility, why do you think that happened? (your attendance, if the interviewee is a women)?  We’ve seen that a high number of women that came to ANC, still did not deliver in this facility, what do you think was the reason to use other facilities? Which facilities they went to? (explore whether they used private facilities or not and how this was linked to choosing to attend ANC here only due to payment or other circumstances like distance, complicated/rapid delivery, unplanned emergency)? | Questions 1-2 are introductory, to get respondents talking.  They also check context.  (availability of financial and non-financial incentives). |
| 1. Other evaluations suggest that being supported by VHWs to access services increases women’s confidence and persuades them to attend health facilities. Does this agree with your knowledge or experience of women’s attendance to health facilities in this locality? 2. What it is about VHW support that increases women’s confidence (trust) in attending the service? 3. How does VHW influence confidence? Ex. Information, rapport, nudging, practical support (transport, helping with other kids), mediator... | Questions 1-2 are introductory, to get respondents talking. They also check context. |
| 1. Some workers suggest that women who have good relationships with VHWs, use health facilities more regularly than other women. Does this reflect your experience of women’s utilization of facilities during the SURE-P programme? How is this different from other facilities that were not part of the programme? 2. Have the usage of health facilities been the same for different groups of women who have good relationships with VHW? (minority/ religion/ urban-rural/ uneducated/ employed, rapid/complicated delivery/emergency/ night/daylight delivery times etc) In what ways have they been different? | Checking mechanism and link between VHW support and utilization of services. |
| **D3-Distrust due to withdrawal of incentives**  In the context of on-going targeted programme to improve access to MCH services to vulnerable pregnant women from remote rural areas, the sudden withdrawal of monetary and non-monetary incentives to support pregnant women to attend the continuum of MCH care (C), will help generate distrust from these women to health workers and wider system, and demotivate pregnant women from attending health facilities (M), eventually leading to reduced utilization of available facility-based MCH services (O) | |
| **Broader questions to establish/confirm common starting point about sub-theory**   * What factors affect women’s trust in health workers and health system in general? | To get respondent s talking about insight related to the information needs matrix |
| 1) Discussions with pregnant women suggest that withdrawing monetary and non-monetary support from pregnant women make them lose faith in health workers and the health system. What do you know about the suspension of incentives to pregnant women in this community?  Prompts:   * What does trust in health workers mean for pregnant women? Also check meaning of trust in health system * Probe effects of suspension of incentives on trust? * Are there instances where suspension of incentives did not affect trust? Why? | Checking for context  Similar to question on sustainability of trust in health system |
| 2) We find from our analysis that pregnant women who distrust health workers and the wider health system stop attending the health facilities. In your opinion How does trust affect women’s attendance in this facility?  **Prompt:**   * Are there times when attendance decreased even when trust in health workers was high? What was the barrier in that example? | Checking outcome |
| 3) Reports from countries show that when many women stop attending hospitals, the overall utilization of services in the facility reduces. How does this information compare with utilization of services in this health facility?  **Prompt:**   * Probe examples of how non- and poor attendance affected overall service utilization in the facility * Check utilization register to see changes in service utilization | Checking outcome |
| **D4-Sustainability of trust in the health system**  In the context of improved staff attitude, upgraded health facilities and functioning WDCs achieved during implementation of the SURE-P programme, pregnant women who receive sustained financial and non-financial incentives to use MCH services **(C)**, are likely to develop and maintain a sense of improved trust (including confidence and satisfaction) with health facilities and staff **(M)**, ultimately leading to improved likelihood of repeated and regular utilisation of MCH services from these health facilities **(O)** | |
| **Broader questions to establish/confirm common starting point about sub-theory**   * What is the role of WDCs in the SURE-P programme? * How can WDCs become more functional for the benefit of pregnant women? | To get respondent s talking about insight related to the information needs matrix |
| 1. Literature shows that continuous and regular availability of incentives to pregnant women increases their trust in the health system. Is this your observation and experience?   Prompts:   * Clarify availability and continuity of incentives to pregnant women * Probe effectiveness of sustained incentives on women’s trust for health system. Any experiences to share? | Checking for context and mechanism |
| 1. Discussions with pregnant women show that apart from monetary incentives, improved staff attitudes increased women’s trust in health system. From your experience, what type of attitudes increase the trust of women? How do these improvements in staff attitudes (Probe for different attitudes mentioned) create and increase trust in the health system among women? | Checking for mechanism |
| 1. Discussion with pregnant women show that those who trust the health system are also likely to use health facilities repeatedly and regularly. Can we ask, how trust in the health system can be built among women? What is it about having trust in the health system that makes women use health facilities repeatedly and regularly?  * Probe for specific examples of how trust leads to repeated use of facilities | Checking outcome; and link between trust and repeated use of facilities |