# Appendix 1. Programme theories represented by Context (C) – Mechanism (M) – Outcome (O) Configurations

These configurations were theorised based on the first wave of data collection and tested with the data collected in the second wave of data collection.

Mechanisms are broken down into Resources and Reasoning<sup>28</sup>. Arrows indicate how a set of CMO is hypothesised to impact the context of another set of CMO.

Programme theories: In the community

### Social capital - Influence of the community

Women and their families rely on informal sources of information about health and socio-cultural traditions. They have little formal education on health and have not perceived a need for PPC. Community level events amongst women (and their families) create social cohesion and social capital – Shared decision making context (Context) Promoting PPC in community events

(Resource) – Influencing behaviours are adopted (Reasoning)

The information is more likely to generate

The information is more likely to generate changes in belief systems of individuals and communities (Outcome)

Critical mass of women within the community who believe in/attend for/are more aware of an accepted healthcare strategy (e.g. facility based delivery, ANC, PPC) so that is becomes the community "norm" (Context)

Women lean informally through their interactions with other women (Resource) and are motivated to behave similar ways (Reasoning)

All women in the community will then accept the healthcare strategy (Outcome)

Change in the belief system about the value of PPC amongst communities with a strong-shared bond creates a context for change amongst women and their families (Context) Information disseminated to other family members about benefits of PPC (Resource) may or may not generate a response such as "fear" in the key decision maker (Reasoning) May or may not positively affect or negatively alter gender relations within the family, which will determine the degree of support that women receive for attending the health facility for PPC (Outcome)

### Gender Roles / Postpartum family planning

Women are not empowered to take decisions about the healthcare that they receive (Context)

Acceptance from women will depend from the presence and/or agreement of the husband (Reasoning)

Women may or may not accept the care offered within a healthcare setting (Outcome)

There is widespread fear of the effects of FP amongst the community including men and wider family and community leaders. Women who wish to limit family size need to be given "permission" from the community before they will seek contraception (Context)

Interventions (Resource) that work to motivate community leaders to become involved (Reasoning)

Are more likely to be successful (Outcome)

#### Barriers to healthcare access

Women and their families do not believe that routine PPC is needed if they do not feel unwell – they face significant socio-cultural barriers to attending for care + fears about poor treatment from HFWs (Context). The risk-benefit analysis decision making across the whole family unit, of not attending for PPC weighted against the structural barriers to reaching (Reasoning) generated in response to the information provided through health promotion activities (Resource 1), including those related to care for their babies (e.g. vaccinations) when care is integrated (Resource 2)

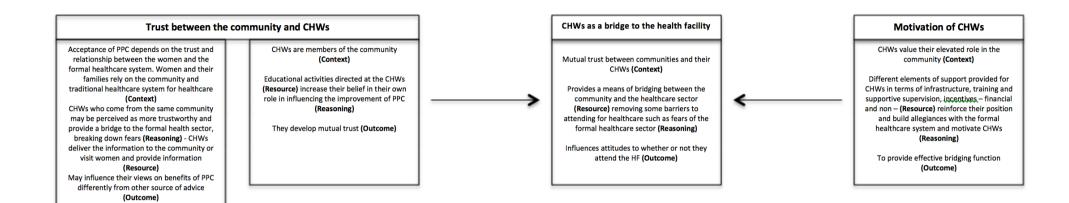
not for care (Outcome)

User fees and/or other financial costs of visiting HF (Context)

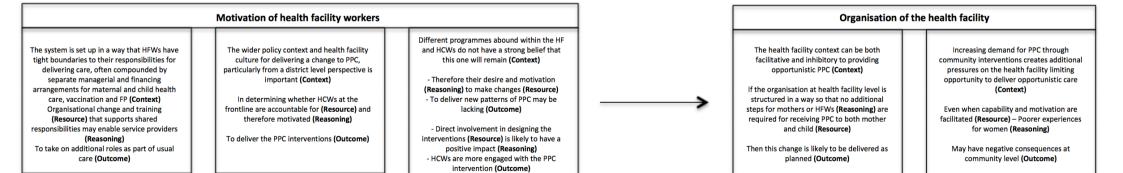
Is a major influence on whether interventions are effective (Resource) in motivating attendance for PPC (Reasoning).

Women may or may not go to the HF to receive PPC (Outcome)

## Programme theories: The link between the community and the health facility



Programme theories: In the health facility



## Programme theories: From the health facility towards sustainability

## Factors with an impact on sustainability

HFWs are not motivated or skilled to deliver PPC (Context)

Interventions increasing the quality of PPC provision (Resource) lead to more positive experiences for women (Reasoning)

Which further embeds the changed culture of attending for care through a shared community experience (Outcome) District facilities are responsible for training and supervision (Context)

Interventions that facilitate key members of the district to champion PPC (Resource) and develop a positive culture (Reasoning)

Influence motivation of HCWs at the frontline (Outcome)

Monitoring systems place emphasis on processes (Context)

Understanding the consequences of inaction or gaps in knowledge that have been associated with poorer postpartum outcomes through coaching and supervision (Resource), help HFWs (Reasoning)

To respond appropriately when they identify problems (Outcome)

HFWs do not feel motivated or empowered to provide emergency or routine PPC due to a range of health system constraints including lack of training and knowledge (Context)

- Training (Resource) may increase selfefficacy and enable the HCWs to obtain more iob satisfaction (Reasoning)
- Through delivery of comprehensive PPC, which in turn are more likely to become embedded (Outcome)
- However training (Resource) may also be perceived as an opportunity for financial reward (Reasoning)
- And not lead to improved behaviours and outcomes (Outcome)

Leadership for the change in the organisation of PPC from district and local facility levels is a key factor **(Context)** 

In whether HFWs feel enabled (Reasoning) to make the changes to PPC (Resource)

And whether these changes remain embedded in usual practice (Outcome)

## **Programme theory: Embeddedness**

The impact that MOMI intervention exert, and their potential sustainability depends on the strength with which they have been implemented and whether this has led to an embedded institutional shift at district level or above leading to their continuation independently from the project team.